## Stella Burnside - Chief Executive

**From:** Gardner, Jeremy [Jeremy.Gardner[redacted]
**Sent:** 28 May 2004 10:53
**To:** Stella Burnside - Chief Executive
**Subject:** FW: Transcript

Transcript CMO.doc

Confidential

file with Theresa Bo

> -----Original Message-----
> From: Shannon, Colm
> Sent: 28 May 2004 10:52
> To: Gardner, Jeremy
> Subject: FW: Transcript
>
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> -----Original Message-----
> From: Shannon, Colm
> Sent: 27 May 2004 14:57
> To: 'sburnside[redacted]
> Subject: FW: Transcript
>
> Second attempt
>
> -----Original Message-----
> From: Shannon, Colm
> Sent: 27 May 2004 14:21
> To: 'sburnside[redacted]
> Subject: Transcript
>
> <<Transcript CMO.doc>>
> This is a very rough transcript as bits of the tape are unclear. The
> Altnaglevin references are around page3. It can only give you a flavour of
> what is said.
>
> Colm

CMO

It sounds grand, but what it means is that I, am fortunate enough to be the boss of this small team of very expert and hard-working doctors in the civil service - doctors like Miriam here (Dr Miriam McCarthy), Miriam in central headquarters, providing advice, and doctors who are providing (unclear) medical referee services so I'm chief of those civil service staff, senior, principal, assistant, I am chief medical officer. It doesn't mean, contrary to what Fergal McKinney or anybody else thinks, it doesn't mean that I'm chief of doctors in the health service. I am not, there is a complete distinction between doctors in the civil service and all those doctors in the health service. I am not their chief, nor am I Northern Ireland's top doctor. (unclear). I am just here to give the best advice I can about public health, which is what I am, public health director, to the Minister on matters that will protect the public health, and more likely to help them about smallpox epidemic, or how we try to ensure, that people get MMR vaccination. I have a role within the health service, and that is about trying to promote standards and guidelines by which the service could be measured, but a very minimal role in trying to help those others whose role it is to be responsible for that and to make sure that people (unclear). So that's the context of my job and that should help you.

DMcD

About standards and guidelines, can we go through a few points in the article. Your mistake, the correction that was in on Saturday, perhaps you can clarify that? How did Lucy's case come to your attention, (unclear) in June 2001 and you corrected that to 2003. There was a note (unclear) that I took where you previously said you became aware of Lucy's death when Raychel died in 2001.

CMO

(Unclear)I didn't. It's not a mistake, it's not important in general issue about what we were trying to portray, but it is important where you're coming from

No they wouldn't have, Denzil, they wouldn't have informed me. There are, as we tried to explain, and as I tried to explain to Fergal McKinney after the interview, there are 15,000 deaths in NI every year, and most of those actually take place in hospital. Most people, whether they are old, very old, or young, actually die in hospitals, a huge percentage of people. So, (question to Dr McCarthy?) about how many of those deaths (unclear) About 3500 would be referred to the coroner – so the coroner has a full time in questioning and investigating some of those deaths. If even just the coroner's deaths were all reported to me for a further or different examination, I couldn't do the job of Chief Medical Officer. Now, what we're looking at, the coroner and I, throughout the whole of the UK, we are looking at the methodology of trying to report untoward deaths and I don't know if you know we had a review of the coroner's system following Harold Shipman, where we are looking at trying to establish maybe exactly we think of medical examiners who sit with the coroner and look at those deaths. But we (unclear) that would be a huge resource to put in place.

DMcD
(Unclear) Altnagelvin – Raychel Ferguson (?)

CMO
As far as I can understand, the difference there is that when Raychel died, she was referred to the Royal and the doctors in the Royal said to Altnagelvin there is a problem here, it does need to be sorted out, it is a regional issue so Altnagelvin immediately referred it to me.
Lucy was also referred to the Royal. I don't think there was that same sort of oh my goodness, there's something here that for the region we need to sort out. I don't think that sort of realisation was there and it would be interesting to look at why that was or wasn't.

DMcD
(Unclear)

CMO

Not in Lucy's death

DMcD
Could you maybe just clarify another thing for me (unclear) when you say in some instances (unclear) may put some children at risk – could you clarify for me

CMO
Nobody really knows Denzil, I mean this is, I don't know if you are keeping up to date with the debate that is raging in the paediatric world.

DMcD
Unclear

CMO
I don't know because I'm not an expert, I have to know a little bit about everything but there is still a debate about proper fluid replacement and there is still a search to find how people could recognise early those children that might be at risk of responding in this dangerous way, developing hyponatraemia, which may go on to be better than

DMcD
Sorry, could I just cut across you there

CMO
If you read all of the literature on it (unclear) I don't know him personally but have read all that he has said and have been reading avidly.

