From the Permanent Secretary
Clive Gowdy CB

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

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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.

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

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,

Brian.

D C GOWDY

Hiddleston
CMO a/c
Dr Carson.
M/ Shanna
M/ Mulhern.

Working for a Healthier People

DHSSPS-C Gowdy

001-041-139

Young, Christine

From: Young, Christine
Sent: 13 May 2004 18:51
To: Campbell, Dr Henrietta; Carson, Ian; Shannon, Colm; Mulhern, Kevin
Subject: Lucy Crawford

This is your hidden copy of letter to Mr Bremner.

cg212.PDF

DHSSPS-C Gowdy

001-041-140

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