Mr P. MacDermott
McCann & McCann Solicitors
Cathedral Terrace
19 Church Street
Belfast BT1 1PG

December 13 2004

Re: Research and background information for Insight: Vital Signs and Insight: When Hospitals Kill

Dear Pearse,

Further to our e-mail contact, please find enclosed the following:

:: a VHS copy of the Issue interview with Dr Henrietta Campbell, March 25 this year;
:: a transcript of that interview;
:: a transcript of an interview with Dr Campbell for the Raychel Ferguson programme last year – the tape containing this interview has been lost;
:: a platform piece in the Irish News by Dr Campbell;
:: e-mail communications between Trevor Birney and the Department of Health regarding that piece;
:: a later e-mail exchange between Trevor and the Department re Dr Campbell's knowledge of the death of Lucy Crawford;
:: the deposition of Dr John Jenkins for the inquest of Raychel Ferguson;
:: the medical report by Dr Jenkins for litigation over the death of Lucy Crawford;
:: a transcript of interview of Dr Jenkins by Trevor Birney for Insight: When Hospitals Kill on June 7 this year;
:: a transcript of a telephone conversation between Trevor Birney and Dr Jenkins on September 10 this year;
:: an e-mail from Dr Jenkins to Trevor early on September 13 this year.
:: a transcript of a telephone conversation between Trevor and Len Tyler (Royal College of Paediatrics) on September 13 this year
:: a transcript of Trevor's doorstepped interview with Dr Donncha Hanrahan on October 11 this year;
:: a transcript of Trevor's doorstepped interview with Dr Murray Quinn on September 25.

The transcripts are of variable quality but I shall provide you with tapes in due course.

Just to remind you: Dr Jenkins came to our attention because of his involvement in the cases of both Lucy Crawford and Raychel Ferguson. He is:
:: a consultant paediatrician at Antrim Area Hospital:
:: a lecturer in Child Health at Queen's University;
:: the Northern Ireland representative on the General Medical Council and a member of its ethics and education committees.

116

He was:
:: the Ireland officer for the Royal College of Paediatrics and Child Health at the time the college visited the Erne Hospital. Dr Moira Stewart, who is also a lecturer in Child Health at Queen's University, was one of the two doctors who conducted the visit or visits after Sperrin Lakeland Trust contacted the College. Dr Jenkins denies, though, having had any knowledge of the matter the College was investigating.

Dr Jenkins was also:
:: the medical expert commissioned by Sperrin Lakeland Trust to provide a report on the death of Lucy Crawford;
:: a key member of the hyponatraemia working group, set up after Raychel's death;
:: with Dr Bob Taylor, the co-author of a paper on the dangers of hyponatraemia which appeared in the Ulster Medical Journal after the group concluded its work.

We are unsure of exactly the nature of Dr Jenkins' role within the Department of Health, athough we do know that he was Dr Campbell's advisor on the issue of the deaths of these children

If you have any questions, please don't hesitate to get in contact. My numbers again are: [redacted](direct line); [redacted] (mobile) and [redacted]. My mobile is probably the best option.

In the meantime, keep well.

Yours,

Ruth O'Reilly

Ruth O'Reilly
Producer, Insight

NO TAPE AVAILABLE

INTERVIEW 17/02/03 HENRIETTA CAMPBELL – CHIEF MEDICAL OFFICER

Dr. Henrietta Campbell what were your concerns whenever you heard of the Rachel Ferguson case and what had actually occurred in Altnagelvin hospital?

Well of course the Health Service is committed to making people better. And whenever, well especially when a young child dies of course everyone is deeply concerned and there is a lot of anguish and concern about this case. And Altnagelvin immediately let me know what had happened, so we were desperately concerned to make sure that if any lessons could be learnt from this that we could put them in place and make sure that nothing like that would ever happen again.

What lessons do you think have to be learnt from the case of the death of Rachel Ferguson?

Well Northern Ireland is a very small place with a population of 1.5million people, when untoward and rare events happen we need to find a way of learning from them. Now they only happen every 5 years or every 10 years. It is very difficult for the service to learn from that to remember what happened to have a memory about those untoward events. And what this has shown to us is that together with the rest of the United Kingdom we need to take part very carefully and very clearly in the systems that are now being put in place to ensure patients safety. Northern Ireland is too small a place to learn of itself from these very rare events.

One of the things according to the paper work that we have seen that, use the word frustrated, the hospital administration of Altnagelvin was learning that in fact something similar had happened to a child in the Royal Victoria Hospital some years before. And that it hadn't that Altnagelvin hadn't learnt of that. Where you made aware of the incident at the Royal Victoria Hospital or was the Chief Medical Officer made aware that a child had died of hyponatremia then at that time.

In the Health Service in Northern Ireland over the last 10 years, I am not aware of any case of Hyponatremia in a normal healthy child. Of course it happens occasionally in very ill patients but we have never before seen it in a normal healthy child and that is was what was deeply concerning and made us realise that there was something we had to learn from this.

But Altnagelvin would say that there were lessons to be learnt out of the Royal Victoria Hospital case and that they were frustrated that they weren't aware of those, they weren't made aware of that case.

I think that the case you are referring to was a child who died about 7 years ago, but unfortunately for this case, had no direct ???? because it was an entirely different clinical situation. But what we do know now is that throughout the world there have been a number of these cases and certainly the evidence that was brought to the inquest showed

that it can happen, it happens very rarely but it has happened before. We didn't know that but we have now been able to put in place measures to help prevent it happening again.

So there is absolutely no direct correlation between the Royal Victoria case and the case of Rachel Ferguson at all?

From what I know of the clinical details the case 7 years ago was of a child who was already very ill and in ?????. And I think that is important to recognise that in this case, here we had a normal healthy child so therefore something had to be looked at, the case needed to be reviewed and they needed to consider what measures needed to be put into place in order to prevent that happening again.

So are we saying here that really, we can't expect a hospital, even a teaching hospital such as Altnagelvin to be aware of something such as Hyponatremia. That if a child goes in and it does happen in a very irregular basis and a highly irregular basis. But we still can't expect a hospital and the people within that hospital at Altnagelvin to be aware of Hyponatremia and be sensitive to the problems of a child at a post-operative situation such as Rachel Ferguson.

What we have recognised in the Health Service in the whole of the United Kingdom over recent years, is that by putting information together from every quarter of the United Kingdom, that we can learn from the rare event, the untoward events. Look for a pattern, see if it has happened before see if there are lessons to be learnt and then together the four countries of the United Kingdom put in place measures to prevent those things happening again. Northern Ireland as I have said is too small a place to effectively learn those lessons from rare events, so therefore we need to be part of a bigger picture. Joining with the rest of the United Kingdom in learning those lessons together.

So you have no concerns, just to absolutely categorical about this, given that the documentation that we have seen from the Altnagelvin hospital, you have absolutely no concern that you were not aware of the case at the Royal Victoria Hospital.

Sorry you asked me two questions.

You have no concerns at all that the information concerning the case at the Royal Victoria Hospital was not disseminated?

When we looked with the consultants from the Royal because we needed them in our review of Rachel's case, we needed their regional and specialist knowledge. When they set down with us to look at guidelines that we could put in place to prevent this thing happening in the future or ever again. When we looked with them from their specialist knowledge, they were able to bring to us lessons that they had learnt from that case, that entirely different case, that lessons which then could be read across which helped us to put in place guidelines which we feel will more effectively prevent this happening again.

After the death of Rachel Ferguson, the hospital itself carried out an investigation and you were involved as well at a different level. The public are maybe quite concerned about the self-regulatory aspect of this and that the hospital investigating itself. Should there not be in this day and age much more accountability in this and that there should be somebody from outside covering, especially when the parents of a child are concerned about what actually happened during the hours and days that this child was in hospital. That they feel even at this stage they still don't know what actually happened in that 3 or 4-day period, I mean that must be quite worrying for you?

We have been deeply concerned to make sure that the Health Service is a learning organisation. That the regulation of quality and standards is secure and effective and we have looked at ways in which this might be better and from April of this year the new arrangements under a document called Best Quality, Best Practice, Best Care new arrangements are now being put in place. Firstly to set standards so that clear standards are defined and put in place for the service and the other part of that is to make sure that we have systems in place which are liable standards to the inspector in order to ensure that those standards are being met. So as of April this year we will be putting in place measures, which will more effectively ensure that quality is at the forefront of all that we do. Up until now those systems for standard development and quality assurance have not been as good as they should be. We have recognised that, but as of April this year, we are moving to a much more systematic approach to ensuring firstly that standards can be developed and put in place but the service knows about them and on the other hand we have an independent inspectorial system which will make sure that those standards are being attired to. Now we would hope that through that we can have an organisation that learns together that puts in place effective measures which make sure that quality is at the forefront and that we can improve patient safety.

So tell me exactly how that would impact on the parents, another Ferguson family in the future. How will they feel that they are getting answers to the questions much quicker and much more clearly and much more accessible than the Ferguson family in this case have. Tell me exactly how they in that inspectorial nature that you talk about, how do they, how do a family actually get to the crux of what happened to their child much quicker as a result of those.

We don't need to wait for legislation for that to happen. I think the message that has been going over loudly and clearly to the Health Service in recent years, is that we must respond to patients concerns but there should be an openness and you know, a readiness to discuss issues of concern. And to make sure that all those questions are indeed answered. It is important that people feel that they can trust the mechanism's that are in place that they can trust the people with whom they are dealing with. And that the Health Service they recognise as something that is doing good is making things better and is moving towards better quality everyday.

So how are they going to get that, how are they going to feel like that? Where is the process of the mechanism that actually makes a family going to feel like that?

The process has to start at the local hospital, with the face to face of the patient or parents or carers with the staff who are involved and it is critical that that discussion, that openness begins right there.

In the immediate aftermath?

I think that it is important that if patients have concerns that those concerns are answered as soon as possible.

Lets just come to Hyponatremia itself are you saying that Hyponatremia is just a freak that it doesn't occur in 1 in 5000 it is more like 1 in a million. It is going to be seen here very rarely and that you wouldn't expect any surgeon or doctor coming through the Health Care System in Northern Ireland to be actually aware of it. And that if it did happen in a hospital tomorrow in Northern Ireland, that you wouldn't be sitting here the day after or a week after explaining a way why another child had died of Hyponatremia. What is to say that another doctor or another child won't die, another doctor won't spot it and another child won't die?

Ok in looking at Rachel's case and in looking at the literature at there was and in taking advice from those who had given expert advice to the inquest, it was clear that we needed to have guidelines in place that would help clinicians to recognise this early on. Recognising that it was a rare event and that any surgeon, any doctor might come across it only once or twice in their lifetime. It was important to have clear guidelines in place, which would raise a level of awareness about this condition and also help clinicians to deal with that, recognising that they would not have to deal with it often.

You would not expect any Clinician in Northern Ireland to be aware of Hyponatremia previous to this case. It is not something that is taught in medical school, Hyponatremia is not something that comes across in medical school?

Hyponatremia in an otherwise normal and healthy child was not something, which was brought for front to the knowledge or experience of clinicians within Northern Ireland. Now you will understand that in Northern Ireland we have quite a number of acute hospitals and therefore we have a lot of paediatric surgery being done outside the centre, outside the regional centre in Northern Ireland. Because those surgeons will be dealing with fewer cases each year, there might be the case in a regional centre or in some of the larger centres in other places in the UK. They will not therefore come across these cases very often in their lifetime. What we need is a learning organisation, a network of care, which reaches out throughout the service in Northern Ireland so that we can indeed learn from those very rare and untoward incidents.

A very senior paediatrician at the Royal Victoria Hospital told me this morning that he wouldn't expect a hospital such as Altnagelvin just to be waiting for information

to be disseminated but also he would be expecting it to be out there researching and examining. And he finds it quite surprising that Altnagelvin being a teaching hospital was not aware of Hyponatremia and as a result is coming to this conclusion at this point.

When we looked at the protocols that were in place throughout all our hospitals in Northern Ireland, it became quite clear that in order to prevent Hyponatremia ever happening that we would have to disseminate guidelines to the service so that they new what the early signs of Hyponatremia might be, how it might be prevented early on and to ensure that that would prevent a case happening again. By disseminating those guidelines drawn up by the profession for the profession we would hope that that information now in the public domain would prevent that ever happening again.

The family of Rachel Ferguson hear and understand that the guidelines that you have been inplacing solving at the inquest. The problem for them is that they feel at the time of Rachel's treatment in Altnagelvin hospital was much simpler than that. The fact that the child was vomiting and continued to vomit for 20/22 hours following her treatment and that their concerns were not listened to there and then. That is their concern that the child was vomiting there was coffee grinds there was obvious signs that the child was very unwell but yet that wasn't, their concerns were not listened to then. Can you understand the frustration of the family when they hear you are now saying that Hyponatremia is one, very very rare, the child was there and quite obviously sick and yet nothing was done then.

I mean for any parent and I am a mother of 3 children, I can understand how they feel. There is no doubt that the death of an otherwise normal and healthy child is very difficult. How could you ever come to terms with that? And it is because of that that we need to make sure that this would never happen again.

But how can you explain to that family that there hasn't been a cover up here, how can you give them confidence that the medical profession hasn't closed ranks and is trying now simply to explain away their daughters death?

In the particular case of Rachel it is not for me to do that that is a matter for Rachel's parents and Altnagelvin and I feel that Altnagelvin and Rachel's parents should come together and discuss those issues. Her parents deserve that sort of attention and I know that Altnagelvin would be willing and would want to reach out to those parents to share that information, so it is not for me to intervene. But as a parent I can empathise with how they feel and recognise that they will want to know exactly what happened.

And you are categoric in your statement of full confidence in the hospital with the way they have treated Rachel Ferguson giving your access to the papers that you have been able to witness and sit and view?

My job as Chief Medical Officer is to look at the issues for the population of Northern Ireland, to make sure that we learn from untoward events, that we learn from the

unexpected death. To look at that to see what measures can be put in place, throughout the Health Service in Northern Ireland, to see what can be done to improve care, to learn from the past. And in developing these guidelines with the medical profession and in disseminating these guidelines, that is a job for me to do. To make sure that as a region, as a Health Service within Northern Ireland, we are improving and using everything that we learn to make sure that the service improves.

And are you aware of the accusations, I am sure you are aware of the accusations as Chief Medical Officer that the medical profession is seen as something that does tend to close ranks and in times of accusations of malpractice or carelessness within the hospital ward. Are you sensitive to those and I mean how can you instil faith in someone especially within the Ferguson family and the wider public out there, that that does not occur here?

It is unforgivable if the medical profession close ranks it is not appropriate in today's world. We need to have a more open engagement with the public so that they can trust what we are doing, doctor's have been saying that, medical leaders have been saying that, there is no room today for the closing of ranks.

