From the Permanent Secretary
Clive Gowdy CB

17 NOV 2004

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

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15 November 2004

Mr Alan Bremner
Director of Television
Ulster Television PLC
Havelock House
Ormeau Road
BELFAST BT7 1EB

Dear Alan,

THE ISSUE PROGRAMME

Thank you for your letter of 9 November 2004.

I agree that it would be appropriate to suspend any further correspondence on this matter at this time.

Yours sincerely,

Clive.

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Mr Clive Gowdy, CB
Permanent Secretary
Department of Health, Social
Services and Public Safety
Castle Buildings
Stormont Estate
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9 November 2004

Dear Clive

The Issue: 11.00pm 25 March 2004

When I wrote to you on 3 June 2004 about a response to your letter of 13 May 2004, I advised you that we were planning to broadcast another programme on the children's deaths, and that after its transmission I would reply to the points your letter raised.

Taking into account what has happened since the second programme's transmission, I hope we can agree to suspend any further correspondence on the matter.

Yours sincerely

Alan

Alan Bremner
Director of Television

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Mr Clive Gowdy, CB
Permanent Secretary
Department of Health, Social
Services and Public Safety
Castle Buildings
Stormont Estate
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3 June 2004

Dear Clive

The Issue : 11.00pm 25 March 2004

Thank you for your letter of 13 May, and for the important points it raises.

When I wrote to both you and Dr. Campbell on 8 April, I told the CMO that we were continuing to investigate the circumstances of the deaths of Lucy and Raychel and the events which have followed them. As you know, Dr Campbell has recently written a newspaper piece about the matter, so the deaths and the CMO's responses to them remain the subjects of considerable public interest.

Since we are considering a second programme, I prefer to postpone a detailed reply to your letter until after the broadcast.

Yours sincerely

Alan

Alan Bremner
Director of Television

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17 MAY 2004

From the Permanent Secretary
Clive Gowdy CB

Department of
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13 May 2004

Mr Alan Bremner
Controller of Programmes
UTV
Havelock House
Ormeau Road,
BELFAST BT7 1EB

Dear Alan

I have taken some time to consider your reply of 8 April to my letter of 29 March. While I was disappointed with that reply, I do not see any merit in opening up a prolonged exchange of correspondence about the rights and wrongs of the events of 25 March – we will both clearly hold to our respective views on the matter. However, I have come to the conclusion that some of the points made in your letter cannot be left unchallenged and so I am sending you this further letter to put our response to these points on the record.

I am particularly concerned at the suggestions in your letter that Dr Campbell was "evasive" in dealing with the questions put to her, that the "veracity" of what she was saying was subject to dispute and that she was contradicting the Coroner's findings. I am sure that you will appreciate that these are very serious comments to make about a person whose honesty, integrity and professional reputation are paramount in fulfilling the difficult and demanding role she performs.

Needless to say, we do not accept that the CMO was in any way evasive or lacking in veracity in the responses she made to the interviewer's questions. You will recall that part of my concern was that the way in which the interview was conducted meant that Dr Campbell was not afforded the opportunity to give the full and frank answers that she wished to make. I should reiterate for the record that Dr Campbell voluntarily agreed to participate in the programme to fully explain the lessons learned and the steps being taken to prevent such a tragedy happening again. There is no question of her doing anything other than being prepared to deal with the facts and that is what she tried to do but was prevented from doing so by the approach adopted by the interviewer.

Your letter makes much of the suggestion that there was a contradiction between the comments made by Dr Campbell and the findings of the Coroner. There is in fact no such contradiction. Let me put it in plain terms. The coroner was correctly identifying that, in terms of the cause of death, it was the administration of the fluid therapy that led directly to the death of Lucy Crawford. What the CMO was saying was that such a fatal consequence was a rare event, that this cause and effect was not commonly known at the time and that administration of this fluid regime was then not an abnormal event in paediatric departments throughout the UK.

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I note that Dr Sumner is recorded as disputing the veracity of the CMO's point that the adverse response was not widely known at that time. We would strongly reiterate the point that there was not a widespread awareness of this reaction and, indeed, we understand that this particular fluid therapy was then in common use in the paediatric department of the hospital in which Dr Sumner himself worked.

