Trevor Birney

From: Marie Dunne - Commun. Mgr [redacted]
Sent: 29 September 2004 10:54
To: Trevor Birney
Subject: RE: Raychel Ferguson

Attachments: Raychel - additional questions - June 04.doc

Raychel - additional questions...

Trevor - Find attached statement which answers the questions outlined below which you had forwarded in June 2004. In relation to the supplementary questions following Dr. Nesbitt's recent response, I would advise as follows:

1. The CMO advised Altnagelvin on 10th May 2002 that she only became aware of the death of a child in the Royal after Altnagelvin had advised her of Raychel Ferguson's death.

2 As outlined in Dr. Nesbitt's response, the CMO's working group was established to pare guidance on the prevention of hynonatraemia and not to consider the case of any specific child or children.

Hope this is helpful. Do you have a date yet for the broadcast?

Regards.

Marie

-----Original Message-----
From: Trevor Birney [redacted]
Sent: 27 September 2004 16:09
To: Marie Dunne - Commun. Mgr
Subject: RE: Raychel Ferguson

Marie,

Thank-you for forwarding Dr. Nesbitt's response.

In relation to his statement, Mr. Nesbitt appears to left the following question unanswered:

1. "Dr. Geoff Nesbitt, then Clinical Director for Anaesthetics in the Trust personally telephoned colleagues in several hospitals in Northern Ireland to alert them to the circumstances of Raychel's death."

Question: Whom exactly did Mr. Nesbitt telephone? I asked Mr. Nesbitt this question when I met him in spring, 2003, and he wasn't able to remember. Can he now recall?

Supplementary to his statement:

2. When Dr. Nesbitt contacted the CMO in May 2002, was she already aware of the death of the child at the Royal in 1997?

3. Others involved in the CMO's Working Group say they studied the Lucy Crawford case as part of their work. Was Dr. Nesbitt never informed of her death and did he not receive the paper work that his colleagues were given?

These are all my questions for the moment for Dr. Nesbitt, however, I did also forward you the following question which also hasn't been answered:

"On 18 June 2001, the Trust's then Medical Director, Dr Raymond Fulton, met with Dr. Ian Carson, Deputy CMO and Medical Directors from other Northern Ireland Trusts. Dr. Fulton described the circumstances of Raychel's death and it was agreed that there was a need for regional guidelines."

Question: Who were the other Medical Directors who attended this meeting?

Marie, we're really up against it time wise. Any chance of a quick response to these?

Best wishes,
Trevor.

Trevor Birney
Editor, Current Affairs
Ulster Television

-----Original Message-----
From: Marie Dunne - Commun. Mgr [redacted]
Sent: 27 September 2004 14:33
To: Trevor Birney
Subject: RE: Raychel Ferguson

Trevor - Find attached Dr. Nesbitt's response to the queries in your email below. Apologies for the delay but as you know I was on leave until 20th September.

Marie

-----Original Message-----
From: Trevor Birney [redacted]
Sent: 14 September 2004 10:19
To: Marie Dunne - Commun. Mgr
Subject: RE: Raychel Ferguson

Marie,

As you know, we're still working on a programme examining the deaths of Lucy Crawford and Raychel Ferguson.

In terms of the death of Raychel, in a meeting I had with Geoff Nesbitt last year he spoke of his concern at the RVHSC not disseminating information relating to the death of Adam Strain in 1996.

Can you ask Geoff when exactly did he find out about the death of Adam?

When did he first speak to the CMO about his concerns?

When did Geoff discover that another healthy child, Lucy Crawford, had died at the Erne Hospital 14-months previous to the death of Raychel?

How many deaths did the Working Group, set up by the CMO, examine?

Best wishes,
Trevor.

Trevor Birney
Editor, Current Affairs
Ulster Television

This e-mail, and any attachment, is confidential. If you have received it in error, please delete it from your system, do not use or disclose the information in any way and notify me immediately. The contents of this message may contain personal views, which are not the views of UTV unless specifically stated.

-----Original Message-----
From: Marie Dunne - Commun. Mgr [redacted]
Sent: 15 June 2004 12:12
To: Trevor Birney (E-mail)
Subject: Altnagelvin statement

Hi Trevor - Statement as promised.