But there is nothing tomorrow for the Ferguson to actually investigate what actually happened. There is no apparatus there is no structure there is nothing for them to still to get the answers to the questions that they have. That is the concern and if there was another Ferguson family tomorrow there still isn't and there still won't be even after April. There still won't be any ability for anyone to actually bring their concerns whether it would be Health Ombudsman or whoever it is, there is still nothing in Northern Ireland for that to be done. And that is a concern is it not.

There is a Health Ombudsman Trevor which the Altnagelvin Trust in their discussion with the Ferguson family should make it quite clear to that family that the Ombudsman is there to take on their concerns, f they feel that the hospital has not adequately met them. There is a system in place for making sure that there is an independent appeal mechanism, Tom Frowley is now the Ombudsman, he is from, he has been the Chief Executive of the Western Area Health and Social Services Board. I can't see why the Ferguson family should not know about that, if they don't they need to be told immediately but if they feel dissatisfied with the conduct of the inquest or dissatisfied with how Altnagelvin handled this case that they can take that to the Ombudsman. An independent enquirer who can take up their case and look into it, it is there it is free it is open and can be comprehensive in the way that it tackles these issues.

And do you think that is the way anyone with any concerns about treatment of a relative or themselves should be going now?

It is important that frontline professionals and Health Service Staff open the discussion with parents, with carers with patients and an early debt and engage with people who feel that they have a complaint or that something has been done improperly. It is important in the first instance to explore fully those mechanisms' at local level. If you feel then that

you are still not happy or if you are dissatisfied about any aspect of that local enquiry then you should feel free to go to the Ombudsman to have that fully investigated.

Finally one of the Union Representatives in Derry has told us that he feels that he is representative of something like 800 members in Derry at Altnagelvin. He feels that the message he is getting from his members there within Altnagelvin is that while the Health Service is continuing under this pressure and that these sorts of things are going to happen. Does that worry you when you hear someone saying that?

There is no doubt that expectation not just from the public but also from Health Professionals and anyone working in the Health Service our expectations are very high. We want to make sure that the best service can be delivered, now that comes at a cost and it will means more resources into the Health Service to allow enough people to deliver quality care, enough resources there to make sure that diagnostic capabilities are there. And that the Health Service is resourced in a way that meets expectations of people.

As Chief Medical Officer when you hear that a family ends up at an inquest in which two of the surgeons who were in charge of examining and looking after their child, don't appear. One who was passed from giving evidence as a result of sitting exams the other who hadn't even contacted the hospital and the coroner had to seek out. Is that worrying when the medical profession treats, or seen to be treating the inquest system here with such contempt?

I don't obviously know the background or detail to that or who didn't turn up or why. But the inquest system within Northern Ireland is another way of bringing into the open issues, which are of concern, and it is one that I feel that people should have been using properly.

Could they have that faith of medical profession....?

Well I mean the Health Service professionals should also use that as a way, not of defending themselves but of making sure that everything that is at issue is in the public domain.

And to do so they have to turn up?

I don't know the detail or the inside of that Trevor that is the first I had heard that and you know, I can look into that for you if you want me to.

I would appreciate that thank you.

INTERVIEW WITH HENRIETTA CAMPBELL – ISSUE PROGRAMME

~~23rd MAY 2004~~

MARCH 25 2004

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 [illegible] 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.

ENDS

128

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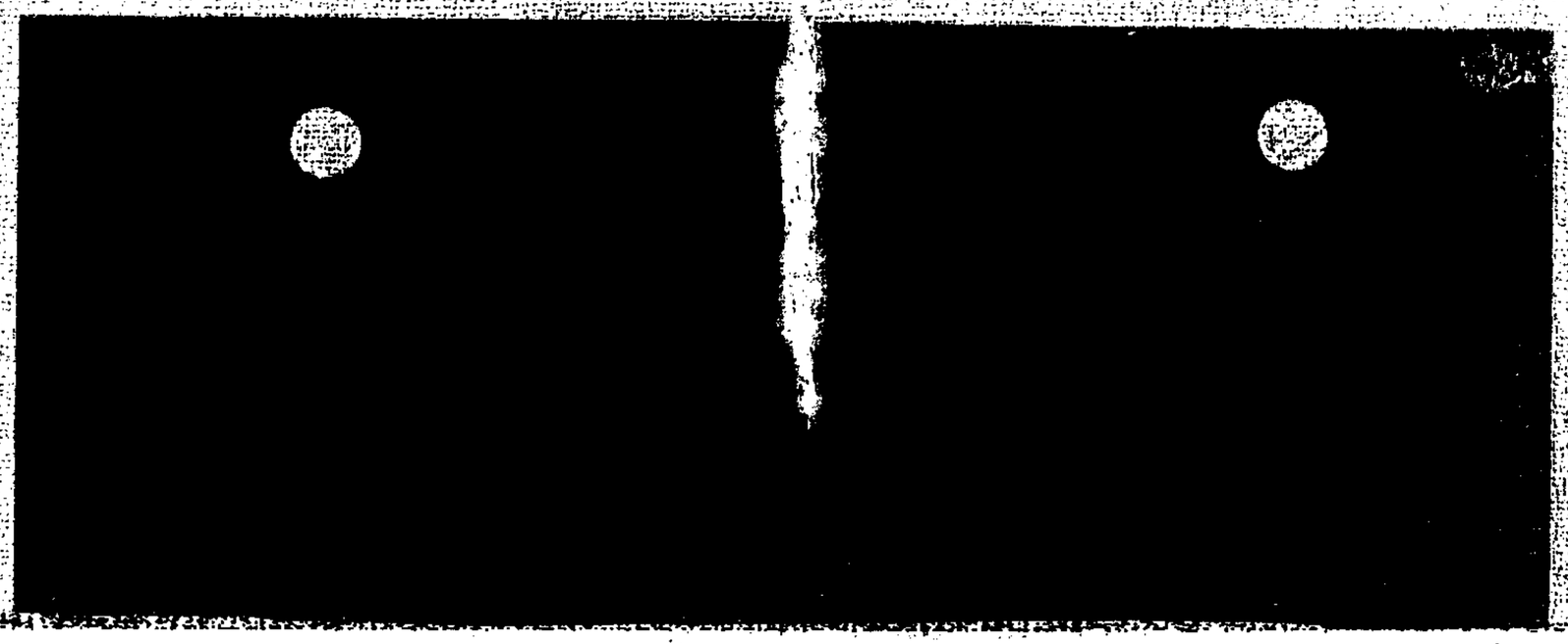
ENDS

129



Measures to prevent cases like baby Lucy's

PLATFORM

By Dr Henrietta Campbell
Chief Medical Officer
for Northern Ireland

Dr Campbell writes in response to a platform article in *the Irish News* earlier this week, by Denzil McDaniel, editor of the Impartial Reporter.

THE death of baby Lucy Crawford is a terrible tragedy and I would like to extend my deepest sympathy to Lucy's parents and family.

In events such as this it is important that the health service learns from what happened and that measures are put in place to prevent such a tragedy happening again.

Lucy's death was comprehensively investigated by the coroner and let there be no mistake, I fully accept his findings. In fact, the coroner referred Lucy's case to me as long ago as June 2001 and since that time I have been working in partnership with the coroner to ensure that measures are put in place to improve the quality of care in our paediatric units.

Lucy died from a medical condition called hyponatraemia, rightly recognised by the coroner as being brought about by the fluids used in her treatment. It is important to note that the fluids used in the treatment of Lucy have been in common use for more than 30 years in all paediatric units across the globe and have saved many young lives. However, it is now known that in some instances these fluids may put some children at risk of the potentially fatal condition called hyponatraemia.

Unfortunately, this condition was not widely recognised amongst health professionals across the UK at the time of Lucy's death.

Having been alerted by the coroner to this issue I convened an expert working group to develop guidance on the prevention of hyponatraemia. This guidance was published in 2002 providing practical advice for doctors and nurses who manage the care of children in hospital. Action is being taken to ensure its implementation throughout Northern Ireland. This guidance has been commended as the first of its kind in the UK and was praised by the coroner and by Dr Ed Sumner, an expert witness called by the coroner to Lucy's inquest.

While there is no doubt that the fluids administered to Lucy were a direct cause of her death, there is still a considerable debate among experts regarding the most appropriate intravenous fluid therapy for children.

Further research is needed in this area and recent medical literature highlights the debate surrounding fluid management in general and hyponatraemia in particular. As a result, I have engaged an international expert in paediatrics to work with this department to ensure that guidance can be kept up-to-date

My role as Chief Medical Officer is to provide advice to the minister and this department on measures to be taken to protect the health of the public. I also have a role to play in setting standards for the quality of medical care. However, I am not responsible or accountable for the delivery of services. Neither am I legally nor clinically accountable for the actions of individual doctors or consultants.

Lucy's death highlighted the need for a formal system to report to me, as the Chief Medical Officer, untoward deaths in hospitals. This is not a straightforward issue as there are 15,000 deaths each year in Northern Ireland, the majority of which occur in hospital.

Approximately 3,500 of all deaths each year are reported to the coroner.

Measures are being taken both by the coroner's office and by the health service to establish a system which will identify untoward deaths and allow early action to be taken.

As Denzil McDaniel pointed out in his article there is nothing which tugs at emotion quite as painfully as the death of a child. As a parent and as a doctor I fully recognise the anguish and pain of the Crawford family. While nothing can recompense for Lucy's death, the health service has an absolute responsibility to ensure that lessons are learned.

As for my part, as Chief Medical Officer, I will continue to work strenuously to play my part in ensuring that the standard of care for children in our hospitals can be assured.

12:

Statement 1: 12:46 Fri., May 21

Trevor

The sentence which you have asked for clarification on and comes from the
Chief Medical Officer should have read as follows -

**"The coroner wrote to me about Lucy Crawford's death on the 3rd March 2003.
He had previously been in discussion with me in June 2001 about the death of Raychel Ferguson who had also died of hyponatraemia."**

I hope this clears up the matter for you.

Kevin

Statement 2: 15:26. Friday, May 21:

Trevor,

Please disregard previous line I gave to you earlier today. The line below is the up-to-date one.

**"The coroner wrote to me about Lucy Crawford's death on the 3rd March 2003.
He had previously been in discussion with me about the death of Raychel Ferguson who had also died of hyponatraemia in June 2001 ."**

Kevin

131

Trevor Birney

From: Baxter, Clare [Clare.Baxter[redacted]
Sent: 13 October 2004 15:30
To: 'Trevor Birney'
Subject: RE: Lucy Crawford

Hi Trevor, here's the response to your question. Anything else let me know.

The Hyponatraemia Working Group was set up by the Chief Medical Officer to develop guidance on the prevention of hyponatraemia and not to consider the case of any specific child. At the time the Working Group was established the CMO was not aware of Lucy Crawford's death.

Clare

-----Original Message-----
om: Trevor Birney [mailto:tbirney[redacted]
Sent: 12 October 2004 19:14
To: clare.baxter[redacted]
Subject: Lucy Crawford

Clare,

Below is the question for the CMO as discussed.

As the Department is aware, we are currently working on an Insight programme examining the death of Lucy Crawford. We intend broadcasting it within the next few weeks.

In the meantime, you can contact me at [redacted] if you have any queries.

Question for Dr. Henrietta Campbell:

1. Was the Hyponatraemia Working Group, set up in June 2001, in any way lated to the death of Lucy Crawford?

I would appreciate a reply at your earliest convenience.

Best wishes,
Trevor.

Trevor Birney
Editor, Current Affairs
Ulster Television

Form 20

CORONERS ACT (NORTHERN IRELAND) 1959

Deposition of Witness taken on WEDNESDAY the 5th day of FEBRUARY 2003 at inquest touching the death of RAYCHEL FERGUSON, before me J L LECKEY Coroner for the District of GREATER BELFAST as follows to wit:-

The Deposition of DR JOHN GORDON JENKINS

of SCHOOL OF MEDICINE, QUEENS UNIVERSITY, BELFAST who being sworn upon his oath, saith

My name is John Gordon Jenkins and I am a Senior Lecturer in Child Health at Queen's University, Belfast. I have 20 years experience as a Consultant Paediatrician initially at the Waveney Hospital, Ballymena and subsequently at Antrim Hospital. I qualified in Medicine from Queens University, Belfast in 1974 and subsequently obtained my Doctorate with Honours in 1980. I became a member of the Royal College of Physicians of the United Kingdom by examination in 1977 and was elected to Fellowship of the Royal College of Physicians of Edinburgh in 1989. I became a founder fellow of the Royal College of Paediatrics and Child Health in 1997. This report has been prepared following review of photocopied material from the case notes relating to the admission of this girl to Altnagelvin Hospital in June 2001, together with other material.

Rachel was admitted with abdominal pain suggestive of acute appendicitis on 7.6.01 and subsequently underwent emergency appendicectomy. She was healthy and well with approximate weight 26 kgs and her preoperative blood investigations were normal (serum sodium 137 mmol/l). Post-operatively she was initially felt to be making good progress but had vomiting and headache. At approximately 03.00 on 9.6.01 she began to have severe seizure activity with further subsequent deterioration despite resuscitation and intensive care. She subsequently died and evidence on

CT scan and at post-mortem was consistent with the diagnosis of cerebral oedema related to hyponatraemia. Her sodium was found to be 119 at 03.30 on 9.6.01 with a repeat specimen at 4.30 giving a result of 118, associated with low levels of potassium and magnesium.

Solution 18 (0.18% saline with 4% dextrose) has been routinely used in Paediatric medical practice for a very long time and is rarely associated with any acute electrolyte disturbances such as were seen in this tragic case. However, this is largely related to the range of conditions commonly seen by Paediatricians and cared for within the medical (as opposed to surgical) environment. By and large these are not associated with the syndrome of inappropriate secretion of antiduretic hormone. It has become increasingly recognised in recent years that a regime utilising solution 18 may not provide the right balance of sodium and free water for children with some clinical conditions, and particularly where there is an increased likelihood of failure to excrete water. This would include situations of stress, pain and nausea, and may be particularly common in the post-operative period. It is the combination of excessive loss of sodium (for example in vomitus) with water retention (as a result of excessive secretion of antidiuretic hormone) which leads to a fall in the concentration of sodium in body fluids and increased risk of brain swelling (cerebral oedema).

This was well described in an editorial in the Journal "Paediatric Anaesthesia" in 1998 by Dr Arieff, but did not receive widespread publicity in journals likely to be read by most Paediatricians or Surgeons caring for children at that time. The potential dangers were highlighted to a wider clinical community in an article published in the British Medical Journal of 31.03.01 by Halberthal et al. However, this topic is not well covered in a number of standard paediatric texts. Most Paediatric Units were still using their traditional regimes based on solution 18 until further concerns were raised within Northern Ireland in September 2001 as a result of two deaths. Steps were taken to convene a Working Group who have subsequently prepared and distributed guidance on the prevention of hyponatraemia in children under cover of a letter from the Chief Medical

Officer dated 23rd March 2002. This highlights the danger of this condition and gives guidance as to how this can be minimised in clinical practice.
It seems that some individuals can develop this condition in circumstances which are clinically no more severe than those experienced by many patients in the post-operative period, but the reasons for this variation in susceptibility are currently not well understood. It has been suggested that females and children may be particularly at risk. It is for this reason that guidance has now been prepared and issued to increase awareness of this poorly recognised condition and to ensure that Units providing care for children take steps locally to introduce care pathways and / or fluid management regimes which take account of this possibility and minimise the risks of occurrence.