In fact, there is still considerable debate among paediatricians regarding the most appropriate intravenous fluid therapy for children. The area of fluid administration in a sick child remains a complex area and within the past few weeks a series of articles published in the highly respected paediatric journal, Archives of Disease in Childhood, highlights the debate on this matter among experts and the many complexities surrounding fluid management in general and hyponatraemia in particular. Regrettably, within such a complex area, problems do on occasion arise as emphasised by the death of a child from hyponatraemia in a major UK hospital as recently as 2003, presenting with a similar clinical condition to that of Lucy Crawford.

Your letter also suggests that the CMO gave an unsatisfactory answer on the reporting of the case. I need to correct you on this point. The Chief Medical Officer became aware of the Lucy Crawford case after being written to by the Coroner. We fully accept that Mr Stanley Miller had alerted the Coroner to the case to draw attention to the similarities with the earlier inquest on Raychel Ferguson, but this does not alter the fact that the Chief Medical Officer was made aware of Lucy's death when the coroner brought it to her attention after considering Stanley Miller's comments and re-examining appropriate documents.

What this pointed up in terms of the reporting of untoward incidents was that there was a lacuna in the arrangements for informing the CMO of such events and that we were hampered by the absence of a formal system to report untoward deaths within hospitals at the time of Lucy Crawford's death. In Northern Ireland there are about 15,000 deaths each year, the majority of which occur in hospital. Approximately 3,500 of all deaths each year are reported to the coroner. Within this context and noting the events involving the deaths of these two young girls, it is clear that it is not any absence of reporting that is at issue, but rather that any new system needs to be capable of identifying those incidents that require further scrutiny and the possible alerting of clinicians of any issues of risk.

I want to take the opportunity to say to you that the conclusions which those making the programme formed on this matter and which you set out in your letter are simply not correct. As I have tried to demonstrate, this is a serious and complex issue and it deserves more than the simplistic treatment which it received in your programme and which identified Dr Campbell and her office as at fault. Unfortunately, the important messages which Dr Campbell tried to convey to the public to explain and reassure them were not allowed to be made by the way in which the interview was conducted.

These messages included the important point that, as part of her responsibility to protect the health of population, following the death of Raychel Ferguson, Dr Campbell convened a working group to

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develop guidance on the prevention of hyponatraemia. This guidance was published in 2002 and Northern Ireland was the first part of the UK to issue such guidance. It provides very practical advice for doctors and nurses who manage the care of children in hospital. I should add that it has been commended by local clinicians, by the Belfast coroner, and by Dr Sumner who praised the guidelines when giving evidence at the inquest into Raychel Ferguson's death.

Furthermore, Dr Campbell has recently initiated two further steps to ensure that the guidance remains up to date and is fully and properly applied. Firstly, she has sought assurances from Trust Chief Executives that the guidance has been implemented. Secondly, she has asked an international medical expert in the speciality of paediatrics to quality assure the guidance in light of the findings of the inquest into Lucy's death and any of the more recent emerging evidence on hyponatraemia since the publication of the guidance in 2002. It was unfortunate that the interviewer did not give Dr Campbell the opportunity to put these points across since this would have provided the necessary balance to reassure the public of the important steps that have been taken since the deaths of these young girls.

Finally, I believe that it is important to make the point that the relationship between the Department and the media is one in which clarity, trust and confidence are critical. When assisting with a current affairs programme, we take the view that it is part of our role to provide information and comments that will be helpful in improving viewers' knowledge and understanding of health issues. This is why it is so important that there is mutual understanding of how the programme will be conducted. This lies at the heart of our concern about the pre-programme discussion between Kevin Mulhern and Trevor Birney. It is our view that the contemporaneous notes made of the conversation between Trevor Birney and Kevin Mulhern and from which you have quoted in your letter, are selective to say the least. They do not refer to Trevor's comments that the programme would not be seeking to hold the Chief Medical Officer accountable or laying blame at her door. Hence our concern about the nature of the information we were receiving and our need for assurances about future contacts.

Yours sincerely,

Gowdy

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Mr Clive Gowdy, CB
Permanent Secretary
Department of Health, Social
Services and Public Safety
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

8 April 2004

Dear Clive

The Issue : 11.00pm 25 March 2004

Thank you for your letter of 29 March which followed our telephone conversation on 26 March. As I explained to you, I viewed the programme before approving its transmission. I therefore stand by what we broadcast.