DMcD
Unclear

CMO
Well look at the data, what we know from the death of and the biggest study of response to fluid replacement is, Miriam can help cite it for me, was a study

CMO

The point that I was trying to make (unclear) is that hyponatraemia is reported as being a very rare incidence, that would be one in every 3000 children receiving those fluids were hyponatraemia has been reported as being fatal. In NI context, that is very rare and the problem for us is that there has been nothing in medical literature that would say who that one in 3000 would be and that was the point I was trying to make.

DMcD

The other point I would like to make is, in your article you referred to the fluid, you don't refer anywhere to the management of the fluid. Is this something (unclear) that you would have been happy about, the management of the fluid?

CMO

What we've done in our guidelines is to say that you have to be careful and you have to monitor the fluid levels and electrolyte (?) levels in the patient, in which the fluid is being (unclear). I think it's clear in what I'm reading in the coroner's report, I haven't got access to medical notes, but anybody reading those reports would say and agree with the coroner that the management of the fluids could have been much much better and that it was inadequate

DMcD

That's an understatement

CMO

It was disastrous for Lucy, there's no doubt of that but what it did mean is that we are adamant in our correspondence with the health service that we have to be extremely careful to monitor carefully, annotate and carefully register what's happening with (unclear)

DMcD

to so that's where the proper interrogation of that lies and it doesn't lie with me, nor would I ever want to cut across what is properly the role of the GMC in doing that.

DMcD
The sooner we're absolutely certain (unclear) possibility of idiosyncratic reaction in Lucy's case and you're not commenting on the fluid management

CMO
Now don't misquote me and try not to get yourself confused. What I'm saying about hyponatraemia in general because I have to talk in general and not about Lucy, because my job to the public health and it is other people's job to interrogate Lucy's death as the coroner has done, and the GMC will do that. What I'm saying is that we now have in the past four years, two children who died of hyponatraemia, now it's written up and recorded in the medical journals that death from hyponatraemia is a rare occurrence One in 3,000 post operative children in a number of (unclear) develop it but we don't want one to happen again in Northern Ireland, they are rare. Idiosyncratic is the wrong word to use because it infers, as you said, that maybe it was because of some genetic makeup of Lucy's. We don't know that yet. We don't know what makes certain youngsters at risk. Ten children given the same fluid, same volumes, children (unclear) and one of them to develop hyponatraemia. What makes them do that? I don't know that yet. Now it may be that someone knows who that might be and together with the other international experts that I have called together to look at this then we can help to reduce the risk even further. That's proper risk management done across a population in Northern Ireland. Now, I mean you are interrogating Lucy's death and that's (unclear) your right to do that but my job is to say are there issues here that the whole of the childhood population in Northern Ireland that we need to be aware of? How can we prevent the next death from hyponatraemia at any cost where the wrong fluid, right fluid, not enough fluid, too much fluid or even fluids given orally, because we know that they can cause hyponatraemia. That's my job Denzil, now I know you're anxious to find answers and in a way we need to make sure who the right people are to

It started to be written up in the journals going back many years, quoting one or two cases here and there, and because the evidence of the experts is what's important here, you do need to refer to what is recently written, which gathers together all of the evidence over the years and begins to put that in place and unravel a picture. Now the most recent and probably the most comprehensive essay on hyponatraemia was about 2/3 weeks ago in the archives, and I don't know if you have seen that one yet but that's the one that you could turn to which gives you a full expression of the debate around hyponatraemia. I'm not an expert you know, I have to know a little bit about everything but if you want to know more, and updates what was said by Dr Evans in a recent inquest, it is an up-to-date debate around hyponatraemia and you need a copy of that we can get it to you.

DMcD
So this supersedes (unclear)

CMO
It expands on the debate and says there is no black and white and we need more research. What it does is it sets out the case on one side and the case on the other and again I would say the conclusions are what we have put in our guidelines which are really about being careful, being watchful and monitoring what's happening to each child and if you don't know what you're doing or what's going wrong, call in the experts. Now as you are probably aware, the guidelines that we have put in place are ahead of many places in the UK and indeed have been commended by them but we will continue to updated those in the light of the new debate and in the light of what a number of international experts will be telling us in the next few weeks as we continue to review the guidelines.

DMcD
And do those experts include (unclear)

CMO

So the response Denzil, to make it mine, is I don't know Ted Sumner, I intend to meet him very soon and have never spoken to him but thankfully Dr McCarthy (unclear) did involve him (unclear)

DrMcC
Unclear

DMcD
I suppose overall, when you said previously, in a previous interview that my job as chief medical officer is to look at the issues of the population of Northern Ireland to make sure that we learn from untoward events.

CMO
Yes

DMcD
Well there don't seem to be too many lessons learned from Lucy's untoward event

CMO
We have produced guidelines Denzil which are commended by Ted Sumner

DMcD
Unclear

CMO
But they are (unclear) we now know, aren't they?

DMcD
(unclear) issues of fluid management haven't been addressed.