The deterioration in Raychel's condition occurred rapidly. The possibility of an electrolyte disturbance being the cause of the fit was considered by Dr Johnson and efforts made to obtain electrolyte results from the laboratory urgently. However, even by the time these became available her condition had further deteriorated and her pupils were found to be dilated and not reacting to light. (evidence that increased intracranial pressure due to cerebral oedema has already caused pressure damage within the brain.) Despite prompt resuscitation and further investigation and management this damage proved irreversible and led to her death.

Conclusion

Having carefully studied the statements provided by the doctors and nurses involved in Raychel's care my impression is that they acted in accordance with established custom and practice in the Unit at that time. Raychel's untimely death highlights the current situation whereby one sector of one sector of the medical profession can become aware of risks associated with particular disease processes or procedures through their own specialist communication channels, but where this is not more widely disseminated to colleagues in other specialities who may provide care for patients at risk from the relevant condition. In the circumstances relating to this incident,

it was only the tragic deaths of two children in Northern Ireland which alerted the wider clinical community to these concerns. These have subsequently been assessed and relevant guidance prepared and disseminated as outlined above.

TAKEN before me this 5TH DAY OF FEBRUARY 2003

Coroner for the District of Greater Belfast

136

MEDICAL REPORT NEVILLE & MAY CRAWFORD on behalf of
LUCY CRAWFORD (Deceased) -v- Sperrin Lakeland Health & Social Care Trust

Strictly Private and Confidential

Date of birth: 05.11.1998 **Date of report: 7.03.2002**
Date of death: 14.04.2000

This report has been prepared at the request of the Directorate of Legal Services, Central Services Agency and is based on material made available including hospital notes relating to admission of the child to Erne Hospital in November 1999 and April 2000. The first admission was for bronchiolitis and is not directly relevant to the problems which occurred during the subsequent admission in April 2000. At that time Lucy was admitted to hospital with a history of fever and vomiting for 36 hours associated with drowsiness for 12 hours. There was no history of cough and her chest was clear on examination. The history and clinical findings had been thought by the GP to suggest urinary tract infection but it was felt on admission that this was more likely to be a viral illness. Initial blood tests were performed and Dr Malik attempted to commence IV fluids but was unable to do so and so called Dr O'Donohoe (the Consultant Paediatrician). IV fluids were then commenced. The nursing notes record observations at 19.30, 22.30 and 23.30 during which time the high temperature gradually came down to 37.4.

There is then a gap in the observation sheet with no apparent entry until an episode of sudden collapse which occurred around 3.00 am. It appears that mother called nursing staff as Lucy had passed diarrhoea and then become rigid. Dr Malik was called and felt that this could be a febrile convulsion so administered Diazepam. He discussed the case with Dr O'Donohoe who then came directly to hospital arriving at 3.20 am. At around this time Lucy's condition further deteriorated as she stopped breathing and required respiratory support.. The on-call Anaesthetist was called at 3.40 am and Dr Auterson arrived shortly after 3.50 am and assisted with the resuscitation including intubation and transfer to the Intensive Care Unit prior to stabilisation and transfer to the Paediatric Intensive Care Unit in the Royal Belfast Hospital for Sick Children later on the same morning. The doctors involved seem clear that there was no episode of cardiac arrest or circulatory instability during this period but it was noted that the pupils became fixed and dilated and did not respond to ventilation or the administration of Mannitol.

Subsequently tests in Belfast revealed evidence of brain stem death and post mortem examination was performed. This showed bronchopneumonia and cerebral oedema with evidence of herniation of the brain. The Pathologist is unable to comment as to whether the bronchopneumonia had been present from admission to Erne Hospital or had occurred in association with the collapse and resuscitation. Further specimens have shown rotavirus infection suggesting that the initial admission was likely to be due to rotavirus gastroenteritis. Urine cultures showed no significant growth.

Strictly Private and Confidential

Comment

This child's admission to Erne Hospital was very typical of gastroenteritis in this age group. This is often associated with high temperature and vomiting with or without diarrhoea and young children can become very unwell. The standard treatment is to administer fluids either orally or (if there is significant dehydration or vomiting) by the intravenous route. The solution used is one which is commonly used in Paediatric practice to provide **maintenance** fluids in these circumstances as it replaces small amounts of electrolytes but also gives Dextrose which is required by young children who are unable to take calories orally during the acute phase of the illness. Initial physical findings were suggestive of poor peripheral circulation with delayed capillary refill time >2 seconds. The GP noted that the mucosae were moist but there is little specific detail in the admission note regarding evidence of dehydration. However, the urea was 9.9 which is slightly elevated suggesting a mild degree of dehydration but with normal electrolytes at that time. This would again be very typical of the condition and would not normally indicate anything other than appropriate fluid replacement with careful monitoring and nursing observation. However, in this situation the intravenous fluids for **replacement** should contain a higher content of sodium (eg "normal saline" - 0.9% NaCl - sodium chloride).

In these circumstances it is always very difficult to understand an episode of sudden collapse. Sudden onset of convulsions is most commonly due to high temperature in young children and this was considered. However, the features were not typical and the temperature had in fact improved since admission. It is unclear as to what alternative diagnoses were considered at this time but the blood test for electrolytes was appropriately repeated immediately. This showed a significant fall in sodium from 137 to 127 and in potassium from 4.1 to 2.5, together with an increase in glucose from 4.5 to 10.9. These changes do raise the question as to the fluid management in the period from insertion of the IV line at 2300 to the collapse at around 3.00 am. Unfortunately there appears to have been confusion between the staff involved as to the fluid regime ordered by the Consultant. In addition it is difficult to interpret the records made by nurses on the fluid balance chart and no totals have been calculated for this period. It will be most important to determine from the staff involved **exactly how much of each type of fluid** was given at each stage throughout this time period, and following the change of fluids to normal saline through until the child arrived in the Paediatric Intensive Care Unit in Belfast.

Other aspects of this tragic case demonstrate a rapid and effective response by the medical staff concerned. In particular both the Consultant Paediatrician and Consultant Anaesthetist appear to have been available within a very short time period of being called and to have done their best in the difficult circumstances involved in caring for a child of this age in an adult intensive care setting for stabilisation and transfer in the absence of a Paediatric transfer service in Northern Ireland.

Over recent years concerns have begun to be expressed regarding the use of 0.18% saline in Dextrose as a standard solution for intravenous use in young children and a number of cases of

symptomatic hyponatraemia have been identified, some resulting in death or cerebral damage. It has been suggested that a more appropriate solution would contain a higher level of sodium and this has recently been the subject of discussions involving the Department of Health, Social Services and Public Safety and production of guidelines. However, it must be emphasised that this is a very recent development and that many Paediatric Units are continuing to use the solution which was initially given in this case. Although the sodium level of 127 is not in itself usually associated with severe problems, it is likely to be the rate at which the sodium falls rather than the absolute level which can cause problems in this setting.

While no definite conclusions can be drawn regarding the cause of this child's deterioration and subsequent death, there is certainly a suggestion that this was associated with a rapid fall in sodium associated with intravenous fluid administration and causing hyponatraemia and cerebral oedema. In these circumstances successful defence of the case would depend on clear documentation regarding the fluid type and rate prescribed, together with clear records as to the exact volumes of each fluid which were in fact received by the child throughout the time period concerned. This is where I would anticipate great difficulty in achieving a successful defence as there appears to have been confusion between the staff involved with inadequate documentation and record keeping. In this respect, unless this can be clarified in a satisfactory manner, it is my opinion that management fell below the standard which would be accepted by a responsible body of medical opinion as reasonable practice at the relevant time.

Dr J G Jenkins MD FRCP FRCPCH
Senior Lecturer in Child Health and Consultant Paediatrician

139

DR JOHN JENKINS JUNE 7 2004

Well Doctor Jenkins we will begin asking you about the condition known as hyponatraemia and just what is your understanding or just of the condition and how it actually occurs.

Well Trevor hyponatraemia is a condition where there is an imbalance of salts in the body, the body has a lot of different salts but sodium is one of the most important ones and hyponatraemia simply means not enough sodium in the body now that can happen either because there isn't enough sodium or if there is too much water then that dilutes the sodium or it could be a combination of both of those.

So where do we see it and how does the condition normally arise.

It happens in lots of different conditions we would see it in our new born babies for example it's a normal process that they have to cope with sometimes after they are born if they have an illness and we would also see it in people who have had an operation because hormone levels change in the body and we can also see it in children who have conditions like gastro-enteritis where they're vomiting or losing sodium from they're gut in that type of problem.

So in Northern Ireland how many cases would we expect to see over the course of a year.

Its something which we would see on a daily basis in pediatric practice but it has to be said that most of those are not severe and most children respond very well normally just to extra oral fluids until the condition settles and they get better.

So how is it identified or is there awareness now in the wards in Northern Ireland or of it and how is it identified that a child is suffering from it.

Well we know that in any situation where a child is vomiting or is has abnormal loses in that sense it's a possibility so we would do a blood test a simple blood test will always tell us what the sodium level is in the blood and we can then take action if necessary to monitor that to correct that if its abnormal.

So there has been some discussion of it in Legal journals which we have already reflected on and whereas some of the deaths that have occurred in Northern Ireland over the last few years in one hand have been described as ……..or physiological while others say they're not that at all what is your view in all that in that debate.

Well I think first of all I have to say its complicated there's no simple black and white in this and that's been reflected within the pediatric community where its still very much an open subject even within the past month articles have been published arguing one way arguing the other way about this condition but I do think that its important recognize that different children indeed different adults will respond to a particular set of circumstances

in different ways and I have seen situations where children have had very severe abnormalities of hyponatraemia but who in fact have not suffered any complications as a result of that and have got better whereas we know that some children unfortunately seem to respond in similar circumstances by developing severe complications which can even lead to death.

So where do you come down the side of the debate are you coming down on the physiological side.

What I'm saying really is that different children can respond so even if appropriate fluids are given its still possible for some children to have a suppose you could say an abnormal response I wouldn't personally use the word idiosyncratic but I know what that term is being used to describe that some children will respond and develop complications where others would not now that's not to say that there may be circumstances where if an abnormal regime is prescribed or a problem arises then all children might develop complications in those circumstances.

Yes that's exactly the point if an appropriate clinical regime is implemented here whether its too much fluid or too much of the wrong fluid or whatever the fact is that a child could be is going to be more susceptible its nothing to do with this physiological or idiosyncratic make up.

Well this is something which we are increasingly recognizing and again I would have to say that its very much in the past few years that this has come to the attention of doctors we can look back and see evidence of this in the past but in most of our own personal experience we haven't had this have practiced pediatrics for over twenty years and have used the same type of fluid regimes that we have been using until recently without seeing any child run into problems with this condition but we now recognize it can happen and we've taken steps to try to avoid it happening wherever possible.

What's your view on solution 18, which has been at the centre of some of these discussions.

Solution 18 was designed very specifically for children because it provides a certain amount of salt it provides their water that they need if they're becoming dehydrated and it also provides glucose which children also need to avoid having a low blood sugar when they're not able to eat or drink anything else so its ideally suited for some children in those circumstances but the problem is I think in retrospect we recognize was being used as a panacea and being used more widely than is perhaps appropriate and so the recent guidance that has produced has shown us that we need to be more specific about the circumstances where it is a safe solution and indeed those circumstances where it is not a safe solution.

So just where to do you think isn't a safe solution.

Particularly in any situation where the body has lost salt then the amount of salt in solution 18 is not adequate to replace those losses.

And we would have known that for some time since solution 18 was around.

Well solution 18 was never designed for those circumstances now if the loss of salt is very minor if a child is say less than 5% dehydrated then in fact the body can cope as long as its given enough fluid with almost any type of fluid the important thing is the amount of fluid is really more important in that situation than the type of fluid if too much fluid is given then problems arise.

You have very specific knowledge of this because of some of the cases that have been around now over the last few years and you yourself got involved in a working group can you just give me some background on that and how you got involved in that.

Yes, it was recognized that after two children had died in Northern Ireland in conditions with hyponatraemia that we needn't to look at this and the Department of Health Dr Campbell our Chief Medical Officer set up the working group which met first in September 2001 and recognizing the urgency of producing guidelines we worked very hard over a period of a number of months and those guidelines where then issued I think it was March 2002 undercover of a letter from Dr Campbell sent out to all of the pediatric units and everyone else who would be involved in caring for children and giving them IV fluids in order to highlight the dangers and also to give guidance about how best this can be avoided.

Who where those two children just for the record.

The two children where Lucy Crawford and Rachel Ferguson.

So June 2001 Dr Campbell called together the working group and what exactly did you do then.

Well I think it was September 2001 that we met the working group first of all met and then had a correspondence mainly by email so that we could do this as quickly as possible to try to agree what guidelines could be produced now we would distinguish between guidelines and a protocol where a protocol is more like a recipe you give a little bit of this and a little bit of that a guideline can't be as specific as that and because of the complexity of this condition its not possible to give a very clear and absolute recipe for every circumstance that could arise in clinical practice so the guideline that we produced highlights the dangers of this condition and gives instructions if you like to those caring for children of the type of things that they would have to look for. For example monitoring the sodium level checking the weight of the child finding out how much the child is losing if they're vomiting or having diarrhea and then prescribing an appropriate fluid to deal with that situation.

Setting out on that course did you examination the details of the cases you were particularly looking at.

That wasn't specifically part of the working group's remit I mean as you've said I have some knowledge of those cases from having looked at the individual circumstances but we did do was we looked back at the literature within the medical journals and we discovered there were references to this condition and although not as many as we might have expected and indeed very few in the mainstream pediatric literature its only been more recently that in fact others seem to have wakened up to this danger as well and it is a very topical issue even at the moment.

Well what is your information and how we came to be aware of the two cases who put up the flag.

Well I suppose from my point of view I became aware of them because the Trust concerned asked me to look at the details and in relation to the Coroners Inquests asked me if I was prepared to give evidence as to my understanding of how these circumstances arose in those two cases.

But in was there because the Royal dealt with the two cases was it the Royal you think that brought it to the attention of the medical community here that they were seeing children coming through that seemed to be suffering from or had suffered from hyponatraemia.

Well certainly informal contact was made and that was in June 2001 where a colleague working in the Intensive Care Unit in the Children's Hospital in Belfast made contact with a number of pediatricians saying that they had seen a second child who again unfortunately died of this condition and that they felt that the current fluid regimes while they had been in place for many years and where indeed used throughout the UK really needed to be looked at again and that was where the process started before the formality of the working group.

