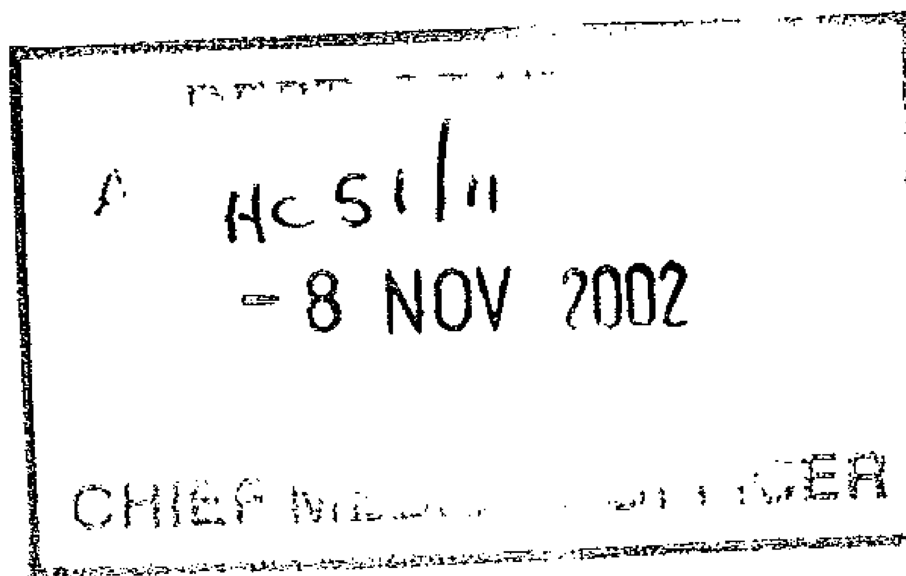
HER MAJESTY'S CORONER

DISTRICT OF GREATER BELFAST

John L Leckey LL.M.
H.M. Coroner
Coroner's Office
Courthouse
Old Town Hall Building
80 Victoria Street
Belfast BT1 3GL
Northern Ireland



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Dr Henrietta Campbell
Chief Medical Officer
Castle Buildings
Upper Newtownards Road
BELFAST
BT4 3SJ

7th November 2002

Dear Etta,

RE: RACHEL FERGUSON, DECEASED
HYPONATRAEMIA IN CHILDREN RECEIVING INTRAVENOUS FLUIDS

I understand you have been made aware by Altnagelvin Hospitals Health & Social Services Trust of the circumstances surrounding the death of Rachel. For your information I am enclosing copy correspondence which has been sent to me by the Trust.

In your letter of 10th May 2002 to Dr Nesbitt you state that the Department of Health was not made aware of the earlier inquest into the death of Adam Strain by either myself or the Royal Victoria Hospital. It is true that I did not formally notify the Department under the provisions of Rule 23(2) of the Coroner's Rules 1963 (copy enclosed). At that earlier inquest Dr Edward Sumner, a consultant Paediatric Anaesthetist at Great Ormond Street Children's Hospital, gave evidence and the opinions he expressed were not contested on behalf of the medical staff at the Royal Belfast Hospital for Sick Children. My clear understanding was that changes would be made in relation to the future management of cases such as that of Adam Strain. Therefore, I did not see a need for formal action pursuant to the Rule. Also, I assumed that there existed some mechanism for dissemination of Dr Sumner's opinions but it now appears that this is not the case. As you are aware Dr Sumner is an acknowledged authority on issues concerning children receiving intravenous fluids.

He is to be a witness in the inquest on Rachel Ferguson which is scheduled to take place in the Old Town Hall Building, 80 Victoria Street, Belfast on the 26th and 27th November.

Should I have reported the circumstances of the death of Alana Scott Cochrane to the Department? You will be aware that this was widely reported in the media last week. Certainly the circumstances of her death gave me cause for considerable concern but I received an assurance at the inquest that the Royal Victoria Hospital was reviewing its procedures.