CMO
Well, we'll give you a copy of the guidelines, I don't know if you've ever seen them. So have a look at that and it is quite clear about insuring close

But quite apart from the medical aspect, the investigation (unclear) should have been done properly (unclear)

CMO

I can't answer that because for me to answer

DMcD

But it is crucial for you to learn from untoward events, you have to be able to say to a health trust, was that investigated properly and four years on we haven't had any answers

CMO

And what I'm saying is that there has been no proper formalised process in place to date for the investigation of untoward deaths. We now recognise that, throughout the UK, not just me but throughout the UK, we know that we have to begin to have a process in place which will allow us early warning on issues such as this. There are bits and pieces...

DMcD

So there is no investigation procedure (unclear)

CMO

Each Trust would be responsible for the investigation and

DMcD

So there's no formal procedure so they wouldn't have to report it to you which I find quite strange but if there's no procedure fine (unclear)

CMO

Well each death will have a different method of investigation and interrogation, that's a question that I have not looked at because it is not my job to look at

DMcD

CMO

Well, within the whole context of what was done about medical care that will arise

DMcD

So the GMC are going to look at the investigation process?

CMO

The coroner and I think I'm right in saying this, the coroner has referred all his papers and conclusions to the GMC so it is comprehensive

DMcD

(unclear)look at the investigation

CMO

Well the issue around how it was established and within the medical network with the Western Board, that clinical network which is Altnagelvin and Erne, those papers have all gone to the GMC and will be looked at

DMcD

And have you written to the Crawford family?

CMO

I have written to the Crawford family

DMcD

Do you know that they were very unhappy about the tone of your letter?

CMO

Well I knew that almost anything I would have wrote would have

DMcD

You could have had a meeting, you could have said, I would like to meet you.

DMcD

Unclear

CMO

Of course it could, everything that everybody wants could be written better

DMcD

(Unclear) doesn't indicate that you have any desire to meet them

CMO

Oh Denzil,

DMcD

It indicates that, if you want a meeting, I will meet you

CMO

And do you know why I said that? I mean, a letter from me, I'm going to come down and meet you. How awful would that have been? They have to feel that they would want to meet me, otherwise, what could be worth

Kevin Mulhern

I think the fact that the CMO offered the meeting indicates that the CMO was happy to meet with them and (unclear) Crawford family at a very difficult time the opportunity to either accept or not accept the meeting. But I think by the CMO writing to them and offering them that meeting shows that there was willingness from the CMO to meet with them.

CMO

Now you have to be fair to me Denzil and not drive this as a further wedge. I'll tell you I actually in my life I try to be honest (unclear) and caring, and to have this misrepresented and to have what I have said picked over, the bones of it, I can't cope with that.

CMO

Well what it would allow me to do is to go back through the literature because obviously what you want is to get to the root of what the physiological medical issues are around fluid replacement and hyponatraemia. Denzil, I have to admit that I am not an expert in this and don't try to set me up as someone who is trying to be, because I'm not. So on all of these issues, when an absolute imperative exists around the detail and the expert view, you can't come to me to have it in here in my head. What I can do is get you the references or refer you to the experts who can do that. You can't ask of me what I'm not. I'm a public health doctor, I'm not a paediatric (unclear). That's why picking over the bones of what I say divert the issue about how we properly ensure that fluid replacement is as it should be, because when I want that to happen, I go to the experts.

DMcD

Well certainly the main criticism in that area would be towards the Sperrin Lakeland Trust (unclear) and the point that I would make would be for you to be able to do your job properly, advising the population of Northern Ireland, did the Sperrin Lakeland Trust fail you in that because they didn't inform you to begin with and I don't think you've said anything today that would make me believe that they've been in contact with you (unclear). So how can you learn lessons from a death that hasn't been properly investigated, or hasn't been investigated at all?

CMO

Well the Minister will, in her interview with you, tell you what procedures are being put in place throughout the UK and particularly the procedures that are being put in place here in Northern Ireland to make sure that issues such as Lucy's death might be dealt with in earlier stages. I fully admit, and have done, that four years ago, they were imperfect and not at all comprehensive and what we need is a system, which allows proper reporting which can be systematically then analysed and teased out so that important issues emerge. I have to admit that over the past four years, attention has been focused on stopping 3000 people dying each year because they smoke. Thousands

properly, I want to do that and will you let me know rather than go to press and say she wouldn't do this or she wouldn't do that. I'm anxious, I promise you,

DMcD
Unclear

CMO
If I feel that I can give you the answers that you need (unclear) because that's only proper. There are other people who have a different role and you need to go to them. Minister has an entirely separate and very important role (unclear)

Colm Shannon
Unclear

CMO
Now I can promise you that I would welcome that so I don't want you going out there and saying she wouldn't answer or she tried to be dishonest or evasive, because it's not what I'm about. So anything that you feel I've been unhelpful with, write to me, and if I have the knowledge or if I can get the knowledge, I'll answer, but I'm not the expert.

TAPE ENDS