So who was that in the Royal did that.

Well the contact that I'm aware of was from Dr Bob Taylor.

So Dr Taylor having spotted these coming through in the Intensive Care Unit alerted the medical community here that there had been two cases Lucy Crawford and Rachel Ferguson within fourteen months of eachother.

That's my understanding its certainly how I became aware of it and how the process started to try to bring something good out of these two tragedies if we can do a little in that respect.

An awful lot experts then got involved and you sat on the working group a lot of pediatrics there and people obviously a great amount of importance was attached to it at that stage by the Chief Medical Officer.

Yes, the fact that we met so quickly and that we worked so hard in producing something and indeed my experience of working groups is that they usually take at least a year to produce anything whereas I think it was probably around six months that we had something out on the website and widely circulated.

And what was the remit given by the Chief Medical Officer at that stage.

I don't have a memory of exactly what the remit was but I know that in my understanding it was to produce guidelines to try to prevent the condition of hyponatraemia occurring where it was possible to do so.

I mean that just gives us an idea of the significance that was attached and the importance of getting you guys in and looking at this that it was important actually to do deal with it and important to get some guidelines out as quickly as possible was that because of the concerning case of other children out there maybe the condition was being misdiagnosed or is that a possibility.

There certainly have been other cases as I've said some children don't respond with severe complications and we would all have seen children who developed hyponatraemia but who got better without problems arising and I think the Chief Medical Officer recognized the significance of this condition that the circumstances differed between the two cases but that that was still no reason for us not to look at the underlying principles and to try to do something to protect children and to increase the safety.

When you look at the Lucy Crawford and Rachel Ferguson's cases as you did back then I mean did you see a problem there with how their bodies reacted individually to the solution 18 or was it the case in both cases that both had been given to much fluid and too much of the wrong fluid and that's what ultimately caused the end of the line.

Well its always possible when you look back at things to I suppose see how things could have been done differently and from my analysis of the situation relating to Lucy Crawford I agree with what the Coroner's verdict was that a mistake was made the wrong fluid was given in the wrong volume and that I think is from my point of view the importance is not just to find where perhaps blame can be attributed but to try to find how the system failed and to try to put in place some changes that will enable the system not to fail for a child in the future with regard to Rachel's death she had vomiting there's no doubt severe vomiting following her operation but in fact many children having vomiting of that severity and don't come to the same problems that she came to and as far as I could determine the fluid management that had been used in her care was the standard one that many other units were using. Now in retrospect we can see that there is a better

way to manage that situation and our guidelines will help people to deal with it in a better way in the future.

And that's the importance out of all of this but when you look back at the Lucy Crawford case and look it really no guidelines could have prevented Lucy Crawford's death if the wrong amount of fluid was given to her nothing that you could have done would prevent that is that the case if mistakes are made as they are going to happen in hospitals.

Well I suppose I look at it from a slightly different angle and that is that mistakes will always be made no one is perfect and other industries like the airline industry have recognized this and so what they have done is put in place systems that find mistakes before they cause damage we don't have those systems in medicine at the moment and a system which required a prescription to be written down communicated properly and checked would have prevented Lucy's death.

Other thing though if you look at how that when you look at how that working group got together it is only due to the informal nature of the way that Bob Taylor brought it to the attention of the medical community unit that it was raised at all, is that a problem as well in terms of communication of what people are seeing throughout the medical community here in Northern Ireland.

Well there certainly has been a problem in that we have not had a system whereby issues that arise in one particular area in one Trust or in one group of patients aren't necessarily recognized by others and this is something which Northern Ireland would be too small to deal with alone so an organization has been developed across the UK called the National Patients Safety Agency its really only relatively recently and is only now getting off the ground but I very much hope that Northern Ireland will be part of that because that is how we could pick these things up by looking at the whole of the UK finding out a case here and perhaps a case in Scotland wherever recognizing them more quickly and being able to take effective action.

The problem with that is that its on the National Patients Safety Organization is only in England and Wales its not in Scotland and Northern Ireland.

At the moment but my understanding is that our Department in Northern Ireland are looking very actively at us joining with them however that's going to work out I'm not aware but certainly it would be my desire I believe it very important that we are part of that work in whatever way that can be arranged as soon as possible.

What do you think are the great lessons out of all of this and there has been great focus and the death of Lucy Crawford and Rachel Ferguson what going back to the sort of work that you were doing in September 2001 what do you think are the great lessons that need to be learnt from the deaths of those two children and what your working group is looking at.

Well communication is at the heart of so many problems where a doctor makes a judgment as to regards the treatment for a child and passes that information on but perhaps doesn't write it down or someone mishears what they say and I think that communication and the record keeping which gives a written record of what a doctor prescribes or the treatment that a doctor wants a child to have that to me is at the core of this that is the thing that can best protect our children.

And do you think that society out there the public interest in general on these sorts of issues do you think that they should be satisfied and have faith in the authorities here that not only can they identify exactly what is going wrong but that they properly investigate it in that it does come to the attention of the right authorities and something is done about it.

Well I think that's what we need to make sure it may be that in looking back we could see ways in which this couldn't have been recognized more quickly although I have to say that the two cases out of the thousands of children who are treated in this way and while there were common factors in the two cases i.e the hyponatraemia there were also different situations one child had an operation one didn't one was older one was younger so there were differences as well the important thing is for us to develop a system which actually enables us to see the similarities in cases that arise and then to take it forward from there.

It was how can I put it, it was so important that Bob Taylor took those two cases to the Chief Medical Officer back in June 2001.

Well I'm not sure that he took to the Chief Medical Officer I mean I'm not fully aware of the circumstances that led to her being formally informed of this but by whatever method certainly it came to the attention of the pediatric community and was taken forward from there.

CONVERSATION WITH DR JOHN JENKINS
FRIDAY SEPTEMBER 10 2004

Hello

Hi, Dr Jenkins?

Speaking.

Dr Jenkins, it's Trevor Birney of UTV. How are you sir?

Hi Trevor, not too bad thanks, and yourself.

Not too bad at all. Are you keeping well?

Yes thanks.

Good. Listen it obviously seems like a lifetime ago that we were speaking to you back in May or June about the programme we're making. We've been continuing to work on it since we came back after the summer and we're now, well we're heading into sort of the last number of weeks but we still don't know exactly when it's going to be broadcast but we're moving into the last weeks of it. Since we have spoken to you, your name has come up during our research in the latter areas and we feel it only appropriate that we come back to you just to give you a chance to sort of clarify some of the things that have been said.

Right.

Basically, the issues that have been raised are really ....

Can I get that call for a second just to get rid of that. Is that okay.

Sorry, yes.

Back with you in a second.

Sorry about that.

You're okay Dr Jenkins.

I'll just unplug the phone.

That's okay. This will only take a couple of minutes. Basically we've been going round various people and talking about the issues that have been raised as a result of the death of Lucy Crawford, and we've realized that you've been involved in

other areas as well as the area of being involved in the Working Group that looked at Lucy's death.

Right, what were the other areas?

Well, we're aware that you were involved in setting up I think it's called an ECAT that went into the Erne Hospital in the autumn of 2000?

I had no involvement in that.

Right.

Who told you that I was involved in it?

The Royal College of Paediatrics.

That's interesting. I became aware that there was a visit taking place but I had no part in setting it up or in being part of the visit.

Right. The College has said it was yourself who was involved in getting together the team that went in.

That's not correct.

Right.

I wasn't asked to play any part in that.

Right.

I didn't, at the time, I didn't even know who was involved in the visit.

Right. Were you aware of the issues that were being ……..

I wasn't even, no I wasn't at the time, I mean in the more recent past, whether it was just because of the publicity that has risen from the Coroner's inquest, I was then made aware that a visit from the College had taken place in relation to this but that is something which I only became aware of after the inquest.

Right. The confusion seems to stem then from, it was the College who said that you were there from Northern Ireland. I'm sure that's not the way it was described but you were the person in Northern Ireland who was involved in putting together the team.

No, no, these teams are put together by a senior officer in London.

Right.

And the local person may or may not be involved, but I was not involved on this occasion.

So you actually had no knowledge of it at all?

At the time that it took place and as I say until relatively recently I had no knowledge.

Right okay.

Sorry I want to be absolutely clear about this. I knew that the College's visit had taken place but I did not know in relation to the particular child or the consultant or the details of the incident that was being investigated.

Right.

I just knew that something was, you know that there had been a visit, but for some unspecified issue. It was not for me to enquire further into that because I was taking no part in it.

Right. You admit that it wasn't you who approached Dr Moira Stewart to take part in it? Did you give the Royal College of Paediatrics her name?

Sorry you're just breaking up there.

I wasn't asked for a name. No-one from the College contacted me to ask me for a name or to ask me to take part.

Right. Obviously some of the confusion has come as that you had been to the Royal College of Paediatrics and you had spoken to someone there and it was that person who said that you were involved.

Right, well I'm sorry you've given inaccurate information. I can imagine why you come to the conclusion that I was hiding some information from you at the time that we met previously. The fact is that I didn't have that incorrect information. I wasn't hiding anything from you.

No, no, no. As I say the important thing for us was to you know we'd only learnt about that since we spoke to you, and as I say we've only just come back from the Royal College. We'd been there yesterday, and we wanted to take the first opportunity to come back to you and talk to you about it. So, that was one of the things we're talking about. The concerns would be that there would a bit of conflict of interest obviously here.

Sure.

You appreciate that given that you then were an expert witness for the Trust and did give a Paper and give evidence at the Coroner's inquest.

Yes but I did not speak to them and I don't see now that there was any conflict of interest because I hadn't had any previous involvement.

Right, okay. Just so that I'm absolutely clear then. Whenever in December 2000, whenever the Trust called in the Royal College of Paediatrics, you at that time had absolutely no knowledge of the issue or the fact that a visit was to take place and advice had been sought?

No, that's not exactly what I said. What I said was that I became aware that a visit was taking place to that Trust but I had no knowledge of what that visit related to, either in terms of the child, the conditions or the consultant concerned.

What were you, how did you find out and what actually were you told?

Well I can't remember now how I found out, whether I was over at a meeting at the College and somebody said to me "Oh by the way there's a visit going on to the one of the Trusts in Northern Ireland" but certainly there was no formal mechanism for notifying me because I was not playing any part in this, I was not being asked to identify anyone to take part or to play any part in it myself, and I don't have any correspondence, I didn't make any notes of it at the time.

Right. Were you aware of the second visit then to the same hospital?

No, I've no memory of their being any .....or of what anyone said to me that there were two visits, no.

Right, you thought there were, in fact to your knowledge there only has been one to the Erne Hospital then in the last five years.

But there would have been no reason for me to know. What I'm really trying to explain to you is that although I had a role for the College in Northern Ireland, it was not a role in respect of which type of activity. This was all managed by senior level in London, thus there was no reason why I should know.

Right. Who would have handled that in the College at that time?

It would have been handled by the predecessor to the Registrar.

Sheila Shribham.

Sheila Shribham is the current registrar, yes.

Yes, is she. Pat Hamilton would have been involved?

Yes, Pat Hamilton was her predecessor, yes.

Pat Hamilton, and

It would have been dealt with through the permanent secretary, Len Tyler.

Well you see Len Tyler, he was there yesterday, like I say it was your name during a discussions that I've had with Len Tyler, and I believe that he came back and clarified them with you, in fact he said that he had spoken to you about it back in June I think it was.

He made me aware that you had been in touch with them but he certainly didn't tell me that he gave them that piece of information because I would have immediately corrected him if he had.

Why did he come to you then?

Well just because apparently he had contact with a journalist from Northern Ireland and because I was sort of the senior College person in Northern Ireland, then "had there been a lot of visits going on in that situation and did you know anything about them, do you know what's going on"?

Right. So he wouldn't have gone to the person who actually sat on it, but really he wanted you and he wouldn't have given you that level of understanding if there was going to be a visit to a hospital in your area?

No, not necessarily because I would not have been playing any part in it. He may have caught up with Moira Stewart as well with regard to your contact with him. I mean, I would have thought it would have been logical for him to do that. I wasn't in a position actually to enlighten him, other than I was able to say "Oh yes, there's been a possible visit and I've agreed to be interviewed" and I had a conversation with him in regard to that because at that stage I was involved in the whole thing and I had been involved in the inquest and so on as well but no, at the time the events took place I was not part of the College's response to whatever request came in. I never saw any request to the College and I wouldn't get the response to that request. It was only in retrospect that I was made aware that this had taken place.

Did you communicate at all with the Trust about the request, even in writing or by telephone?

About what request?

About their request to the College on this issue?

No, I've had no communication with the Trust about that. I had no involvement in it other than being made aware that it took place retrospectively. That communication with the Trust was entirely within the legal process.

You do say that you did speak to, you were made aware at the time that a visit was happening but that you knew nothing of the issue or the personalities, so you were aware that someone from the College was visiting the Erne Hospital in December 2000?

I don't remember now, and I have absolutely no notes of it, because it wasn't seen by me as being an important issue, I have no memory as to when someone mentioned to me that a visit was taking place, but it was mentioned casually to me, you know, something by way of observation, not because I was playing any part in it.

Right. Unfortunately that consists completely of what your colleagues are saying.

Well I'm delighted to hear that because I don't have a clear memory of dates and times because there was no reason to keep a record of it, but I'm absolutely clear about the fact that I wasn't involved in the process in any way at all.

Right.

If you want clarity on that then you would have to go back to Len Tyler again and the appropriate thing would be for him to make contact with me and to agree with his version of the story so that I can try and clarify it for him.

Yes. That's what Len had said and certainly indicated whenever he spoke to me in the conversation that I had with him that he had spoken to you about the visit, and ...

.....

Was that, was that the date, I mean was he talking about this year.

Yes, when I initially went to the College about it's involvement at the Erne.

Oh yes, I'm not denying that they made contact with me at that stage in the proceedings. What I'm saying is that at the time that these events took place I had no involvement.

Yes. And when you obviously spoke to Len then you were fully aware of exactly what the personalities of the issues were?

I was not, when he first spoke to me, I was not aware of the full membership of the visiting team.

Of the issue, or you were aware of the issue?

Well at that stage she had already been in touch with William ……., hadn't she?

Who, I had.

I mean let's try and clarify the sequence of events. What I remember is about the time Len mentioned it to me you had already been in touch with me so whenever he said that you had been in touch with him I would be able to say "Oh yes I know what that's about".

Yes, no. We only talked about this after, we only realized with Len saying that you had been involved in the Royal College of Paediatrics visit, after we had interviewed you. That's why we haven't come back to seek clarification until we were absolutely sure what exactly was there evidence that you had been involved in it, and that's why.

What you're saying is about the time that Len approached me about it, then I already knew that you were involved and so I was in a position to discuss what I knew about it, but I did not have information on that until it was given to me at that time at the College as to any other membership of the team that went to Erne.

Right. Well I never told Len that the issue was about Lucy Crawford.