We fully accept that Dr Henrietta Campbell ("the CMO") is in no way responsible or culpable for the deaths of Lucy Crawford and Raychel Ferguson. Our involvement with the CEO in relation to this issue began in March 2003 when an **Insight** team met with Stella Burnside, Chief Executive of the Altnagelvin Trust to discuss the death of Raychel Ferguson. It was the Chief Executive who directed us to Dr Campbell, telling us that she was best informed to do the interview and, in fact, had already agreed to speak with us.

At that time, the CMO told us in an on-the-record interview for **Insight** that:

"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, through the Health Service in Northern Ireland, to see what can be done to improve care, to learn from the past."

Given her acknowledgement of her public obligation and accountability we decided that it was entirely appropriate to interview the CMO for **The Issue** programme on 25 March and to see if **"measures (had) been put in place.....to learn from the past".** In my notes of our telephone conversation I have recorded you as saying that there are "legitimate concerns" about the CMO not being told about untoward events and that there are procedural shortcomings in the communications (about untoward events) between some Trusts and/or Boards and your Department. I would respectfully

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suggest that if systems failures remain in March 2004 and if families such as the Crawfords and the Fergusons are so aggrieved, we are entitled to ask the CMO what has been put in place, and learned from the past.

You have criticised us for not briefing Mr Mulhern appropriately. As you know, we sent Mr Mulhern an e-mail about our plans some two weeks before the programme, and a week prior to that our Current Affairs Editor, Trevor Birney, had an explanatory conversation with Mr Mulhern about the matters we were interested in. You spoke to me about Mr Mulhern's report of the conversation Mr Birney had with him on the evening before the programme's transmission. Our notes of that conversation record Mr Mulhern's major concern was how the Sperrin Lakeland Trust and the Western Health Board were to be represented on the programme. Mr Mulhern did not attempt to explain the role of the CMO in relation to these untoward deaths despite admitting that the Sperrin Lakeland Trust "had kept Lucy's death to themselves". This last remark goes to the heart of the matter – when did the CMO know about Lucy's death, and when should she have been told? You will consequently understand why we pursued this important line of questioning. We absolutely refute that Mr Mulhern discussed the message that the CMO wanted to get across. He was preoccupied with what the public perception of the Sperrin Lakeland Trust was and what it should do, given the gravity of the allegations made by Mrs Crawford, and he undertook to phone the Trust's Chief Executive and suggest he make himself available for interview the following morning. We have contemporaneous notes of this conversation.

As we discussed in our telephone call, you are displeased about the conduct of the interview. When we spoke I said that an interview of this nature is not shaped solely by the presenter – the interviewee's response is an equally important factor. I said the CMO had been evasive.

We were determined to test the allegations made by both families that they had been appallingly treated, that there had been an unacceptable communications failure between the Trusts, the Board and the CMO, and that the Coroner and the CMO disagreed about the cause of death.

The CMO began her response by expressing her deep regret on the deaths of the children and the anguish of the families. She then chose to rehearse the argument that the deaths were due to an idiosyncratic physiological response to the fluids on the part of the two children. She said:

"The rarity in this event, and you do have to return to the medicine, the physiology behind these two events. The rarity in these two events was the abnormal reaction which is seen in a very few children to the normal application of fluids."

This completely contradicts the Coroner's findings which said nothing about physiology or an unpredictable and abnormal reaction. He totally rejected the CMO's contention that there had been a normal application of fluids. The Coroner said:

"The collapse which led to her death was a direct consequence of an inappropriate fluid replacement therapy in that the use of 0.18% saline to make deficits from vomiting and diarrhoea was wrong, too much of it was given and there had been a failure to regulate the rate of infusion."

The CMO repeated her argument about the idiosyncratic reaction, and then when pressed said that she agreed with the Coroner's findings. She also claimed that in 2000 "very few people" would have understood the cause of the children's deaths.

We spoke again to Dr Ted Sumner after the programme, and he disputes the veracity of the CMO's claim. He has told us that articles on hyponatraemia were first published in the eighties in the British Medical Journal, and that the outcomes of fluid maladministration would have been understood long before 2000.

The presenter was therefore having to deal with the following inconsistencies: firstly, the CMO offers her explanation of the cause of death - and then accepts the Coroner's findings which directly contradict her explanation. Secondly, she holds to the view that only a few medical professionals in Northern Ireland in 2000 would have been aware of hyponatraemia, yet the presenter knows this is also contradicted by the medical experts who gave evidence at both Raychel's and Lucy's inquests. Their view is that the potential risks in the administration of fluids would have been well known at that time.

