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Radio Ulster Evening Extra 17.00 – 19.00

Thursday 18 March 2004

Transmitted at 17.10 Duration: 5m 43s

Crawford/Ferguson Inquest

Audrey Carville, Presenter:
Well with me in the studio now is the Chief Medical Officer for Northern Ireland Dr Etta Campbell. Dr Campbell good evening to you.

Dr Henrietta Campbell, NI Chief Medical Officer:
Good evening Audrey.

Audrey Carville:
At the inquest last month into Lucy Crawford's death, the coroner John Lecky said Lucy died from poor treatment compounded by poor record keeping. You've studied the case, could her death have been prevented?

Dr Henrietta Campbell:
Well firstly, if Mr and Mrs Ferguson are listening, I would like to extend to them my personal heartfelt sincere sympathy to them. Based on the knowledge that we now have, the death of both Lucy and Rachel may indeed have been entirely preventable. And as a parent, I share with the Ferguson's, I know how dreadful that conclusion is for them. And I don't know how they can be comforted or how that could be reconciled with them. What I would say, is that I would like to meet with Mr and Mrs Ferguson because I think there are important lessons beyond the issue of fluid replacement and medical care which we need to learn. Big, broad messages for the Health Service about communicating, particularly with parents.

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Audrey Carville:

In relation to Lucy's case at the Erne Hospital, you've read the case notes. What is your own opinion of the treatment that the baby received?

Dr Henrietta Campbell:

What we now know is that the fluids which were given to Lucy were the ones that were being used in ordinary custom and practice throughout the whole of the National Health Service, except for one or two practitioners who had begun to recognise this issue of hyponatremia [?] where the body goes through this abnormal response in very few cases, and you begin to get oedema [?] or swelling of the brain. Now in retrospect, and knowing all the evidence that has been published since Lucy's case and over the last four years, we now know that condition exists, that it can happen, all be it in very few patients. But we need to be very alert and very aware to ensure that it never happens again.

Audrey Carville:

But when Lucy died, she died a year before Rachel did. Shouldn't that have been known in the immediate aftermath of her death, that maybe then Rachel's death could've been prevented?

Dr Henrietta Campbell:

On speaking with the Sperrin Lakeland Trust, it's quite clear that they did not realise at the time, nor would they have been expected to, that there were implications for the wider service from that case. And certainly on looking back, and with the benefit of hindsight, had we been able to reflect on that case, had we been able to begin gathering the evidence, it might have been that Rachel's death might never have happened.

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Audrey Carville:

So should the investigation, should the inquest into Lucy's death happened a lot sooner than it did?

Dr Henrietta Campbell:

Well the coroner did not feel at that time that an inquest was required. And it wasn't until Rachel's death that he put the two deaths together and began to realise that there might be a pattern. And at that time we were then alerted to this new and emerging problem of hyponatremia or retention of fluids in a very small number of children. And it was after that we quite urgently began to gather together the evidence and put in place guidelines for the whole Health Service. The first time those guidelines had been done across the UK, and we've now shared those guidelines with the rest of England, Wales and Scotland, so that they too might be helped in their practice.

Audrey Carville:

So those guidelines are in place which you hope will not lead to a similar situation happening again. That cannot be guaranteed though because at the end of the day it's human error that's involved?

Dr Henrietta Campbell:

It's a very complex issue because there's still a great deal of debate in the medical journals as to what causes hyponatremia and who indeed will be affected by it. So there's still much we have to learn. What we do recognise now are the early symptoms of hyponatremia. And what we would hope is with that knowledge out in the Health Service, with people being kept up to date and aware of those early symptoms, that something like that might be prevented.

Audrey Carville:

You've heard there the Ferguson's saying they want someone to be held accountable for the death of their daughter. The Crawford's say all they want from the Sperrin

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Audrey Carville:

Lakeland Trust is an apology. They were very critical of the way they were treated by the Trust. Do you accept that confidence within the medical profession from the public has been damaged as a result of these cases?

Dr Henrietta Campbell:

I can see why that might be the case. What I can say is that with the guidelines in place, and with careful monitoring and implementation of those guidelines, the risk of that happening again should be markedly reduced. But we do need to learn now about that condition. However, I believe that we do need to engage with patients, with parents, in a new and different way. And certainly we need to listen to what the people are saying; to what Mr and Mrs Ferguson are saying, ways of improving that communication.

Audrey Carville:

Okay. Well thank you very much for coming in this evening. Dr Etta Campbell, the Chief Medical Officer for Northern Ireland.