But if he knew which Trust it was, and you know what the issue was, then it wasn't hard to put together two and two, and once he phoned me I was able to say "Oh if that's about Sperrin Lakeland, then yes". He was able to talk about ……..and Sperrin Lakeland so it wasn't hard for me at that stage to know who it was that they were talking about.

Were you concerned at that point in the conversation with Len that your name was being linked to it?

Well I didn't realize it was other than that I was the representative for the College in Northern Ireland and so I wasn't surprised that Len had contacted me once you had made contact with him, but I had no knowledge of the fact that it was being suggested that I had been involved in the visit. If that had been mentioned to me I would immediately have corrected that.

Well, to end up it was Len who said the reason he had called you was because you were involved in setting up the visit.

That's ……

And that you as the local representative would be involved in that as would happen in any other part of the UK.

Well I mean I'll try and contact Len and I'll correct him but that is not the case. I mean I agree if it had been the case there would be an issue as to whether there was a conflict of interest.

Yes, I grant you that, but that's the concern.

There's nothing, I did not have any involvement with the process they put to us at that time except the College's point of view.

And whenever you put together the report for the Sperrin Lakeland Trust in the spring of 2001, were you aware at that point of anything about the visit by the Royal College to Enniskillen, and the allegations that had been made?

No, no. At that point all I knew as I said was that a visit had taken place but I had no involvement or knowledge as to the details of that visit. I certainly hadn't seen a report or been part of producing a report. The information was got to me by the Trust on which I did my report and it was the only information that I used to get to the conclusions that I got to.

Okay, okay. In conclusion, just to clarify, the conclusion you came to in that report John, was that Lucy died as a result of the wrong fluid and too much fluid.

Oh yes, I mean I haven't got the papers in front of me and I don't want to tied up in .....

No, no, no.

When I'm not probably directly .....at the moment but I mean the Coroner asked me specifically did I agree with what he was going to put on his report and I said yes I agreed with that. I mean I haven't got my own report in front of me so I wouldn't like to .....

Of course. When you became involved in the Working Group and you were looking .....you would have been aware of the details and the fact that that was your medical opinion why she had died.

Oh yes.

And so you know you were looking at a death through hyponatraemia and .....so there was no conflict there, but you weren't at all concerned that this wasn't a death due to hyponatraemia?

Oh no, not at all. I mean I have absolutely no query that that was what her death had been due to. You know we'd gone into some debate before the Coroner's inquest as to types of fluid, amounts of fluid and different experts came up with slightly different

approaches to fluid management in childhood but we didn't disagree on the basic underlying cause of death by any means.

Okay, did Adam Strain form any part in your, did the death of a young child called Adam Strain form any part of that Working Group. Did you look at that case as well?

I'm not sure. It's not a name that immediately rings a bell for me.

Right, okay. That's fine.

The other case that I was involved in that I did know about was the Derry case, the Raychel Ferguson case.

Yes, it was Raychel Ferguson which you had been involved in as well and the Lucy Crawford case, and those are the two cases that you both looked at.

Yes.

I really appreciate I've taken up twenty minutes of your time and I really appreciate it. Can I come back to you. Can I come back to you John. I don't think there's any point in asking for you to do another interview at this point about this, but you know, if there is some clarification I would appreciate if you would, but at this point unless you have any concerns we want to address these issues and we'll work through them and if there's anything further we'll come back to you on them. Is that okay.

Yes. I'm just glad we clarified it.

You can understand our position when we were being told when we talked with the Royal College of Paediatrics, ...about what happened. We wouldn't want it to land back at your door again?

I'm glad that you took the opportunity to check it out with me, but certainly I just don't agree with what you've been told there and I will try and make contact with Len to try to see where he got this information from. So if there is anything to help maybe clarify that I'll do my best.

Okay. Well listen thank you very much John and as I say I'll come back to you as we work through this stuff anyway.

Yes, well I would certainly be grateful to know when the programme is going out.

Yes, so would I at this point and we have a man standing outside my door. Hopefully he's going to tell me soon, but as soon as we know we'll make sure everyone who has taken part knows as well.

Okay.

Okay John. Thanks, bye-bye.

roreilly

From: Trevor Birney [tbirney[redacted]
Sent: 13 September 2004 09:52
To: roreilly[redacted]
Subject: RE: hyponatraemia

Dear John,

Thank-you for your e-mail, which I received this morning.

As I said during our conversation on Friday, we are continuing to investigate events surrounding the deaths of Lucy Crawford and Raychel Ferguson.

Given your concerns, it may be necessary to conduct another interview to give you the opportunity to express your position in relation to the RCPCH visit at the Erne Hospital.

Either way, as promised, we'll come back to you asap.

Best wishes,
Trevor.

Trevor Birney
Editor, Current Affairs
Ulster Television

-----Original Message-----
From: j.jenkins[redacted] [mailto:j.jenkins[redacted]
Sent: 13 September 2004 07:21
To: tbirney[redacted]
Cc: len.tyler[redacted]
Subject: hyponatraemia

Dear Trevor

Further to your detailed questions during our recent telephone conversation, I would like to confirm that I was not involved in arranging, nor did I take part in, an RCPCH visit at the request of the Sperrin Lakeland Trust.

I have confirmed this with Len Tyler at RCPCH, who has assured me that he did not lead you to understand otherwise.

I am also copying this to Len as I would like to ensure that there is no confusion regarding this matter.

John Jenkins

--
Dr J G Jenkins

157

Senior Lecturer in Child Health and Consultant Paediatrician Antrim Hospital ANTRIM
BT41 2RL
N Ireland
UK

j.jenkins[redacted]

158

CONVERSATION WITH LEN TYLER, SECRETARY, ROYAL COLLEGE OF PAEDIATRICS AND CHILD HEALTH
MONDAY SEPTEMBER 13 2004

Hello.

Hello, is that Trevor?

It is, yes.

Hi, Len Tyler phoning you back.

Okay, hang on a second to get this in front of the recorder. How are you?

Okay, what can I do for you?

Basically Len, I was trying to clear up some of the stuff we were talking about on Thursday. John Jenkins I believe was speaking to you and John said that he was only aware of one visit.

Did he.

Yes.

No, two.

He was only aware of one visit to Erne Hospital.

In 2000 or 2002.

Well he says that he only learnt of the visit to the hospital in February this year.

Right, possibly yes. John was officer for Ireland.

He was yes.

So he would have been, he should have been fairly well informed of what was going on, but I'm as sure as I can be that what I told you is right, that there were two approaches, one in 2000 and one in 2002.

Right. And there was definitely another visit in 2002?

Well like I say I don't actually have copies of the various reports. It could have been done over the telephone. No, I don't think so. Again I'm as sure as I can be, but the people that could tell you would be the Trust.

Yes. But by coming to you we want to try and get you know .....

A short cut.

To get it absolutely clear about the Royal College part in it.

You drew our attention quite rightly to an anomaly. You thought that there was one visit and it had taken us three years to produce a report which didn't seem right. Then it was relatively easy to check that and find that there had actually been two quite separate, two requests for assistance, one in 2000 and one in 2002, and I'm as certain as I reasonably can be without actual copies of reports in front of me. John might not have know I suppose about the first one, it's possible.

Well John said he was told in autumn of 2000 about the visit.

Right.

So as you say in his position, in his capacity, how did you describe him ....

He was officer for Ireland.

And in that position he would have been told and explained and would have been involved?

No, not necessarily because the thing we stressed was that these visits, the contents of any reports, is confidential to the Trust. I would have expected that he would be told but it could be that they didn't, and again without, I don't actually have the files and things on each of the visits here, and I don't actually have the report.

The thing is we're only interested, as I said to you before we left on Thursday, we're only interested in one issue, and that was the issue which you went back and checked in the first instance and that was around a consultant called O'Donohoe, who is now under investigation by the GMC, and when you went back and checked that cross referenced O'Donohoe, Enniskillen, Erne Hospital, Sperrin Lakeland Trust, and came back and you hadn't spoken to John, you said that yes that was right. Remember you said something like "Yea, you're right. Your dates are right. It was the autumn of 2000" and we did go in. Now you may have gone in on a completely separate issue of course in 2002, I'm not .....

You must understand when I say "we" I mean we would have recommended somebody.

Yes, yes, but you know what I mean. But when you said that a visit did occur in the autumn of 2000, and you said that John had concurred with that, maybe the visit in 2002 was a completely separate issue.

As I say we can't actually say anything about either of the visits unless the Trust wants to say something. If the Trust wants to tell you what was in either of the reports that's absolutely fine because it's their report but it would have been done on the basis that it was confidential to them so you would need to get whatever it was each time and look back at my notes of what John said to me. We did a report, we provided names to the Trust.

That's what John said to you?

Yes.

And when was that?

Oh, sometime, well that would have been back .....but John knows that a report was done. You're saying that .....

When did John say that. When did John .....

Well I haven't actually got a date.

When do you think that was?

I don't know. Sorry what's the significance of that anyway?

No, there's none, but John said there was only one.

That's what my notes say. John said we did a report so reading between the lines I guess he may have been saying that he only knew about one but at that stage I think I too thought there was only one report so it wouldn't have struck me as particularly odd. I mean, if you can tell me what it is you need to know and why I'm sure I can do some research but I'm not quite sure what, I mean I think we can establish that there were definitely two requests for information and I don't know that there is any doubt about that, but if John only knows about one then he only knows about one, but it wouldn't seem to me terribly significant one way or the other.

Well you know, it could well be, and I'm not saying that it is, and I don't know Len whether it is or not, I'm simply wanting to clarify, John has said that there was only one, and you said to me before Thursday that there was only one, do you know what I mean and now it seems to be getting confused that there are two and John, who you've just said there said he knows that there was a request and you supplied, and what does John say there .....

My notes against, there is confidential written on the report, so I had gone back and I had annotated to say yes, John confirmed that we did a report, ie we provided names to the Trust, so I don't think John did it on purpose because he didn't know that we did a report and as I say I don't actually have a date when he said that but clearly it was some time

after 15 June which is when we had our first conversation but it could have been some time after that when I annotated the .....but I'm not quite sure .....

We are just trying to make sure in terms of accuracy when the concern was. If we had put the programme out before last Thursday we would have used your information and your information was that there was only report. In the absence of the Trust confirming anything we only had the Royal College of Paediatrics in your form to go on and given that you had confirmed that a report had been done, there was a visit, that John had set up the people to take part, the names of the ECAT, that we would then could have been caught out and we all could have been caught out and the Royal College would have had to go back and clarify, we would have had to clarify and I'm simply trying to ensure that we are absolutely right, and I'm still a little concerned that the second visit had absolutely nothing to do with the original issue.

Why not ask the Trust then.

They will not confirm anything you see and that's their prerogative. They will not confirm anything and as I say the issue is not with the Trust, it's with you now because you've said one thing and it's now being changed to a second position.

Yes, but that's not quite the way I would see it, but sure if that's what ..... I mean I've got a notion of what you said that there was a visit in autumn 2000, and that it concerned O'Donohoe and Asbhar you gave me, and you wanted to know whether that was right and I confirmed that that was right. At that stage I had no idea actually that there had been a second visit, and there was only the first one as far as I could see, so I don't think you could say that I gave you a misleading answer, or certainly not a confusing or misleading answer.

No, but you were able to confirm those details without speaking to John. You know what I'm saying.

I do indeed but what I can't remember is what I asked John. In other words whether I said "Did he know about the visit to Sperrin Lakeland Trust" and he might have said "Yes" so I mean I sort of understand where you're coming from but the way in which you're asking it sort of makes me slightly more cautious, perhaps even than I should be.

No, no, no.

I'm not quite sure why any of these is particularly significant. I mean .....

In terms of what. In terms of the .....

In terms of the case.

Well my concern would be what was in the report and what the Trust did with it then, you know. That's not an issue for you. We are ensuring that we get our facts right in terms of a report was conducted, who it was conducted by and all of that and what action did the Trust actually take.

Sure.

I mean what is the point of you guys putting these people in and getting involved.

Only to give them advice.

And the advice not to be adhered to.

No, it's then for them.

I understand, but I mean ……..

What I mean is it's guidance, okay, and it would then be for the Trust, it's entirely up to them what they decide to do with that report, its typical of any consultant, you know at the end you can say "Yes, that's very useful advice, we're going to do that, or "Um, well what's your view, or we'll do something else entirely" so that they should not take our advice is not in itself necessarily ……., necessarily culpable, if you see what I mean.

I agree with you in that. I mean that's really up to them and it is not up to you whether the advice is acted on or not but going back to the conversation you had with John in June whenever he came back to me, John simply says that the request had come in he had ……getting together the experts to go in.

Okay, well again if that's what he said.

That's corroborated by what you said. What is that on your notes there.

I'm just looking to see whether he actually said that he did, he might have been, it doesn't actually say in the notes. In the normal course of things the request might actually come to me and I would pass it on to Sheila who you met on Thursday, or her predecessor who was Pat Hamilton and they would then propose names to the Trust, and I'm just trying to think, I think we would actually contact the people if I'm right and ensure that the thing was set up and then they would go off and visit and thereafter it would be between them and the Trust. At some stage I would have thought that we would have consulted John either formally or informally about it but again without the file in front of me I can't say definitely that he was consulted or that he wasn't.

But John obviously was whenever ……..

- Not knowing exactly why you needed the information I'm not sure whether I could say "Well we'll do the research and find out whether he was or whether he wasn't", but at the moment it doesn't actually seem terribly important point.

I think the thing is for us to make sure. John Jenkins is a very well known consultant paediatrician here and obviously it's important for accuracy for us about what exactly his role was of putting it together and obviously your memory, given that the first person you turned to once I came to you back in June, the first person you turned to was John.

Only because you know he was officer for Ireland and would therefore presumably have been able to remember it, but again I'm not even sure if he was necessarily the first person I turned to. He was simply the first person I managed to get hold of which may not be all the same thing. Look, as I said before, I really don't want to be unhelpful.

Could I simply ask you then to clarify exactly the issue surrounding the two visits and I understand your position about confidentiality, but if the second visit was in relation to the same two names as the first visit was.

Honestly, you will really have to ask the Trust. The whole point of the visit is that they are confidential. I'm not suggesting that it would, I mean I can't see that it would make a great deal of difference if I told you or if I didn't, but I think that I can only say to you that it's a matter for the Trust and you'll just have to ask them. Have you tried them. I mean they may be, have you actually asked them.

Well we want to make sure that we're going to have enough information that is correct, and our concern is that .....

But why not just ask them. I mean I can't see any reason why they wouldn't be willing to .....

Well it's going to have very great relevance for the Trust.

Well possibly.

If you were seeking disclosure of a document and the document hadn't been disclosed then, and the Trust knows that it didn't disclose it, it won't want to tell us anything to do with the document.

Right, but that means really I can't either. I mean do you see my point.

I understand that but that's the point that you are simply making.