Regards.

Marie

<<Raychel - Insight 3 - June 04.doc>>

This email is confidential and intended solely for the use of the individual to whom it is addressed. Any views or opinions expressed are solely those of the author and do not necessarily represent those of Altnagelvin Hospitals Health and Social Services Trust.
If you are not the intended recipient, be advised that you have received this email in error and that any use, dissemination, forwarding, printing or copying of this email is strictly prohibited. If you have received this email in error please contact the sender.

Incoming Mail Disclaimer
Altnagelvin Hospital HSS Trust may monitor the content of emails sent and received via its network for the purposes of ensuring compliance with its policies and procedures.

[redacted]

Additional questions from Trevor Birney received 16th June 2004

(1): In the statement, you say:

"Dr. Geoff Nesbitt, then Clinical Director for Anaesthetics in the Trust personally telephoned colleagues in several hospitals in Northern Ireland to alert them to the circumstances of Raychel's death."

Question: Whom exactly did Dr. Nesbitt telephone? I asked Dr. Nesbitt this question when I met him in spring 2003, and he wasn't able to remember. Can he now recall?

Answer: In a letter dated 14th June 2001 to Dr. Raymond Fulton our Medical Director at the time, Dr. Nesbitt reports that he telephoned a number of hospitals, specifically naming the Royal Belfast Hospital for Sick Children, Craigavon Area Hospital and the Ulster Hospital, to alert them to this death and discuss fluid management.

(2) In the statement, you say:

"On 18 June 2001, the Trust's then Medical Director, Dr Raymond Fulton, met with Dr. Ian Carson, Deputy CMO and Medical Directors from other Northern Ireland Trusts. Dr. Fulton described the circumstances of Raychel's death and it was agreed that there was a need for regional guidelines."

Question: Who were the other Medical Directors who attended this meeting?

Answer: At the time, these meetings were informal and ad-hoc designed to provide an opportunity for Medical Directors to network and share experiences or concerns. Brief notes of the proceedings were taken but these were not routinely retained so it is not possible be sure precisely who attended this particular meeting.

(3) Again, in the statement, you say:

"The matter was also raised by Dr Fulton with Dr. W. McConnell from the Western Health and Social Services Board who advised that he would speak to Dr. Henrietta Campbell, CMO. On 5th July 2001, Dr. McConnell confirmed that he had notified the CMO."

Question: Why was it necessary for Dr. McConnell to advise Dr. Fulton that he would speak to Henrietta Campbell given that Mrs. Burnside had spoken to her directly in the days following Raychel's death and Dr. Fulton had attended a meeting chaired by the Deputy CMO, Dr. Ian Carson?

Question: There seems to have been a huge emphasis on contacting the CMO – why?

Answer: As part of Altnagelvin's learning environment and our system of clinical governance, unexpected clinical incidents, 'near misses' and unexpected deaths are all reported to the Trust's Risk Management Department. These incidents are then reviewed.

The unexpected collapse and sudden death of Raychel Ferguson precipitated such a review and that review revealed literature on post-operative hyponatraemia, which was not common knowledge. As a result, Dr Geoff Nesbitt, then Clinical Director in Anaesthesia, Dr Raymond Fulton, then Medical Director, and Stella Burnside, Chief Executive, believed it was essential to disseminate this information as widely as possible.

Given that the information was applicable to a number of Trusts, it was felt that a regional approach to the provision of guidance was the most appropriate way forward, thus the CMO was alerted. Notifying the Western Board's Consultant in Public Health, Dr. W. McConnell, and the Deputy CMO, were further opportunities to emphasise the importance of this issue and ensure the widest possible dissemination of guidance.

We do not know what arrangements exist in other hospitals for responding to this type of incident. All we are able to say is that our system of review of clinical incidents identified a post-operative problem with a fluid (Solution 18) that was in common use in Northern Ireland and other parts of the UK. We believed it imperative that this was brought to the attention of our colleague Trusts to prevent similar clinical incidents.
ENDS

29th September 2004

Provided by: Communications Department, phone [redacted]