NO TAPE AVAILABLE

## INTERVIEW 17/02/03 HENRIETTA CAMPBELL – CHIEF MEDICAL OFFICER

**Dr. Henrietta Campbell what were your concerns whenever you heard of the Rachel Ferguson case and what had actually occurred in Altnagelvin hospital?**

Well of course the Health Service is committed to making people better. And whenever, well especially when a young child dies of course everyone is deeply concerned and there is a lot of anguish and concern about this case. And Altnagelvin immediately let me know what had happened, so we were desperately concerned to make sure that if any lessons could be learnt from this that we could put them in place and make sure that nothing like that would ever happen again.

**What lessons do you think have to be learnt from the case of the death of Rachel Ferguson?**

Well Northern Ireland is a very small place with a population of 1.5million people, when untoward and rare events happen we need to find a way of learning from them. Now they only happen every 5 years or every 10 years. It is very difficult for the service to learn from that to remember what happened to have a memory about those untoward events. And what this has shown to us is that together with the rest of the United Kingdom we need to take part very carefully and very clearly in the systems that are now being put in place to ensure patients safety. Northern Ireland is too small a place to learn of itself from these very rare events.

**One of the things according to the paper work that we have seen that, use the word frustrated, the hospital administration of Altnagelvin was learning that in fact something similar had happened to a child in the Royal Victoria Hospital some years before. And that it hadn't that Altnagelvin hadn't learnt of that. Where you made aware of the incident at the Royal Victoria Hospital or was the Chief Medical Officer made aware that a child had died of hyponatremia then at that time.**

In the Health Service in Northern Ireland over the last 10 years, I am not aware of any case of Hyponatremia in a normal healthy child. Of course it happens occasionally in very ill patients but we have never before seen it in a normal healthy child and that is was what was deeply concerning and made us realise that there was something we had to learn from this.

**But Altnagelvin would say that there were lessons to be learnt out of the Royal Victoria Hospital case and that they were frustrated that they weren't aware of those, they weren't made aware of that case.**

I think that the case you are referring to was a child who died about 7 years ago, but unfortunately for this case, had no direct ???? because it was an entirely different clinical situation. But what we do know now is that throughout the world there have been a number of these cases and certainly the evidence that was brought to the inquest showed

that it can happen, it happens very rarely but it has happened before. We didn't know that but we have now been able to put in place measures to help prevent it happening again.

**So there is absolutely no direct correlation between the Royal Victoria case and the case of Rachel Ferguson at all?**

From what I know of the clinical details the case 7 years ago was of a child who was already very ill and in ?????. And I think that is important to recognise that in this case, here we had a normal healthy child so therefore something had to be looked at, the case needed to be reviewed and they needed to consider what measures needed to be put into place in order to prevent that happening again.

**So are we saying here that really, we can't expect a hospital, even a teaching hospital such as Altnagelvin to be aware of something such as Hyponatremia. That if a child goes in and it does happen in a very irregular basis and a highly irregular basis. But we still can't expect a hospital and the people within that hospital at Altnagelvin to be aware of Hyponatremia and be sensitive to the problems of a child at a post-operative situation such as Rachel Ferguson.**

What we have recognised in the Health Service in the whole of the United Kingdom over recent years, is that by putting information together from every quarter of the United Kingdom, that we can learn from the rare event, the untoward events. Look for a pattern, see if it has happened before see if there are lessons to be learnt and then together the four countries of the United Kingdom put in place measures to prevent those things happening again. Northern Ireland as I have said is too small a place to effectively learn those lessons from rare events, so therefore we need to be part of a bigger picture. Joining with the rest of the United Kingdom in learning those lessons together.

**So you have no concerns, just to absolutely categorical about this, given that the documentation that we have seen from the Altnagelvin hospital, you have absolutely no concern that you were not aware of the case at the Royal Victoria Hospital.**

Sorry you asked me two questions.

**You have no concerns at all that the information concerning the case at the Royal Victoria Hospital was not disseminated?**

When we looked with the consultants from the Royal because we needed them in our review of Rachel's case, we needed their regional and specialist knowledge. When they set down with us to look at guidelines that we could put in place to prevent this thing happening in the future or ever again. When we looked with them from their specialist knowledge, they were able to bring to us lessons that they had learnt from that case, that entirely different case, that lessons which then could be read across which helped us to put in place guidelines which we feel will more effectively prevent this happening again.