I would welcome an opportunity to discuss such inquests with you or one of your colleagues. If you felt I should make formal reports to the department on a more regular basis I would certainly consider that. Also, perhaps you would advise me if there is a mechanism in existence for advising the medical profession of the outcome of such inquests and the opinions of independent experts called to give evidence.

I will await hearing from you.

With best wishes.

Yours sincerely

J L LECKEY
H M CORONER FOR GREATER BELFAST

P.S. You may be aware already of the Shipman Inquiry consultation paper. Just in case you are not I am enclosing a copy.

[17.-(1) A document may be admitted in evidence at an inquest if the coroner considers that the attendance as a witness by the maker of the document is unnecessary and the document is produced from a source considered reliable by the coroner.

(2) If such a document is admitted in evidence at an inquest the inquest may, at the discretion of the coroner, be adjourned to enable the maker of the document to give oral evidence if the coroner or any properly interested person reasonably so desires.

(3) Such a document shall be marked by the coroner in accordance with these rules with the additional words "received pursuant to Rule 17".][18]

8. All exhibits produced in evidence at an inquest shall be marked with consecutive numbers and each number shall be preceded by the letter "C".

19. The coroner shall make, or cause to be made, a note of the evidence of each witness, and such note shall be signed by the witness and also by the coroner.

20. No person shall be allowed to address the coroner or the jury as to the facts unless the coroner shall so permit.

21. [Where the coroner sits with a jury he shall sum up the evidence to the jury and draw their attention to such of these Rules as may be relevant before they consider their verdict.][19]

22.-(1) After hearing the evidence the coroner, or where the inquest is held by a coroner with a jury, the jury, after hearing the summing up of the coroner shall give a verdict in writing, which verdict shall, so far as such particulars have been proved, be confined to a statement of [the matters specified in Rule 15].[20]

(2) When it is proved that the deceased took his own life the verdict shall be that the deceased died by his own act, and where in the course of the proceedings it appears from the evidence that at the time the deceased died by his own act the balance of his mind was disturbed, the words "whilst the balance of his mind was disturbed" may be added as part of the verdict.

23.-(1) Any verdict given in pursuance of Rule 22 shall be recorded in the form set out in the Third Schedule.

[(2) A coroner who believes that action should be taken to prevent the occurrence of fatalities similar to that in respect of which the inquest is being held, may announce at the inquest that he is reporting the matter to the person

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17 The proviso to Rule 16 (nothing in this Rule to preclude the coroner or jury from making a recommendation designed to prevent the recurrence of similar fatalities) was revoked by the Schedule to the 1980 Rules.

18 Rule 17 substituted by the Schedule to the 1980 Rules.

19 Rule 21 substituted by the Schedule to the 1980 Rules.

20 Reference to Rule 15 substituted by the Schedule to the 1980 Rules.

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or authority who may have power to take such action and report the matter accordingly.][21]

Removal and Deposit of Bodies

24.-(1) Each coroner shall make arrangements with one, or more than one, reputable funeral undertaker for the expeditious removal, in appropriate vehicles, of dead bodies which require to be removed for the purpose of investigating the cause of death or otherwise, and such means of transport shall be used wherever it is practicable to do so.

(2) Where a coroner takes possession of a dead body he shall, if necessary, take appropriate measures to ensure that the body will not decompose while it is in his possession, and for that purpose he may take such steps to preserve the body as he deems necessary.

(3) Where a dead body is conveyed to a mortuary ...[22] or other suitable place, the body, and the clothing, if any, shall be carefully examined for any articles or property that may be thereon, and an inventory of the clothing and other articles or property found on the body or amongst the articles of clothing shall be made, and at least two persons shall be present when this duty is performed.

The examination and preparation of the inventory shall be carried out by the mortuary attendant or by such other person as may be deputed by the authority or person in charge of the mortuary ... or place, and shall be witnessed by the constable or other person who accompanied the body, and the inventory shall be signed both by the person making the examination and by the witness. If a relative is available, he shall be invited to be present and to act as a witness should he so desire.

The person in charge of the mortuary ... or place shall not allow the body to be removed therefrom without the sanction of the coroner, and all articles taken from the body shall, unless required by the Police, be retained in safe keeping by the person in charge of the mortuary ... or place until they are no longer required for purposes of the investigation or inquest, when they shall be handed over to the next of kin of the deceased or his representative.