Thirdly, even on the matter of the reporting of the case, the CMO gives an unsatisfactory answer:

"We learnt of this untoward event, Lucy's death, when Raychel died and the Coroner saw that he had two cases presented to him which looked similar in terms of tragic outcomes. So the Coroner, noticing a pattern, reported those two cases to me."

Fearghal McKinney knew that this was also not the case. Belfast Coroner, John Leckey, said in his preliminary statement at Lucy's inquest that it was a health official in Omagh who had spotted similarities in the cases of Raychel and Lucy. Nowhere did he claim that he had identified the pattern. Mr Leckey told the Inquest:

"On 27th February, 2003 I received a letter from Mr Stanley E Miller, Chief Officer of the Western Health and Social Services Council in which he referred to an inquest I had held a short time previously into the death of Raychel Zara Ferguson aged 9 years. She had died from cerebral oedema due to hyponatraemia and I understand that the publicity surrounding the inquest led Mr. Miller to speculate if the two deaths had any common features."

Given this statement, is it not reasonable to ask the CMO if it was appropriate that the only way she was to learn of Lucy's death was through the inquest process? If this is typical, it appears that the referral requirements are not defined, and that the CMO is only learning indirectly and belatedly what she should know directly and immediately.

When one considers the importance of these three points, can we criticise an interviewer for robustly interviewing a CMO who contradicts herself on the cause of death; significantly downplays the level of understanding of the importance of fluids management; does not find out about an untoward event until three years after it happens, and does not learn of it from the hospital itself?

You told me that Dr Campbell was very upset by the way she was interviewed, and you will probably know that she has also written to me about how she was treated. It is never our intention to cause distress to any programme participant, and we have always valued our relationship with both Dr Campbell and your Department's staff.

The programme, however, was about the distress of two families who clearly had been treated appallingly by health officials. The following week, the Sperrin Lakeland Trust issued a public apology to the Crawford family for the way they had dealt with Lucy's case. On April 1st, the Impartial Reporter led with a front page article headlined "Trust – we killed Lucy". The paper also reported the Chief Executive of the Sperrin Lakeland Trust as saying that (at the time of Lucy's death) "there was no formal reporting mechanism for unexpected deaths to be conveyed to the CMO". How are the public meant to reconcile the CMO's stated role to "make sure we learn from untoward deaths" when she had not put in place any reporting mechanism before Lucy's death nor Raychel's death 18 months later. I note that, since our broadcast, the Health Minister Angela Smyth has felt the need to state that "work is underway to improve the mechanism for reporting and investigating".

We believe that it was in the public interest to raise the issues surrounding the death of the children and the way their families were subsequently treated by the system. We also believe that the rigorous questioning was entirely justified because it was important to challenge the inconsistencies in the CMO's position, and to reveal a number of professional shortcomings in the system which, it would appear, her Office has not yet rectified.

I have written separately to Dr Campbell and have also copied this letter to her.

Yours sincerely

Alan

Alan Bremner
Director of Television

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Dr Henrietta Campbell, CB
Chief Medical Officer
Health, Social Services and Public Safety
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

8 April 2004

Dear Dr Campbell

Thank you for your letter of 29 March.

As you know, Clive Gowdy conveyed his concerns to me on the day after the programme's transmission and he also sent me a letter of complaint.

I am sorry to learn of your distress. However, I have had to state in my reply to the Permanent Secretary that we believe strongly that some of your responses to the questions we asked were deficient and, as such, must have been discomfiting. Fearghal's questioning was certainly robust, but I would respectfully suggest that the inconsistencies in your answers were bound to require close scrutiny on Fearghal's part.

I am genuinely appreciative of the contributions you have made to many of our programmes, and we would be disappointed if your Office were to step back from what has been a most positive partnership. However, I have to tell you that because of what emerged in the programme and what has since been said by other parties about systems failures relating to the deaths of Lucy and Raychel, we plan to produce further reports on the matter. It would, I believe, be a matter of considerable regret to many people if your Office felt unable to be involved.

Yours sincerely

Alan Bremner

Alan Bremner
Director of Television

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From the Permanent Secretary
Clive Gowdy CB

1 APR 2004

Department of
Health, Social Services and Public Safety

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30 March 2004

Mr Alan Bremner
Controller of Programmes
UTV
Havelock House
Ormeau Road,
BELFAST BT7 1EB

Dear Alan,

We spoke following the transmission of "The Issue" programme on 25 March. I am now writing formally to record my concern at the way in which this programme was handled and at the unacceptable treatment of my Chief Medical Officer, Dr Henrietta Campbell.