But that isn't my document. It really isn't my information to disclose.

No I understand that. I mean the important thing for us is that we give the Royal College of Paediatrics the opportunity to clarify their position and ensure that in terms of accuracy exactly how it was involved in this and what was it's role. That's the important thing for us to give you the opportunity to ensure what you said is accurate, and all I'm saying is that up until Thursday we had one perception and that position seems to have changed, not only in relation to the document itself, but what you do with these documents.

Right, well I'm not sure about that. The problem is that you sort of come to us saying this is the position and I on the whole tend to trust you if you sort of say to us "Well this is what happened. These are the people who were sent in and we know this", if I didn't have any reason to disbelieve you I wouldn't necessarily either check that or correct you. Say for example early on you said to me "Well I told you it was Donohoe" but according to my notes you told me it was Donohoe and which would mean I merely said "Yep, if you say so". I understand what you're saying that you want to go to the Trust with as much information as you can but .....

We want to go to there and we want to go to broadcast a programme that is as accurate as possible. Now the Trust may find itself in a position where it's unable to clarify any of this and which means it falls back on what you've said both on the record in terms of Sheila and our conversations, and as I say the recordings of the conversations I had with you personally have changed in terms of what the transcript of those said and what you now say.

No, I don't think so. You asked me originally about a visit in autumn 2000 and you wanted to know when we went in, when it was completed and what the remit of the report was, okay. That was what I checked and I confirmed to you that there had been such a visit. It was only when you said to me "So why did it take two years to complete the report" that, and as you would have gathered on Thursday, it just seemed extremely odd, and I went back and checked and there had in fact been two separate requests and that was the reason for the disparity between those two .....

Well when was the first one completed then?

Well we don't know. All I have is a note, no wait a minute, I thought we did track that, it was late 2000, wasn't it.

Yes, it was completed in December 2000.

I don't think we actually keep a record of that but if that's what I said on Thursday I know that I had actually gone back and checked that date. It was the one in 2000 that I wasn't absolutely sure.

Or 2002.

Sorry it was the one in 2002, that's right, that I wasn't absolutely sure about.

You did say December 2000.

Okay, if I said December 2000 then I would have actually got that from somewhere and that was from .....

From David .....

No, I don't, oh from David Leonard, yes.

But you think, just to make absolutely sure, that was the completion. Was it completed in December 2000?

Again I didn't actually make a note of that at the time. I mean if this is really important I don't mind going back. Just hang on for thirty seconds and I'll go back and double check that.

Okay no problem. Thank you Len.

Sorry, David's not there. No-one seems quite to know where he is. However, if I said December on Thursday I'm sure that I'd only just checked it with him.

Yes, and that would have been the actual finish of it.

I think that would have been the date on the report but what I need to get a feel for is precisely how important this is.

It's in the overall context Len. I'm not saying that it's going to be the headline of any report that we do.

No, but all I'm saying is if it is critical that you need to know whether that was the date on the report or the date the report was delivered or the date the report was completed or whatever, my feelings from David was that the report was finished and done in December, whatever we said, December 2000, but if it's absolutely critical to the week or whatever then I will try and find out.

No, no honestly. December 2000 is fine. I think the most confusing thing is the second visit. We have obviously got sources in this story.

So okay.

The sources have told us that they know nothing of another visit.

Right.

And then when we go back to John and speak to John and find out that John knew nothing of the second visit and that was just the worrying thing. I'm not saying that there wasn't. Of course if you guys say there was then there must have been but all I'm saying is a lot of the protagonists, a lot of the guys, didn't know.

Right. So who apart from John is saying that they didn't know?

People who had intimate knowledge of the first visit at the hospital.

Right.

Now that's not to say that they were not involved and had no reason to be involved in the second visit. Do you know what I mean, that's not to say that at all. It's just that no-one seems to be aware at all of it.

Right, okay. I don't know what I can do except to repeat that there were two requests from 2001 and 2002 but .....

Could you just check with David the date on the second one. If the first one was completed in December 2000. you've obviously not had a big problem letting us know that the first one was completed in December. Can you just tell us exactly when the second one was finished.

I think if he'd actually had a date for the second one I think I would have told you on Thursday. The problem as I say is that our records of the finished product seem pretty incomplete.

No, no, no. But if the request had come through you, you surely would obviously know when the request came and who was involved with it. Was it the same paediatricians that were involved in going back in, Moira Stewart from the Royal and as far as we are aware it was somebody else from London.

Right. We never actually said who was involved in either visit though you've obviously talked to Moira. No I think that's another one where we would need to say "talk to the Trust". I mean you know if you .....

I know, but there's another .....

I can only say if they don't want to tell you more I don't quite understand why but I respect it if you see what I mean. Presumably phone their press office. I mean I can't see any reason why they shouldn't want to give you this information.

Have you made the Trust aware.

Of .....

That we've been speaking to you?

Is there any reason why I shouldn't?

No, no, not at all. I mean .....

Clearly we all talk to each other and I would have thought that, I mean, sorry, they haven't actually said to me you know "We would be quite happy to supply the information" but I didn't get the impression that they were in any sense defensive about it.

Yes, okay. At what level in the Trust would deal with bureaucracy. Would it be the Medical Director there?

In terms of requesting a visit?

Yes, generally speaking, would it come from the Medical Director or from the .....

From the Medical Director or it might come from the Chief Executive.

In this instance would it come from the Chief Executive?

I don't know. Again, if it's important.

Well it would help in us directing .....to you.

Well why don't you talk to the Chief Executive there. That would be the Chief Executive of, I mean most of the questions you're putting to me I would put either to their Chief Executive, or you know if you normally go through their press office, to their press office, and see whether they can get her.

Okay. Well listen Len I've used up far too much of your time already.

It's okay.

If you can actually nail down when the second request was made and when the report was delivered it would be extremely helpful for us.

Okay. If I can find out that information then I will but I mean it would .....

In terms of it I would not be pestering you for anything else if you could give us that. That would help in terms of how we would continue to investigate this because obviously if there are people without any knowledge of a second visit.

I do understand. The problem is I get the impression, I don't think it's a false impression, that you're quite telling me everything you know and even though I can't really see .....with any of it, it makes me wonder whether there is stuff that I don't know.

I mean I'll be absolutely honest with you, we are .....

I mean that's why I'm being perhaps slightly more cautious than I would be over a lot of these things.

I understand that position.

All I can do under those circumstances is simply stick to exactly what the position like this should be anyway which is it's their visit, it's up to them to tell you as much or as little as they wish.

I think my concern is of course that as a journalist I have to (a) protect sources, so I've got to be very careful, and I don't think, it's not that there are any concerns that you're going to put the phone down from here and ring the Trust or ring anyone else and alert them to exactly what we're saying, but my concern is that by saying something that may inadvertently help the Trust identify who it is I was talking to, your not playing games with that person's position and I don't really want to do that.

Sure, but I mean you could only do that without being a lot more open with us as to who it might be and what the risks are because as I say at the moment I know you've got some sort of story there. I can only speculate about exactly what it might be and I'm naturally going to be cautious and I'm not unnaturally going to ask anybody that I can get hold of whether there's anything that I ought to know. If it's really important to know exactly when the second report was done that may be information that I can find but as I say you have to understand that the processes are as I described. In other words we set it up and thereafter it's the Trust's and it could be that we don't, you know as I day, not only don't we have a copy of the report but we don't even have it recorded as to when it was delivered, in which case I would be relying on people's memories but I can .....

That would be most helpful.

Let me see what I can find.

I mean you can understand, without having to get into any detail of it Len, the fact is that if you get four or five of these a year and then one small hospital with three paediatricians, three paediatricians are based in the Enniskillen hospital, and you're in there twice in three years, I mean how many hospitals are there in the UK?

Oh I don't know, hundreds of them.

You can understand, it seems a bit .....

I do understand what you're saying to me but …….

You know I'm not jumping towards a conspiracy here, but certainly there would be some concern about why the Trust has called you in twice and what exactly was being examined and that's up to the Trust to explain why you did that but certainly as far as I'm concerned I don't want to, it would undermine your position and mine if I'm going to the Trust with the wrong information. The Trust would say well the Royal College actually says they were in twice and it turns out that you weren't in twice that would be, it would just undermine us all.

I don't think they're going to say that. I mean I don't see why they would say that. If they did then you would need to get back to me and say that's what they'd said.

The only other person who would know a lot of this is John and he only recalls one.

Well maybe he was only involved in one, I mean again it's not a question I put to him because I hadn't realized it was at all an issue.

No it's not. John was the Irish officer, that's not how you describe him, but he was the front man here and so I would expect John to know exactly what was going on and John accepts that.

I've got a copy of his email to me today was it saying he wasn't involved in arranging the visits and again if that's what he says then I'm sure that's right. He wouldn't necessarily have been and I don't have any records certainly which say anything to the contrary but that's the only thing I've got from John.

But he did speak to you since you were there?

No, I haven't actually spoken to him but I've got this, I'm just trying to think, did he phone me, no I don't think so.

Why do you think it says in the second line of the email that he's concerned at Len Tyler?

Because I think he may have emailed me. I'm just trying to remember. I don't think it's terribly significant.

Well it is if John's misleading me.

No, he's not.

You just said that you didn't speak to him since we spoke before.

No I think it was an email. I think it was an email, but all I'm saying is that is, no I mean, did we speak or did he email or what, I can't remember now. Do you want me to .....I can't deal with this particularly if it's not significant. You seem to be assuming that we had something to cover up which isn't the case.

No, I'm just surprised that you can't remember if you actually spoke to him or not. I know that these matters were back in 2000 and 2002. It worries me slightly .....

That I can't remember whether it was a phone call or an email.

John Jenkins, you obviously understand, if he's sending me an email at twenty past seven this morning, he understands the importance of this and grasps the significance of it. All I'm saying to you is that John is saying to me that he has left the decision with you and I just confirmed it. I'm slightly concerned that you don't remember the call.

No, I remember the discussion as it were but I've exchanged a number of emails and I'm just seeing if it's one of those. No it doesn't seem to be. In that case it must have been a telephone conversation but I really have, what he said is correct.

Okay. Well look we'll leave it that you're going to try and nail down exactly when you were called in in 2002.

I will see if I can find that.

That would be brilliant. Thanks.

Bye-bye.

DR DONNCHA HANRAHAN DOORSTEP
MONDAY OCTOBER 11 2004

TB: Dr Hanrahan, my name is Trevor Birney. I'm from UTV.
DH: Hello. Hi.
TB: I'd just like to ask you a couple of questions about the Lucy Crawford death. Dr Hanrahan, first of all, can I ask you why you didn't tell the coroner?
DH:I have nothing to say to you, as I said to you on the phone already, didn't I?
TB: Yes. But I want to ask you a question about why you didn't tell the coroner about the presence of hyponatraemia.
DH: Could I say I don't like being doorstepped like this?
TB: Well, I'd like to ask you a question about hyponatraemia …
DH: Excuse me (opening car door)
TB: … why you didn't tell the coroner about hyponatraemia, Dr Hanrahan. Why you didn't put it in your statement.
DH: Can I say … I said all I wanted to say at the inquest. I've spoken to you on the phone already so I have nothing further to tell you.
TB: Why did you not tell the coroner, Dr Hanrahan, about the presence of hyponatraemia? Why did you not say anything in your statement, your affidavit? It was only until you got to court, when you got to court that you actually mentioned it. You realize there is a GMC investigation into this now?
DH: I've nothing further to say. I'm sorry aobut that.
TB: Were you covering up for Dr O'Donohoe?
DH: No, no, no.
TB: Were you covering up?
DH: No, of course not.
TB: Well, why did you not mention the presence of hyponatraemia when you spoke to the Coroner?
DH: I've nothing further to say to you. Can I leave it at that? Thank-you very much.
TB: Can you not explain to me why?Are you not interested in answering these questions?
DH: Not to you. And I don't like being confronted like this all of a sudden. I've nothing further to say to you.
TB: … why you didn't tell the coroner about the presence of hyponatraemia when Lucy died …
DH: I've nothing further to say to you.
TB: … given that you and your colleagues were aware of the presence of hyponatraemia …
DH: I've nothing further to say to you.
TB: … and you realize the significance of that, given the GMC investigation.
DH: I've …
TB: If you'd said that then …
DH: I've said this already to you on the phone, haven't I? That I wasn't going to comment further to you at this juncture.
TB: Well, we think there are issues of public interest here, Dr Hanrahan. Obviously you understand that if coroners are not being told or being misled …

DH: Yeah
TB: … of information of what caused children's deaths, there are parents in Enniskillen who are still worried about exactly what is the truth behind this.
DH: I appreciate that completely but …
TB: So why did you mislead the Coroner?
DH: I didn't mislead the Coroner and I can't say anything at the moment to you. OK?
TB: Well, whey can't you answer that question?
DH: I, at th, I just don't feel that it's appropriate to answer you that at the moment.
TB: Why? Why not?
DH: OK. Because I've not, I'm not going to answer the question at the moment.
TB: Well, given that you and your colleagues, Dr Caroline Stewart, and others were aware of the presence of hyponatraemia …
DH: Mm, hm …
TB: … you were aware of that at the time of Lucy's death. …
DH: Yeah …
TB: … why did you not tell that to the coroner when you spoke to him.
DH: Em, I would need to check up my facts on this and I have nothing further to offer you at the moment, OK?
TB: So you don't know whether you did or didn't?Well, the Coroner said you didn't mention it.
DH: I didn't? Right.
TB: You said gastroenteritis.
DH: OK, yeah. I just, I just don't want to be doorstepped like this. I am suddenly confronted by you with this. It's not fair to me at the moment. OK? And I'm not going to say anything further at the moment.
TB: You can't explain yourself at all?
DH: Not at this juncture, no, I can't. I'm not going to comment any further.
TB: We've given you several months. We've asked these questions for several months and you've been aware of them.
DH: And I've decided that I'm not going to be subjected to this kind of questioning at the moment. I'm not. I'm not happy with it at all and I've nothing further to add.
TB: So you've no explanation at all for the Crawford family about …
DH: I've nothing further …
TB: … about why …
DH: … to add to you and if the Crawford family wish to speak to me about it, I've absolutely no problem at all about that at all.
TB: But you've no explanation at all?
DH: I've no explanation that I'm going to provide at the moment, no.
TB: Do you appreciate that Lucy did die of dilutional hyponatraemia? That that was the cause of her death?
DH: Look, I don't want to get into any of the details. I can't discuss this case with you at the moment.
TB: Why not?
DH: OK. Because I don't feel it's appropriate, OK?
TB: Well, we've given you ample opportunity, Dr Hanrahan.