Post-Mortem Examinations

25. Where a coroner directs or requests that a post-mortem examination shall be made, it shall be made as soon after the death of the deceased as is reasonably practicable.

26. [If the deceased died in a hospital, the coroner shall not direct or request a pathologist on the staff of, or associated with, that hospital to make a post-mortem examination if:-

(i) that pathologist does not desire to make the examination, or

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21 Rule 23(2) substituted by the Schedule to the 1980 Rules.
22 The word "morgue", wherever it occurs in Rule 24(3), was deleted by the Schedule to the 1980 Rules.

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Altnagelvin faces more tough questions

Did our child die like Raychel?

ALTNAGELVIN HOSPITAL today faces more tough questions after the family of a young Dungiven girl who died in 1990 claimed that the manner of her death was strikingly similar to that of tragic nine-year-old Raychel Ferguson.

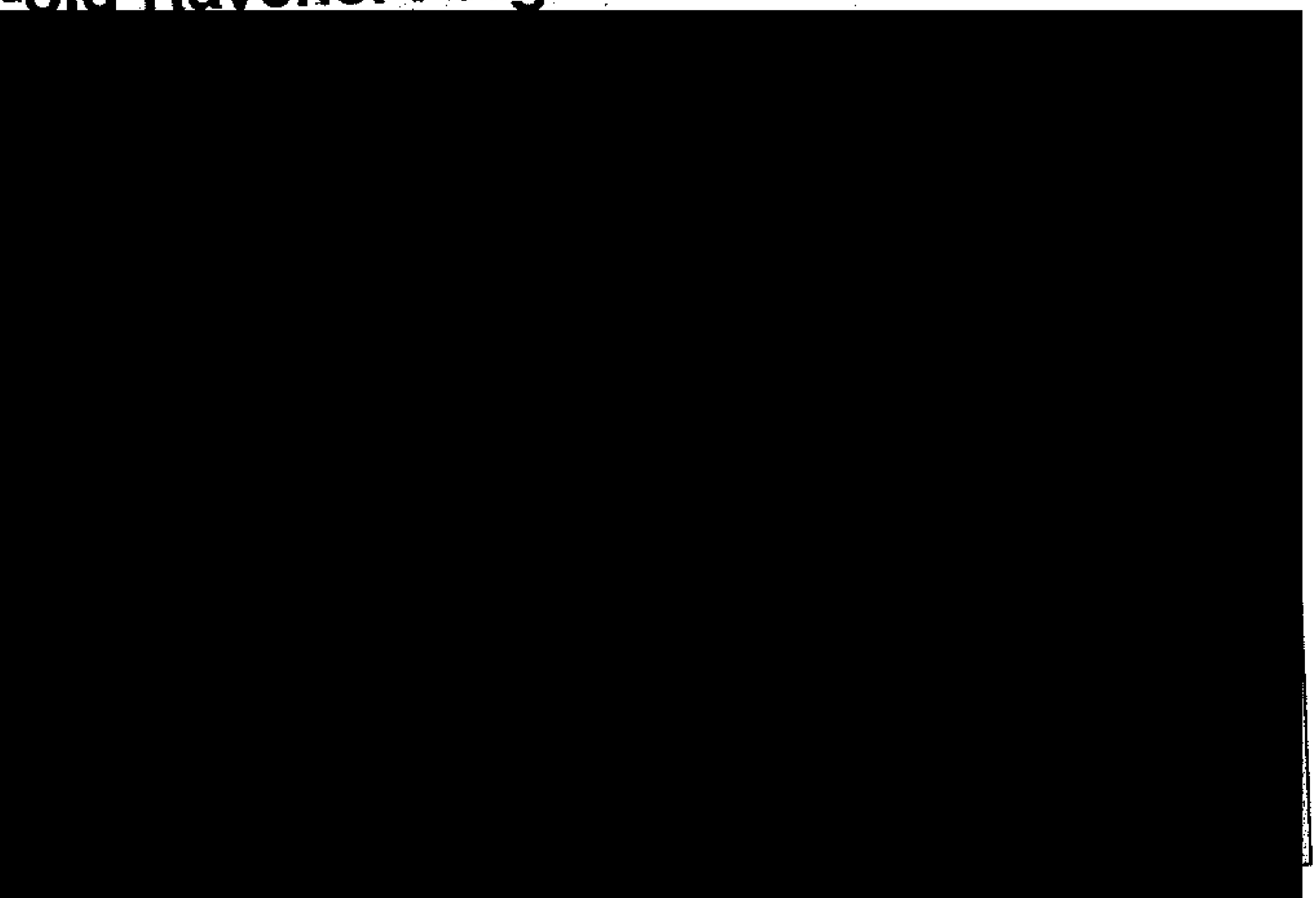
The family of Lorna Moore, who was 14 when she died, said last night that they relived their 1990 nightmare when they watched last week's UTV Insight's documentary, detailing the tragic story of the young Derry girl who died in 2000 after a routine appendix operation.