**After the death of Rachel Ferguson, the hospital itself carried out an investigation and you were involved as well at a different level. The public are maybe quite concerned about the self-regulatory aspect of this and that the hospital investigating itself. Should there not be in this day and age much more accountability in this and that there should be somebody from outside covering, especially when the parents of a child are concerned about what actually happened during the hours and days that this child was in hospital. That they feel even at this stage they still don't know what actually happened in that 3 or 4-day period, I mean that must be quite worrying for you?**

We have been deeply concerned to make sure that the Health Service is a learning organisation. That the regulation of quality and standards is secure and effective and we have looked at ways in which this might be better and from April of this year the new arrangements under a document called Best Quality, Best Practice, Best Care new arrangements are now being put in place. Firstly to set standards so that clear standards are defined and put in place for the service and the other part of that is to make sure that we have systems in place which are liable standards to the inspector in order to ensure that those standards are being met. So as of April this year we will be putting in place measures, which will more effectively ensure that quality is at the forefront of all that we do. Up until now those systems for standard development and quality assurance have not been as good as they should be. We have recognised that, but as of April this year, we are moving to a much more systematic approach to ensuring firstly that standards can be developed and put in place but the service knows about them and on the other hand we have an independent inspectorial system which will make sure that those standards are being attired to. Now we would hope that through that we can have an organisation that learns together that puts in place effective measures which make sure that quality is at the forefront and that we can improve patient safety.

**So tell me exactly how that would impact on the parents, another Ferguson family in the future. How will they feel that they are getting answers to the questions much quicker and much more clearly and much more accessible than the Ferguson family in this case have. Tell me exactly how they in that inspectorial nature that you talk about, how do they, how do a family actually get to the crux of what happened to their child much quicker as a result of those.**

We don't need to wait for legislation for that to happen. I think the message that has been going over loudly and clearly to the Health Service in recent years, is that we must respond to patients concerns but there should be an openness and you know, a readiness to discuss issues of concern. And to make sure that all those questions are indeed answered. It is important that people feel that they can trust the mechanism's that are in place that they can trust the people with whom they are dealing with. And that the Health Service they recognise as something that is doing good is making things better and is moving towards better quality everyday.

**So how are they going to get that, how are they going to feel like that? Where is the process of the mechanism that actually makes a family going to feel like that?**

The process has to start at the local hospital, with the face to face of the patient or parents or carers with the staff who are involved and it is critical that that discussion, that openness begins right there.

**In the immediate aftermath?**

I think that it is important that if patients have concerns that those concerns are answered as soon as possible.

**Lets just come to Hyponatremia itself are you saying that Hyponatremia is just a freak that it doesn't occur in 1 in 5000 it is more like 1 in a million. It is going to be seen here very rarely and that you wouldn't expect any surgeon or doctor coming through the Health Care System in Northern Ireland to be actually aware of it. And that if it did happen in a hospital tomorrow in Northern Ireland, that you wouldn't be sitting here the day after or a week after explaining a way why another child had died of Hyponatremia. What is to say that another doctor or another child won't die, another doctor won't spot it and another child won't die?**

Ok in looking at Rachel's case and in looking at the literature at there was and in taking advice from those who had given expert advice to the inquest, it was clear that we needed to have guidelines in place that would help clinicians to recognise this early on. Recognising that it was a rare event and that any surgeon, any doctor might come across it only once or twice in their lifetime. It was important to have clear guidelines in place, which would raise a level of awareness about this condition and also help clinicians to deal with that, recognising that they would not have to deal with it often.

**You would not expect any Clinician in Northern Ireland to be aware of Hyponatremia previous to this case. It is not something that is taught in medical school, Hyponatremia is not something that comes across in medical school?**

Hyponatremia in an otherwise normal and healthy child was not something, which was brought for front to the knowledge or experience of clinicians within Northern Ireland. Now you will understand that in Northern Ireland we have quite a number of acute hospitals and therefore we have a lot of paediatric surgery being done outside the centre, outside the regional centre in Northern Ireland. Because those surgeons will be dealing with fewer cases each year, there might be the case in a regional centre or in some of the larger centres in other places in the UK. They will not therefore come across these cases very often in their lifetime. What we need is a learning organisation, a network of care, which reaches out throughout the service in Northern Ireland so that we can indeed learn from those very rare and untoward incidents.

**A very senior paediatrician at the Royal Victoria Hospital told me this morning that he wouldn't expect a hospital such as Altnagelvin just to be waiting for information**

**to be disseminated but also he would be expecting it to be out there researching and examining. And he finds it quite surprising that Altnagelvin being a teaching hospital was not aware of Hyponatremia and as a result is coming to this conclusion at this point.**

When we looked at the protocols that were in place throughout all our hospitals in Northern Ireland, it became quite clear that in order to prevent Hyponatremia ever happening that we would have to disseminate guidelines to the service so that they new what the early signs of Hyponatremia might be, how it might be prevented early on and to ensure that that would prevent a case happening again. By disseminating those guidelines drawn up by the profession for the profession we would hope that that information now in the public domain would prevent that ever happening again.

**The family of Rachel Ferguson hear and understand that the guidelines that you have been inplacing solving at the inquest. The problem for them is that they feel at the time of Rachel's treatment in Altnagelvin hospital was much simpler than that. The fact that the child was vomiting and continued to vomit for 20/22 hours following her treatment and that their concerns were not listened to there and then. That is their concern that the child was vomiting there was coffee grinds there was obvious signs that the child was very unwell but yet that wasn't, their concerns were not listened to then. Can you understand the frustration of the family when they hear you are now saying that Hyponatremia is one, very very rare, the child was there and quite obviously sick and yet nothing was done then.**

I mean for any parent and I am a mother of 3 children, I can understand how they feel. There is no doubt that the death of an otherwise normal and healthy child is very difficult. How could you ever come to terms with that? And it is because of that that we need to make sure that this would never happen again.