DH: But I don't ...
TB: ... refused all attempts to explain to us as to actually why you didn't mention to the coroner.
DH: Yeah. Yeah. There's no obligation upon me to discuss with you at the moment, OK? Thank-you very much. OK?
TB: You're not prepared to give any explanation?
DH: Not at this juncture. No. No.
TB: Are you ever going to explain it?
DH: I don't know. I can't say. I'd need to talk to my advisers about this.
TB: Do you appreciate that the Crawfords have a right to know?
DH: If the Crawfords wish to speak to me I would have absolutely no problem with this. I have said this with every single time I met them. If they wish to speak to me under any circumstances, I would speak to them. There is absolutely no problem with that at all.
TB: But even when they came up to you and you spoke to them in June, you didn't explain to them then. You didn't take that opportunity to explain to them that the child had died of dilutional hyponatraemia.
DH: Erm, this ...
TB: You directed them back to Dr O'Donohoe.
DH: I'm not going to talk about the detail of the case with you. I can't do that.
TB: You have had several opportunities to explain to the Crawfords and you've failed. I mean, you could have explained when you met them, or interviewed them, as you said in your affidavit. You didn't take that opportunity.
DH: Now, listen, I'm feeling very uncomfortable at the moment being interviewed like this. You can appreciate that. I'm sure you can't ...
TB: Well, we've given you ample opportunity Dr O'Hanrahan, to give us an explanation.
DH: So I need to ...
TB: .... why didn't you say this?
DH: I need to talk to my ?? (inaudible), OK? So if you'll excuse me. Thank-you very much. (Gets into car and drives away)

Dr Murray Quinn
(Doorstep at home in Claudy, Saturday September 25)

TB: (48:12) Dr Quinn?

MQ: Ah, what are you doing here?

TB: Dr Quinn. My name is Trevor Birney. I'm from UTV, sir.

MQ: I just wonder why you have the camera going?

TB: Well, I have. I just want to ask you some questions about this report.

MQ: What report?

TB: This report you completed into the death of Lucy Crawford for Sperrin and Lakeland Trust.

MQ: What I would like to say is, I had nothing to do with the treatment of Lucy Crawford. I'm very sorry that she died. The death of a child is an absolute tragedy …

TB: So why did you not reach any conclusions about her death?

MQ: (48:40) Because this is a … I did a case-notes report for the, um, Director, no the Medical Director of Sperrin Lakeland, the Director of Patient treatment, the Chief Executive and I said that what they should do when I did the case report was - the case review, the notes review, was that they should get an independent person from outside our board to give an opinion as I had no intention of … (49:14)

TB: But why does it not say that in your report?

MQ: … as I had no intention of being involved in any formal complaints procedure …

TB: That wasn't a complaints procedure at that stage.

MQ: … or any …

TB: The family hadn't asked …

MQ: I said … no … excuse me!

TB: But it … none of that is …

MQ: Sorry, are you … do you allow me to speak …

TB: Yes, I can.

MQ: … or are you not going to?

TB: But I'd like to ask you the question. None of …

MQ: I, I …

TB: … that is contained in your report.

MQ: I, I've a few things that I want to say.

TB: OK

MQ: I've come out. I'm speaking to you. There you are. You've doorstepped me on a Saturday afternoon to come, you know …

TB: Well, I …

MQ: … I've plenty of work to do. So maybe you want me to speak …

TB: I would like you to speak. Yip.

MQ: The first thing I would say is, the people that you've been dealing with through the hospital have said you've been pretty rude with them. OK? That's the first thing I'd like to say (49:54). I did a case notes report. I told the people down in Sperrin Lakeland that I'd no intention of being involved in either formal complaints procedures – and I have in the past been involved with other boards in that … I had no intention of being involved in any legal case if that was what was happening and that they should get an independent person to represent them if they wanted to take it further …

TB: So why did you … just … The question that we want to ask is, in this report which had nothing to do with legal actions, when this was just part of the chairman, the chief Executive's review into the case that you completed on 26th June … (50:29)

MQ: No, no, this wasn't a review. This was <u>my</u> case-notes review …

TB: This is your medical report, yes.

MQ: … so that they could discuss with me where they should go …

TB: Well, why did you not …

MQ: What I said was, what I said was …

TB: How did you … Could I ask you a question, sir?

MQ: No you can't. What …

TB: Well, I would like to ask you a question. Why did you not come to the conclusion that she died of hyponatraemia. How did you fail to do that?

MQ: Because this is not a medical report.

TB: It is. It says `medical report' right there.

MQ: No. This is a case note review.

TB: Well, it says `medical report', sir.

MQ: That's not what it is.

TB: OK. So it's … that's wrong. That's not .. So you got that wrong as well?

MQ: No, no, no. It's a case notes review …

TB: Well, why did you not say `case notes review'?

MQ: It doesn't matter what's written there.

TB: Well, it … whether it is or not, why did you fail to come to the conclusion that she died of hyponatraemia …

MQ: Because I wasn't …

TB: … when everyone else did?

MQ: Because I was not asked to come to a conclusion.

TB: Sorry, you came to the conclusion that you couldn't find a conclusion.

MQ: What I was asked was to review the notes and see where they should go next. I told them where they should go next.

TB: But you didn't say that.

MQ: They should go to an independent person outside the Western Board. What aspect of the, what aspect of this do you want to …

TB: I would like to ask you, first of all, how, unlike every other expert, you decided Lucy started receiving …

MQ: Which, which …

TB: … liquid …

MQ: … which expert?

TB: Well, Dr Sumner or Dr Evans who gave evidence at …

MQ: Ah, so, Dr Sumner.

TB: … at her inquest. Dr Jenkins, Dr Auterson …

MQ: Dr Sumner is?

TB: All these people said she got too much fluid and the wrong fluid.

MQ: Well, I …

TB: You say that nowhere in your … .

MQ: I calculated, I calculated what you would expect to give her for a …

TB: No but you miscalculated completely …

MQ: No, I didn't …

TB: You said from 7pm in the evening …

MQ: No, no, I didn't miscalulate …

TB: … when Lucy never … yes you did. You said Lucy had a volume of fluids over seven hours between admission and 3am. Lucy only started receiving fluids at 11pm.

MQ: No, no no. If you actually look at the chart …

TB: No. Yes …

MQ: … if you actually look at the chart, she had …

TB: She had 150ml of water …

MQ: No, no, no …

TB: … between nine o'clock …

MQ: No, no, no … not water. She received oral rehydration solution.

TB: … so … Do you think that contributed towards her death?

MQ: I think she had received … I took … I said how much oral, how much fluid …

TB: 150 ml …But she didn't receive it . She only started receiving the oral rehydration at 9pm.

MQ: Anyway …

TB: 9pm, not 7pm.

MQ: Anyway, what's …

TB: so … no, no, no, no, Sir. You haven't answered that question.

MQ: No, well I (52:32)

TB: How did you calculate that? No-one calculated that over a seven-hour period. Everyone calculated from the moment she started receiving Solution 18 through a drip at 11pm …

MQ: So, yeah, so …

TB: How did you, how did you miscalculate that so badly?

MQ: No. I didn't miscalculate.

TB: You did!

MQ: No, I did not.

TB: You did!

MQ: I put exactly the calculations that I did there.

TB: Yes. Which are completely wrong.

MQ: No, they're not.

TB: And it's now …

MQ: … no they're not.

TB: This report is now completely discredited. Do you understand that?

MQ: It's not a report.

TB: It is! It's a medical report.

MQ: It's a case note review. It's a case note review.

TB: Did you write that?

MQ: Which part?

TB: Did you write …

MQ: Case note review.

TB: …medical report? Did you write that?

MQ: It may have been typed.

TB: And that is your hand. But that is your … You do recognize, this is your document?

MQ: What I would like to say is …

TB: This is your document?

MQ: It may be.

TB: Is it your document? Well it says your name on it. Is it your document?

MQ: It may be.

TB: It is your document. Well, I'm saying it is your document and it says `medical report', not `case note review'.

MQ: A point I'd like to make is that back in 2000, the commonest fluid used for children who where deemed to be unwell, dehydrated, the initial fluid that was given to hundreds of children all throughout the UK was fifth normal saline. Now you'll see that … (Trevor flicking through pages) you've probably got someone to look at that, who said that I said that fluids were …

TB: Well, the Coroner has expressed real concern and, I mean, you say here, `I find it difficult to be totally certain as to what occurred to Lucy in or around 3am'. A doctor of your experience, a consultant …

MQ: The only …

TB: … a paediatrician of your experience …

MQ: The only, no, this is …

TB: No-one, no-one, everyong is now totally certain what happened.

MQ: Anybody …

TB: Everybody is totally certain who has given evidence in the …

MQ: Anybody who wrote anything without the full information, which I did not have …

TB: Why did you not?

MQ: … because I did not want to talk to the parents; I did not want to talk …

TB: No, no, no. Neither …

MQ: …to the medical staff; I did not want to

TB: No, but neither did Dr Sumner …

MQ: … to talk to the nursing staff.

TB: … nor Dr Evans.

MQ: Well, how did they come to a conclusion?

TB: Well, they've come to their conclusion because they say it's simple: whenever you give a child 400ml of the wrong fluid over a four-hour period, she will suffer from hyponatraemia and cerebral oedema. You don't even understand that.

MQ: Oh, actually, I do.

TB: Well, why did you not put that in your report?

MQ: Because it's not a report …

TB: Do you not accept she died of hyponatraemia?

MQ: That's what the coroner said.

TB: Do you accept that?

MQ: It may be. I mean, there are a lot of explanations …

TB: So you disagree with the Coroner?

MQ: No, I don't disagree. I'm not saying that at all …

TB: Look, I'll read you the coroner's findings …

MQ: No, it's fine. It's OK.

TB: The coroner said it was the wrong fluid and too much of it. (54:50)

MQ: Fine. I think I'm going to make no more comments. OK? I've said my piece. The commonest fluid used for rehydrating children back in 2000 was fifth normal saline. That has changed. It actually changed after a case in Alt…

TB: A death in Altnagelvin Hospital. Did you warn Altnagelvin Hospital when you read Lucy Crawford's notes? Did you say anything about the dangers of rehydrating children who used dangerous …

MQ: Eh…

TB: Did you accept …

MQ: So that's the commonest fluid that was used.

TB: Did you say anything to Altnagelvin? (55:14)

MQ: That was the commonest fl;uid was used at that time. I'm very sorry that Lucy Crawford died and I hope that her parents are allowed to grieve in private, not in public. Thank you.

TB: But do you think they deserve the truth?

MQ: Thank you.

TB: Do you think they deserved the truth of what happened?

MQ: They've been through the formal complaints procedure. They've been through a court case where I understand they got financial compensation for, for whatever reason. They've been through … and there's been another TV programme. There've been paper reports, none of which … the Coroner's court. So they're got the answers (shrugs).

TB: They don't. They say they don't.

MQ: Well, they've got the answers.

TB: They say they don't. I mean, they say that this report actually compounded their problems because of your failure …

MQ: No, no, no. compounds the problems?

TB: Yes. Because you failed. You ignored the evidence.

MQ: No, I didn't ignore the evidence. This is …

TB: Well, explain to me, Dr Quinn.

MQ: … from limited evidence.

TB: The same evidence that Dr Evans and Dr Sumner came to. (Dr Quinn puts his hands up and starts to walk away) No, just explain to me something …

MQ: No, no, that's fine. Thank you very much.

TB: How did you? How …How did you …

MQ: That's it. That's it. No that's finished.

TB: Did you …

MQ: Finished.

TB: Do you …

MQ: Finished.

TB: Do you admit that Lucy Crawford died of hyponatraemia?

MQ: That's what the Coroner …

TB: Do you in your expert …

MQ: I have no comment to make on anything because I did not talk to the parents. I did not talk to the medical representatives and I did not talk to the nursing staff.

TB: So, did you …

MQ: (Shrugging, hands up) Finish.

TB: … feel you could do a report like this without talking to these people.

MQ: I did a case note review (56:36)

TB: It doesn't say that. It says `medical report'.

MQ: and I said to Dr Kelly and to Mr … ah … what's his name …

TB: Fee.

MQ: … Mr Fee that I would discuss it with them. I was sweet-talked into writing a summary which is not the complete amount of discussion that I had at that time, so anyone who make a …

TB: You were sweet-talked?

MQ: … if I were …

TB: You were sweet-talked?

MQ: … if I were … if I were …

TB: Sweet-talked by whom?

MQ: If I were to write a medical report, I would talk to all the people involved. I did not so …

TB: Sorry it says …

MQ: … the information that I had was …

TB: It says …

MQ: Excuse me!

TB: It says `medical report'.

MQ: No. The information that I had was limited and I think that anybody who comes to any conclusions there, they …

TB: So you're prepared to put yourself, name to a document of a medical review …

MQ: Anyone, anyone …

TB: … with limited information?

MQ: anyone who comes to a conclusion without speaking to all these people, I think would have to go back and look at their evidence.

TB: I …

MQ: Thank you very much.

TB: Did you do that?

MQ: (Shrugging). I've no …I wasn't involved with this. Thank you (walks down path and into house).

TB: And did you say anything to Altnagelvin about your concerns of hyponatraemia? Have you raised fluid management at Altnagelvin? (door clicks shut and Dr Quinn disappears inside) (57:45)

INSIGHT SCRIPT

Programme title: Vital Signs
Production number: 03/07/09
TX date: 27-02-03
Reporter: Trevor Birney
Producer: Ruth O'Reilly

INSIGHT OPENING TITLES

COMMENTARY:
On a summer's day in June 2001 this little girl was admitted to hospital to get her appendix removed. Three days later she was dead. Tonight Insight hears from the expert who says the fluids system used by Altnagelvin caused the condition which killed nine year-old Raychel Ferguson. We set out the tell-tale signs the hospital missed and the obstacles now frustrating her parents who say they still don't know why a routine operation went so drastically wrong.

TITLE BAR: VITAL SIGNS

MARIE FERGUSON (AT THE CEMETERY):
"It is very heartbreaking for my to come here but it is the only place now that I can feel that I am close to Raychel. I come here and talk to Raychel and tell Raychel that, tell her what is happening, the boys are away to school, the boys are coming back from school and I have to go home now to make the dinner but I will be straight back as soon as I get that done. And then at night when we come over to say night-night we will see you in the morning."

COMMENTARY:
Hundreds of miles away in London, this eminent physician has studied the events that led to Raychel's death. Dr Ted Sumner, who was a paediatric anaesthetist at the world-renowned Great Ormonde Street Hospital, was an expert witness at Raychel's inquest and believes she should never have died.

DR TED SUMNER:
Q) Did Altnagelvin hospital fail Raychel Ferguson?
A) Well, in that she was a normal little girl who came in for a minor procedure and then died as a result of it, then I would say that was a failure.
Q) A catastrophic failure?
A) A catastrophic failure.

COMMENTARY:
Raychel Ferguson was Ray and Marie's only daughter. A lively child, she was like a second mother to the two youngest of her three brothers as they grew up at Coshquin on the outskirts of Derry. Like many of her friends, she had a passion for fashion and the boy band Westlife.

