Marie Dunne - Commun. Mgr

From: Marie Dunne - Commun. Mgr
Sent: 23 March 2004 11:06
To: Theresa Brown - Risk Management; Alan Moore - Dir of Estates; BURNSIDE STELLA; Geoff Nesbitt; Irene Duddy (E-mail); Manus Doherty; McCARTNEY RAYMOND; Niall Smyth; Tom Melaugh
Cc: Sinead McCracken - Business Services; Jennifer Mayse - Comm Mgr Assis; Marie McLaughlin - Chief Executive P.A.
Subject: Rachel Ferguson/Lucy Crawford media coverage

Importance: High

Please find attached transcripts from the recent radio interviews given by the CMO on the above and provided to me by the DHSSPS Executive Information Service.

I understand UTV are to broadcast a piece on this on Thursday night (25th) around 10.30pm/11pm in a programme called 'The issue'.

Marie


Rachel Ferguson - vening Extr...


Rachel Ferguson -BBC Newsline ...

RF – ALTNAGELVIN

023-020-040

Programme	**Evening Extra**
Date & Time	**18.3.04 17.10**
Subject	**Chief Medical Office to probe children's deaths**
Prepared By	**Typist: Hilary Tushingham** **MMU KC/KC**

AUDREY CARVILLE

Well with me in the studio now is the Chief Medical Officer for Northern Ireland, Dr Etta Campbell. Dr Campbell, good evening to you. At the inquest last month into Lucy Crawford's death, the coroner John Leckey said Lucy died from poor treatment compounded by poor record keeping. You've studied the case, could her death have been prevented?

DR ETTA CAMPBELL

Well firstly, if Mr & 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 deaths of Lucy and Raychel may indeed have been entirely preventable and as a parent I share with the Fergusons, I know how dreadful that conclusion is for them and I don't know they can be comforted or how that can 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 fluent investment and medical care which we need to learn. The broad message is for the health service about communicating particularly with parents.

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 ETTA 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'd begun to recognise this issue of hyponatraemia where the body goes through this abnormal response in just a 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 4 years, we now know that that condition exists, that it can happen, albeit in very few patients but we need to be very alert and very aware to assure that it never happens again.

AUDREY CARVILLE

NB – This transcript was typed from a transcription unit recording and not copied from an original script.

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

DR ETTA CAMPBELL

On speaking with 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 that it might have been that Raychel's death might never have happened.

AUDREY CARVILLE

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

DR ETTA CAMPBELL

Well the coroner did not feel at that time that an inquest was required and it wasn't until Raychel's death that he put the 2 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 hyponatraemia or retention of fluids in a very small number of children. And it was after that, that we then 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, can it, because at the end of the day it's human error that's involved?

DR ETTA CAMPBELL

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It's a very complex issue because there's still a great deal of debate in the medical journals as to what causes hyponatraemia and who indeed will be affected by it. So there's still much that we have to learn. What we do recognise now are the early symptoms of hyponatraemia and what we would hope is that 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 heard there the Fergusons saying that they want someone to be held accountable for the death of their daughter. The Crawfords say all they want from the Sperrin Lakeland Trust is an apology, they were very critical of the way they were treated by the Trust. Didn't you accept that confidence within the medical profession from the public has been damaged as a result of these cases?

DR ETTA 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 more 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 people are saying, to what Mr and Mrs Ferguson are saying, about ways of improving that communication.

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Programme	**BBC Newsline**
Date and time	**18.3.04 – 18.29**
Subject	**Children's deaths**
Prepared by	**Typist: Pauline Meleady** **MMU: PMcC/KC**

MARK CARRUTHERS

The deaths of two children need not have happened, according to the Government's top doctor. The Chief Medical Officer, Doctor Etta Campbell, in an exclusive television interview for BBC Newsline, said that the death of a 17-month old baby following treatment at the Erne Hospital in Enniskillen was entirely preventable. Doctor Campbell told BBC Newsline that had a fuller picture of the child's death been known sooner, it could have prevented a second tragedy a year later.

DONNA TRAYNOR

The case of the toddler, Lucy Crawford, was highlighted at her inquest last month. The coroner found she died after errors in her treatment. She'd been given too much fluids to treat dehydration. Another child, 9-year old Raychel Ferguson, died in similar circumstances. Both cases are now under investigation by Doctor Campbell who's been speaking to BBC Newsline's Julian O'Neill.

JULIAN O'NEILL

Doctor Jarleth O'Donoghue, the consultant in charge of Lucy Crawford's care at the Erne Hospital, leaves her inquest last month. The General Medical Council is deciding whether or not to investigate him. Also examining the case is Northern Ireland's Chief Medical Officer. She's received new paperwork on the toddler's death from the coroner, who found errors in treatment caused Lucy's death in 2000.

DR ETTA CAMPBELL

Lucy's death was entirely preventable. I think we've learnt that very early on and certainly from the inquest that has become very clear. It is of paramount importance to the Health Service that that should never happen again.

JULIAN O'NEILL

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This is 9-year old Raychel Ferguson from Londonderry. She died at Altnagelvin Hospital a year after Lucy, again as a result of the incorrect administration of fluids. Her parents are suing and are angry that the lessons of Lucy's death were not learned in time.

RAY FERGUSON

If the doctors had have known about it, our Raychel would still be here today. She'd be still here today. I do believe, do feel and believe she'd be here if they had have knew about the Crawford's case, our Raychel would still be here. They'd have treated her a lot different. Words can't explain, you just feel empty all the time. You do feel empty.

MARIE FERGUSON

You're living, but you're in a different world, to be honest with you. It's changed our whole lives completely.

JULIAN O'NEILL

The Chief Medical Officer now accepts there was a potentially fatal flaw in the system.

DR ETTA CAMPBELL

On looking back at the issues, I think if we'd had an early inquest into Lucy's death, then it might have been that the death of Raychel might never have happened. We have to recognise that. What the coroner has now agreed is that he will draw to our attention very early on those deaths about which he has concern.

JULIAN O'NEILL

New medical procedures were put in place in 2002. But so concerned is Doctor Campbell, that she has now written to each health trust to ensure that they are being followed to the letter.

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