**But how can you explain to that family that there hasn't been a cover up here, how can you give them confidence that the medical profession hasn't closed ranks and is trying now simply to explain away their daughters death?**

In the particular case of Rachel it is not for me to do that that is a matter for Rachel's parents and Altnagelvin and I feel that Altnagelvin and Rachel's parents should come together and discuss those issues. Her parents deserve that sort of attention and I know that Altnagelvin would be willing and would want to reach out to those parents to share that information, so it is not for me to intervene. But as a parent I can empathise with how they feel and recognise that they will want to know exactly what happened.

**And you are categoric in your statement of full confidence in the hospital with the way they have treated Rachel Ferguson giving your access to the papers that you have been able to witness and sit and view?**

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, throughout the Health Service in Northern Ireland, to see what can be done to improve care, to learn from the past. And in developing these guidelines with the medical profession and in disseminating these guidelines, that is a job for me to do. To make sure that as a region, as a Health Service within Northern Ireland, we are improving and using everything that we learn to make sure that the service improves.

**And are you aware of the accusations, I am sure you are aware of the accusations as Chief Medical Officer that the medical profession is seen as something that does tend to close ranks and in times of accusations of malpractice or carelessness within the hospital ward. Are you sensitive to those and I mean how can you instil faith in someone especially within the Ferguson family and the wider public out there, that that does not occur here?**

It is unforgivable if the medical profession close ranks it is not appropriate in today's world. We need to have a more open engagement with the public so that they can trust what we are doing, doctor's have been saying that, medical leaders have been saying that, there is no room today for the closing of ranks.

**But there is nothing tomorrow for the Ferguson to actually investigate what actually happened. There is no apparatus there is no structure there is nothing for them to still to get the answers to the questions that they have. That is the concern and if there was another Ferguson family tomorrow there still isn't and there still won't be even after April. There still won't be any ability for anyone to actually bring their concerns whether it would be Health Ombudsman or whoever it is, there is still nothing in Northern Ireland for that to be done. And that is a concern is it not.**

There is a Health Ombudsman Trevor which the Altnagelvin Trust in their discussion with the Ferguson family should make it quite clear to that family that the Ombudsman is there to take on their concerns, f they feel that the hospital has not adequately met them. There is a system in place for making sure that there is an independent appeal mechanism, Tom Frowley is now the Ombudsman, he is from, he has been the Chief Executive of the Western Area Health and Social Services Board. I can't see why the Ferguson family should not know about that, if they don't they need to be told immediately but if they feel dissatisfied with the conduct of the inquest or dissatisfied with how Altnagelvin handled this case that they can take that to the Ombudsman. An independent enquirer who can take up their case and look into it, it is there it is free it is open and can be comprehensive in the way that it tackles these issues.

**And do you think that is the way anyone with any concerns about treatment of a relative or themselves should be going now?**

It is important that frontline professionals and Health Service Staff open the discussion with parents, with carers with patients and an early debt and engage with people who feel that they have a complaint or that something has been done improperly. It is important in the first instance to explore fully those mechanisms' at local level. If you feel then that

you are still not happy or if you are dissatisfied about any aspect of that local enquiry then you should feel free to go to the Ombudsman to have that fully investigated.

**Finally one of the Union Representatives in Derry has told us that he feels that he is representative of something like 800 members in Derry at Altnagelvin. He feels that the message he is getting from his members there within Altnagelvin is that while the Health Service is continuing under this pressure and that these sorts of things are going to happen. Does that worry you when you hear someone saying that?**

There is no doubt that expectation not just from the public but also from Health Professionals and anyone working in the Health Service our expectations are very high. We want to make sure that the best service can be delivered, now that comes at a cost and it will means more resources into the Health Service to allow enough people to deliver quality care, enough resources there to make sure that diagnostic capabilities are there. And that the Health Service is resourced in a way that meets expectations of people.

**As Chief Medical Officer when you hear that a family ends up at an inquest in which two of the surgeons who were in charge of examining and looking after their child, don't appear. One who was passed from giving evidence as a result of sitting exams the other who hadn't even contacted the hospital and the coroner had to seek out. Is that worrying when the medical profession treats, or seen to be treating the inquest system here with such contempt?**

I don't obviously know the background or detail to that or who didn't turn up or why. But the inquest system within Northern Ireland is another way of bringing into the open issues, which are of concern, and it is one that I feel that people should have been using properly.

**Could they have that faith of medical profession....?**

Well I mean the Health Service professionals should also use that as a way, not of defending themselves but of making sure that everything that is at issue is in the public domain.

**And to do so they have to turn up?**

I don't know the detail or the inside of that Trevor that is the first I had heard that and you know, I can look into that for you if you want me to.

**I would appreciate that thank you.**