MARIE FERGUSON:
"Ah, she just loved all her brothers, but Jason and Jamie, the youngest two, she just doted on the two, she was just like a second mother to them and very particular about her bedroom, she wouldn't let anybody into her bedroom, especially Jason and Jamie. If they went into you would hear Raychel from the end of the street shouting `get out of my room'. But no, she loved her brothers so much."

COMMENTARY:
On June 7 2001 Raychel came home from school a winner. She'd won a medal in her sports day but she wasn't in the mood for celebrating. Instead, she complained of stomach pains.

MARIE FERGUSON:
" Raychel then followed me into the living room and then that's when I noticed her face had changed, a grey colour. I said, no, there is something badly wrong here. So I rung Mary and put Raychel into the car and collected Ray and took her straight to the hospital."

COMMENTARY:
At Altnagelvin Hospital Raychel was quickly diagnosed as suffering from appendicitis and underwent surgery that night. The operation went ahead without complications.

RAY FERGUSON:
"Raychel wakened up around, just shortly before 8 o'clock and she is chatting starting to come round great, fantastic I thought. She got up out of the bed, I couldn't believe this, Raychel getting out of the bed just a short while after the operation, she walked up the corridor with me and she walked back down again, I think she went to the toilet and she came back. I said everything is great, I said I will scoot down and get to pens and colouring book, came back up chatting away, she sitting drawing and then she set on the bed and started drawing, I phoned Marie, I said you will not believe our Marie is up and down the corridor the walking."

COMMENTARY:
But eleven hours after the operation came the first sign that all was still not well with Raychel.

RAY FERGUSON:
"I think Marie came over at 10.30 and we were chatting away and she said to Marie guess what mummy I vomited but she never told me, shortly afterwards she said mummy I have to vomit again. So Marie took her out to the toilet, carried her out to the toilet, Marie came in and said she had a big vomit down in the bathroom she nearly filled the sink.

COMMENTARY:
Then she was sick again. But those caring for Raychel didn't seem especially worried.

RAY FERGUSON:
"It was right and regular, I went down a number of times to the nurses and they just said, 'ah her stomach is empty now she will not throw up any more'. But we left then around 3 o'clock, we had to get the boys from school. Marie came back over at 4.00 again now, and soon as I walked into the ward Raychel was just lying on the bed and there was a lady across from Raychel with her child she said that since you left at 3.00, your daughter hasn't stopped vomiting, she had been vomiting constantly and then I was talking to Raychel and said are you alright love. But at this stage she was really weak, she was very pale, I kept talking to her, but Raychel wasn't really responding she was just looking at me with her eyes. I said my God, you are weak love there is something wrong."

COMMENTARY:
Raychel was in fact exhibiting the early signs of a condition called hyponatraemia. Dr Sumner says there was nothing unique about Raychel that caused her to develop it. Instead, he says, the hospital was responsible. Like any other patient after an operation, Raychel's brain was telling her body to retain water. It's known as the anti-diuretic response. But the hospital was giving her more water through a drip which, according to Dr Sumner, began a vicious circle. Firstly there was too much water in Raychel's system, causing her brain to swell. This swelling was making her sick. By vomiting so heavily, Raychel was losing vital sodium which would otherwise have helped her system balance itself out. The drip was not replacing that lost sodium and was giving her too much water. By giving Raychel too much fluid and not enough sodium, Dr Sumner says the hospital was causing the lethal condition.

DR TED SUMNER:
"If you give generous volumes of a solution that doesn't contain much sodium, contains mostly water, then you will get dilutional hyponatraemia. And of course in Raychel's case this problem was exacerbated by her vomiting which makes you lose sodium. So sadly she was on a course to get hyponatraemia because she was being given, first of all she mounted the anti-diuretic hormone response which is absolutely routine, usual. She was given a very generous amount of post-operative water and she vomited, so to me it isn't surprising that after 24 hours she became moribund from this condition."

COMMENTARY:
So the hospital was giving too much water and not enough sodium. A basic blood test would have identified the problem and a conventional saline drip corrected it. But other patients were given similar fluids to Raychel. So why did only she die? Dr Sumner says it was because Raychel was vomiting so much. And he says the hospital failed again by not monitoring how sick she was.

DR TED SUMNER:
"Well, I would think that after the second large vomit, that would go my mind, that should have raised alarm bells that there was something wrong."
AND: "I think that by, after the second big vomit at 10.30 in the morning they might have decided to see how much she was losing ... in this way and probably replace it intravenously by the same volume of saline."

COMMENTARY:
Raychel continued being sick into the evening. At around teatime one of the doctors gave her an injection of an anti-sickness drug. She was now weak and listless - more evidence of hyponatraemia.

RAY FERGUSON:
"I brought the boys, her wee brothers over and a wee friend and when I came in she didn't look well at all to me. She didn't even acknowledge her brothers and usually she is piping up once she sees her brothers, she never even acknowledged them. Her wee friend set down beside her, she never even acknowledged her. I said to Marie she doesn't look well at all, you know, she is really lifeless in the bed more or less, you know just lying there, just more like a glaze looking around."

COMMENTARY:
Then came another vital sign of Raychel's accelerating deterioration... a headache ... a result of Raychel's brain swelling and pressure building up within her skull.

RAY FERGUSON:
"I just said to the nurse 'look my daughter is not very well at all, she is not well' I said she has got up on the bed there now, with her hands on her head, shouting daddy, daddy my head is very sore and I said her face is very red. I will come in now and give her a paracetamol. I just said right to myself, you know better."

COMMENTARY:
The anti-sickness drug wasn't working either. Raychel was sick again ... only the material she was bringing up contained what looked like coffee grounds ... an unmistakable sign that Raychel was vomiting blood.

RAY FERGUSON:
"I went out a phone Marie and I was kind of panicking on the phone and I said to Marie our Raychel is not well at all and I don't even think the nurses is even taking me on. That is what you did say, he said ' the sweat is running down my back, our Raychel is not well, she is throwing up blood now and everything."

DR TED SUMNER:
"Well, I think after vomiting coffee grounds that really is abnormal, really, because it implies bleeding in the stomach ... It is something that happens to a very stressed patient for example but it is completely pathological so I think at that stage that would be the final stage in my view that something could have been done. Because they didn't have very long. I mean, that was 9 o'clock by which time her electrolytes, the cerium, sodium and potassium and magnesium would all have been very deranged, but not too late to do something about it.

COMMENTARY:
The hospital has claimed that Raychel's sickness wasn't unusual ... a nurse at the inquest said she'd seen other patients who'd been sicker after an operation ... but with no ill-effects.

DR TED SUMNER:
"It was severe vomiting and prolonged ... and also she must have strained and strained vomiting because she had little haemorrhage marks in her neck."

RAY FERGUSON:
"We kept coming out and saying to the nurses, look there is something wrong. 'Its only natural', they kept telling us, 'after an operation'. That is all we got, 'it was only natural'."

COMMENTARY:
The Fergusons said good night to Raychel at about half past twelve on the morning of Saturday June the ninth. Unknown to them they were also saying good bye. A phone call came from the hospital about three hours later. Raychel was now suffering convulsions.

RAY FERGUSON:
"Raychel was all tightened up on the bed, you know shacking more or less in the bed and the nurse said to me, 'your daddy is here now' so I grabbed her by the arm but her arm is really stiff and I said ' Raychel daddy is here now Raychel' she never acknowledged one thing at all. So I went out and phoned her right away and said Marie go and come over here right away, she said what is wrong I said just come over. By this time when I came back in they just lifted her as soon as I came in, lifted her out of the bed and rushed her down to the treatment room.

COMMENTARY:
But the realisation of just how sick Raychel was had come too late. The fits marked the point where her brain had become so swollen, it was being forced into the hole at the bottom of the skull, a process known as coning. Two brain scans were carried out on Raychel ... she was given the Last Rites and it was arranged for her to be transferred to the Royal Belfast Hospital for Sick Children. But by this stage the damage was massive and most likely untreatable.

DR TED SUMNER:
Q) "When you read the notes at the point in which Altangelvin decided to transfer Raychel to the Royal Victoria Hospital for Sick Children what was he condition in your estimation then?"
A) "Well she had already become unconscious and was and had changes in her pupils implying that she had already undergone this coning process which unless active steps are taken, is usually fatal. I think she was very sick indeed at that stage. It is possible that she was already in an irreversible cerebral state at the time, which was irrecoverable at that stage."
Q) "She was brain dead?"
A) "I think so."

COMMENTARY:
While police escorted Raychel's ambulance the seventy-five miles to the Royal, her parents made the harrowing journey in another car. They arrived in Belfast clinging to hope … only for the doctors there to give them devastating news.

RAY FERGUSON:
"They came in and told us she is brain dead. That was very hard to, we would have to decide to switch off the machine because she is really brain dead. Well Marie didn't want to switch off the machine, so we went outside for a bit of fresh air have a chat talk about it, I kept saying to Marie, Marie she is not there now, its only the machine now that is making her breath, she is already gone. So we decided then we talked to the family, so we decided then for the doctors to go ahead to switch it off. So we went down into the room were she was lying, lifted her out of the bed onto Marie's knee and the nurse said to the other doctors: when you are ready. So they took the pipe out which was keeping her breathing and Raychel just died in Marie's arms, you could never forget that. She died in her arms." (continues with Marie sobbing)

Fade to black

REPORTER PIECE TO CAMERA:
Still struggling to come to terms with the shock of losing a daughter, the Fergusons were also in dark about what had actually caused her death. They were told it was hyponatraemia but that didn't explain how or even why she had developed it. Their quest for answers led them to Altnagelvin hospital, but a meeting here with senior staff two-and-a-half months after Raychel's death left Marie feeling that the authorities were closing ranks.

MARIE FERGUSON:
"I just asked when I went in, what happened to Raychel ... He turned round and said he never seen anything like it, it is very rare. I said well surely when Raychel was throwing up the vomiting and she was throwing up blood, I said surely then there was cause for concern somewhere, for someone to something. I will never forget it the nurse in the chair she just folded her arms and set back in the chair and she said Mrs Ferguson we had no cause for concern.

COMMENTARY:
Compounding the Fergusons' grief was the discovery that Altangelvin didn't learn from the death of another child - a toddler - from hyponatraemia at the Children's Hospital in Belfast seven years ago. Altnagelvin has hinted that the Royal should have passed on the lessons of that death to other hospitals more effectively. But doctors at the Royal have told Insight that they would expect any teaching hospital like Altnagelvin to be actively on the lookout for all new medical developments. Northern Ireland's most senior doctor has now acknowledged that the Province may have been lagging behind other regions in this respect.

DR HENRIETTA CAMPBELL, CHIEF MEDICAL OFFICER:
Q) "What lessons do you think have to be learnt from the case of the death of Raychel Ferguson?"
A) "Well Northern Ireland is a very small place with a population of 1.5million people, when untoward and rare events happen we need to find a way of learning from them. Now they only happen every 5 years or every 10 years. It is very difficult for the service to learn from that to remember what happened to have a memory about those untoward events. And what this has shown to us is that together with the rest of the United Kingdom we need to take part very carefully and very clearly in the systems that are now being put in place to ensure patients safety. Northern Ireland is too small a place to learn of itself from these very rare events."

COMMENTARY:
Hyponatraemia IS rare. But that doesn't mean it's unheard of ... and Dr Sumner says the fact that hospitals can cause it, means they SHOULD know about it.

DR TED SUMNER:
"I would expect them to be aware of this, I would. Yes I would, it is something that is taught to every medical student and, as I said in Court, I mean, I was taught about the need for input and output measurements for the professional management of fluid therapy in the post-operative patient. It is a Cinderella area and I think it is hard to say why people aren't interested in it or think it is routine and therefore things will always sort, the body will sort itself out, you know."
"How surprised were you to read the facts of this case that this hadn't been spotted?"
"We I think it was a very, it is a tragic case, this and I was very sad actually that this series of events had been allowed to happen."
"Were you surprised by them?"
"I supposed I was surprised. I was surprised and possibly a little exasperated that the sort of the basics, the really true basics of fluid therapy had not been understood. That you replace what is being lost. And it seems to me to be totally basic post-operative fluid management.
Dr Sumner (Tape 5 - 6:32:45 - 6:33:30): " I think it was in the back of everybody's mind, Raychel has appendicitis, it wasn't even a very severe appendicitis and it was always in the back of their mind, I think, "Oh she will be all right until it was too late"

COMMENTARY:
Insight approached Altnagelvin Hospital but but senior management declined to take part in this programme, citing the possibility of future legal action by the Fergusons. Altnagelvin changed its fluids protocol after Raychel's death and the Department of Health drew up new guidelines about Hyponatraemia to be displayed in wards. This cases certainly raises questions about standards in our healthcare system ... but it's also being held up as an example of why that system needs to be more open.

MARIE FERGUSON:
"We feel that somebody has to be held accountable for what happened to Raychel. We want somebody more or less, to put their hands up and say I am to blame, we are to blame, but we know ourselves that is never going to happen."

COMMENTARY:
Earlier this month the Fergusons arrived at the Coroner's Court in Belfast hoping that Raychel's inquest would cast more light on what had happened to her. But they came away disappointed. The Inquest system here doesn't allow the Coroner to reach verdicts or apportion blame. His finding was what already knew: that Raychel died of a Cerebral Oedema caused by Hyponatraemia. But the Fergusons were particularly incensed that the two surgeons who dealt with Raychel and who were responsible for her fluids, were not there to give evidence. One was excused, the other didn't turn up, the court was told he was off on leave.

RAY FERGUSON:
"Well Dr Leckey he excused one which I don't agree, he shouldn't have excused him even he had exams he shouldn't have excused him. He was supposed to be looking after our Raychel he had questions to be answered to, but we never got the answers from him."

COMMENTARY:
The Fergusons search for answers about Raychel's death continues but they're still haunted by what could have been had healthcare professionals simply listened to them while their daughter was still alive.

DR TED SUMNER:
Q) The parents of Raychel Ferguson will feel. Raychel Ferguson parents would say that they were raising the alarm bells but they weren't being listened to. Is there an issue of arrogance here that parents are too easily dismissed?
A) I think it is a good point, I think there is often a feeling among medical and nursing staff that they know best. In my opinion it is always very unwise to dismiss the opinions of the parents after all it is they who know their child best. And in this case there does seem to have been a failure of communication."

RAY FERGUSON:
"If they had maybe took more heed of what we were saying about the vomiting and the blood and that and had really got that checked, then Raychel would have been here ... They are professionals, we have to go with what they say. But yet she was our daughter and we knew that she wasn't well."

PAUSE

MARIE FERGUSON:
"I am just sorry I took her to the hospital, I thought I was doing the best thing for Raychel. " (weeps)
AND (Marie in Raychel's room)
" I come in here every night and say, look at her picture and say look Raychel what did happened love. I keep saying to her, I come in here and talk to her and say that someday somebody will be hopefully be held accountable for what they done to you, because you didn't deserve what you got."

CLOSING TITLES
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