by Eamonn Houston

Like Raychel Ferguson, Lorna Moore was admitted to the hospital complaining of stomach pain and later underwent surgery for suspected mild appendicitis.

The mother of the girl claimed last night that Lorna, who was perfectly healthy before being admitted to the hospital, vomited on a number of occasions after her operation, suffered a seizure and was declared brain dead days later. Her symptoms, the family believe, bear a striking resemblance to those experienced by Raychel Ferguson.

"We've been living in doubt for 12 years," Mona said. "After we watched that programme everybody was ringing us and crying. It was like going through it all again. I feel that if I tell Lorna's story then I'll have done something."



Mona and Paddy Moore pictured with a photo of Lorna.

Lorna, described by her family as a perfectly healthy teenager, was admitted to Altnagelvin on Christmas Eve 1990.

"She was vomiting in the car on the way to the hospital," Mona sa[illegible]. On January 11 she died after th[illegible] life support machine that was keeping her alive was switched off."

A[illegible]rding to the young girl's sister [illegible]ne Marie, Lorna began complaining of a severe headache after the operation and also vomited during the evening.

Mona Moore said: "Her eyes were swollen and bloodshot. We asked the nurses about her on three or four occasions and were told that it was normal after an operation. My daughter Anne Marie said that she had been complaining of a severe headache and had vomited into a dish."

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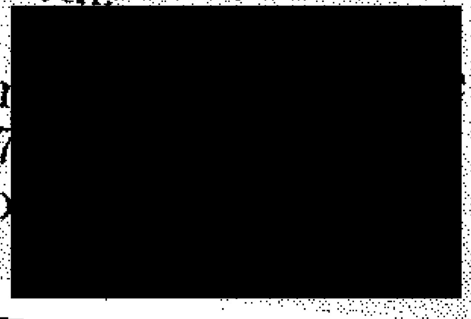

Did our child die like Raychel?

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The family claim that Lorna was then sedated in some way by medical staff and fell into a deep sleep until midnight of December 24.

Mrs. Moore said that she rang to check on her daughter's condition at 2.00am on Christmas morning then 5.40am and again at 8.00am and was told she was fine. She claimed that a nurse phoned at around 10.45am to query whether Lorna had ever suffered from seizures and to say that the young girl was unwell.

"Five minutes later there was a call requesting that the whole family go to the hospital."

By lunchtime, the Moores say, their daughter was in intensive care.

"We were told to prepare ourselves, but we couldn't understand why she was on a life support machine. We were told by a doctor that she had suffered some form of seizure and that her heart had stopped for several minutes."

Lorna spent 17 days on a life support machine during which time the family say she underwent a series of tests.

Father, Paddy said: "There were a lot of questions we asked that were unanswered. We support the Ferguson family in all they are doing." Doctors told them 12 years ago that their daughter died from Meningococcal Septicaemia, something the family disputes to this day. The condition can be fatal within hours.

The Moores yesterday contacted the Patient's Advocate at Altnagelvin and allege that they were told their daughters medical records would have been held for eight years.