In the discussions with the Department's Information Office prior to the programme the Editor of the programme, Trevor Birney, assured Kevin Mulhern that in interviewing the Chief Medical Officer, UTV were not holding her accountable and that any criticisms were not aimed at her. Kevin explained the role of the CMO and made Trevor aware of the messages which the CMO wanted to get across. Trevor indicated that he was content with this approach and assured Kevin that the CMO was not the target of the programme.

Unfortunately, this was not borne out by the way in which the programme was handled. An openly bullying and intimidating approach was adopted by the interviewer and it became evident that Dr Campbell was indeed the target for blame. Dr Campbell was offering her full and voluntary cooperation in the making of the programme and there was no need for such hostile and aggressive questioning. I therefore can only conclude that the programme set out to pin the blame on someone and, as Dr Campbell was the only person prepared to come into the studio, she would do.

Moreover, I have to express my concern at the interviewer's unwillingness to allow Dr Campbell to answer questions properly. This undermined any possibility of an objective consideration of the tragic circumstances surrounding Lucy Crawford's death. The repeated interruptions and the aggressive interviewing style unfortunately did not allow Dr Campbell to fully explain the lessons learnt and the steps being taken to ensure such a tragedy never happens again. This acted against the public interest and was completely unacceptable.

I have to say that, having watched the interview a number of times, it is clear that the interviewer failed to understand the role of the Chief Medical Officer and her relationship with the rest of the medical profession. She is neither legally nor clinically accountable for the death of Lucy Crawford, nor for the actions of individual doctors or consultants. To seek to make her accountable in the line of questioning used was to give a false impression to the public and did a great disservice to a distinguished and respected professional.

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I must express my deep disappointment at the treatment accorded to Dr Campbell. The discourtesy shown to her was in complete contrast to her openness and willingness to appear on the programme. She re-scheduled a number of important meetings, yet on arrival in UTV no effort was made by the presenter or the producer to make her feel welcome or at ease in the studio.

I believe her treatment was completely unacceptable. As a result, our trust and confidence in the team that produces this programme has been seriously undermined. I accept that the media have a role to challenge officials and to draw the facts out for the public, but the way in which this interview was conducted was improper and inappropriate and you will appreciate that we will need to have a reassurance about the treatment of officials before we would be prepared to put anyone else forward for interview on this programme.

I trust you will carefully consider the issues I have raised.

Yours sincerely,

Dan Gowdy.

D C GOWDY

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From the Chief Medical Officer
Dr Henrietta Campbell CB

Department of
Health, Social Services and Public Safety

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Mr Alan Bremner
UTV Controller
Havelock House
Ormeau Road
BELFAST

Your Ref:
Our Ref:
Date: 29 March 2004

Dear Sir

I was asked to appear on "The Issue" programme on Thursday, 25 March 2004. I agreed to appear having been assured by Trevor Birney that the while the interview would be challenging it would be straightforward and for my part non-controversial.

On arriving at the studio I was treated in a very abrupt and off-hand manner and was ushered to the interview table with no briefing from the production team. The interviewer was Fearghal McKinney. He then conducted the interview in an extremely aggressive and bullying manner. On at least three occasions I asked him to allow me to answer his questions as I felt that I was being given no opportunity to speak. When the interview was over I asked Mr McKinney why he had treated me with such anger. In his reply it was clear to me that he and the production team thought that I was "fair game". It was also evident that Fearghal McKinney had chosen to ignore briefing from our press office which had clearly outlined my role and responsibilities.

As a public servant and as Chief Medical Officer, I recognise the role that the media has to play. However, I do not believe that my treatment by the team on The Issue was acceptable. I have been and remain deeply distressed by the event and feel that I was bullied and harassed.

I have been approached by UTV on numerous occasions in the past 10 years to contribute to various programmes. I believe that I have at all times been gracious and accommodating, often going out of my way to contribute. That relationship has been jeopardised.

I would welcome an explanation surrounding the events of last Thursday. I would also ask for an apology for the dishonesty and lack of integrity of the production team prior to the interview and for the verbal harassment I received from Fearghal McKinney.

Yours sincerely

Dr Henrietta Campbell

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*** RX REPORT ***
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RECEPTION OK

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DESTINATION TEL #	[redacted]
DESTINATION ID	
ST. TIME	31/01 12:47
TIME USE	06'25
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