Mr Clive Gowdy, CB
Permanent Secretary
Department of Health, Social
Services and Public Safety
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

8 April 2004

Dear Clive

The Issue : 11.00pm 25 March 2004

Thank you for your letter of 29 March which followed our telephone conversation on 26 March. As I explained to you, I viewed the programme before approving its transmission. I therefore stand by what we broadcast.

We fully accept that Dr Henrietta Campbell ("the CMO") is in no way responsible or culpable for the deaths of Lucy Crawford and Raychel Ferguson. Our involvement with the CEO in relation to this issue began in March 2003 when an **Insight** team met with Stella Burnside, Chief Executive of the Altnagelvin Trust to discuss the death of Raychel Ferguson. It was the Chief Executive who directed us to Dr Campbell, telling us that she was best informed to do the interview and, in fact, had already agreed to speak with us.

At that time, the CMO told us in an on-the-record interview for **Insight** that:

"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, through the Health Service in Northern Ireland, to see what can be done to improve care, to learn from the past."

Given her acknowledgement of her public obligation and accountability we decided that it was entirely appropriate to interview the CMO for **The Issue** programme on 25 March and to see if **"measures (had) been put in place.....to learn from the past"**. In my notes of our telephone conversation I have recorded you as saying that there are "legitimate concerns" about the CMO not being told about untoward events and that there are procedural shortcomings in the communications (about untoward events) between some Trusts and/or Boards and your Department. I would respectfully

DHSSPS

suggest that if systems failures remain in March 2004 and if families such as the Crawfords and the Fergusons are so aggrieved, we are entitled to ask the CMO what has been put in place, and learned from the past.

You have criticised us for not briefing Mr Mulhern appropriately. As you know, we sent Mr Mulhern an e-mail about our plans some two weeks before the programme, and a week prior to that our Current Affairs Editor, Trevor Birney, had an explanatory conversation with Mr Mulhern about the matters we were interested in. You spoke to me about Mr Mulhern's report of the conversation Mr Birney had with him on the evening before the programme's transmission. Our notes of that conversation record Mr Mulhern's major concern was how the Sperrin Lakeland Trust and the Western Health Board were to be represented on the programme. Mr Mulhern did not attempt to explain the role of the CMO in relation to these untoward deaths despite admitting that the Sperrin Lakeland Trust "had kept Lucy's death to themselves". This last remark goes to the heart of the matter – when did the CMO know about Lucy's death, and when should she have been told? You will consequently understand why we pursued this important line of questioning. We absolutely refute that Mr Mulhern discussed the message that the CMO wanted to get across. He was preoccupied with what the public perception of the Sperrin Lakeland Trust was and what it should do, given the gravity of the allegations made by Mrs Crawford, and he undertook to phone the Trust's Chief Executive and suggest he make himself available for interview the following morning. We have contemporaneous notes of this conversation.

As we discussed in our telephone call, you are displeased about the conduct of the interview. When we spoke I said that an interview of this nature is not shaped solely by the presenter – the interviewee's response is an equally important factor. I said the CMO had been evasive.

We were determined to test the allegations made by both families that they had been appallingly treated, that there had been an unacceptable communications failure between the Trusts, the Board and the CMO, and that the Coroner and the CMO disagreed about the cause of death.

The CMO began her response by expressing her deep regret on the deaths of the children and the anguish of the families. She then chose to rehearse the argument that the deaths were due to an idiosyncratic physiological response to the fluids on the part of the two children. She said:

"The rarity in this event, and you do have to return to the medicine, the physiology behind these two events. The rarity in these two events was the abnormal reaction which is seen in a very few children to the normal application of fluids."

This completely contradicts the Coroner's findings which said nothing about physiology or an unpredictable and abnormal reaction. He totally rejected the CMO's contention that there had been a normal application of fluids. The Coroner said:

"The collapse which led to her death was a direct consequence of an inappropriate fluid replacement therapy in that the use of 0.18% saline to make deficits from vomiting and diarrhoea was wrong, too much of it was given and there had been a failure to regulate the rate of infusion."

The CMO repeated her argument about the idiosyncratic reaction, and then when pressed said that she agreed with the Coroner's findings. She also claimed that in 2000 "very few people" would have understood the cause of the children's deaths.

We spoke again to Dr Ted Sumner after the programme, and he disputes the veracity of the CMO's claim. He has told us that articles on hyponatraemia were first published in the eighties in the British Medical Journal, and that the outcomes of fluid maladministration would have been understood long before 2000.

The presenter was therefore having to deal with the following inconsistencies: firstly, the CMO offers her explanation of the cause of death - and then accepts the Coroner's findings which directly contradict her explanation. Secondly, she holds to the view that only a few medical professionals in Northern Ireland in 2000 would have been aware of hyponatraemia, yet the presenter knows this is also contradicted by the medical experts who gave evidence at both Raychel's and Lucy's inquests. Their view is that the potential risks in the administration of fluids would have been well known at that time.

Thirdly, even on the matter of the reporting of the case, the CMO gives an unsatisfactory answer:

"We learnt of this untoward event, Lucy's death, when Raychel died and the Coroner saw that he had two cases presented to him which looked similar in terms of tragic outcomes. So the Coroner, noticing a pattern, reported those two cases to me."

Fearghal McKinney knew that this was also not the case. Belfast Coroner, John Leckey, said in his preliminary statement at Lucy's inquest that it was a health official in Omagh who had spotted similarities in the cases of Raychel and Lucy. Nowhere did he claim that he had identified the pattern. Mr Leckey told the Inquest:

"On 27th February, 2003 I received a letter from Mr Stanley E Miller, Chief Officer of the Western Health and Social Services Council in which he referred to an inquest I had held a short time previously into the death of Raychel Zara Ferguson aged 9 years. She had died from cerebral oedema due to hyponatraemia and I understand that the publicity surrounding the inquest led Mr. Miller to speculate if the two deaths had any common features."

Given this statement, is it not reasonable to ask the CMO if it was appropriate that the only way she was to learn of Lucy's death was through the inquest process? If this is typical, it appears that the referral requirements are not defined, and that the CMO is only learning indirectly and belatedly what she should know directly and immediately.

When one considers the importance of these three points, can we criticise an interviewer for robustly interviewing a CMO who contradicts herself on the cause of death; significantly downplays the level of understanding of the importance of fluids management; does not find out about an untoward event until three years after it happens, and does not learn of it from the hospital itself?

You told me that Dr Campbell was very upset by the way she was interviewed, and you will probably know that she has also written to me about how she was treated. It is never our intention to cause distress to any programme participant, and we have always valued our relationship with both Dr Campbell and your Department's staff.

The programme, however, was about the distress of two families who clearly had been treated appallingly by health officials. The following week, the Sperrin Lakeland Trust issued a public apology to the Crawford family for the way they had dealt with Lucy's case. On April 1st, the Impartial Reporter led with a front page article headlined "Trust – we killed Lucy". The paper also reported the Chief Executive of the Sperrin Lakeland Trust as saying that (at the time of Lucy's death) "there was no formal reporting mechanism for unexpected deaths to be conveyed to the CMO". How are the public meant to reconcile the CMO's stated role to "make sure we learn from untoward deaths" when she had not put in place any reporting mechanism before Lucy's death nor Raychel's death 18 months later. I note that, since our broadcast, the Health Minister Angela Smyth has felt the need to state that "work is underway to improve the mechanism for reporting and investigating".

We believe that it was in the public interest to raise the issues surrounding the death of the children and the way their families were subsequently treated by the system. We also believe that the rigorous questioning was entirely justified because it was important to challenge the inconsistencies in the CMO's position, and to reveal a number of professional shortcomings in the system which, it would appear, her Office has not yet rectified.

I have written separately to Dr Campbell and have also copied this letter to her.

Yours sincerely

Alan Bremner
Director of Television