ALTNAGELVIN HOSPITALS HEALTH AND SOCIAL SERVICES TRUST

Statement for Insight Programme

15th June 2004

The following is the sequence of events following the sad death of Raychel Ferguson in June 2001.

- Raychel's unexpected collapse and sudden death on 10th June 2001 triggered the Trust's Critical Incident Investigation procedure, which has been in place since 1998.

- As the investigation developed, including a literature review, it became clear that although Altnagelvin's procedures in respect of the use of perioperative fluids in children was common practice in most hospitals at that time, there may have been a problem in relation to the use of Solution 18 for children.

- 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.

- 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.

- 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.

- On 22nd July 2001, Dr. Fulton spoke directly to the CMO about this matter and the CMO suggested that CREST (Clinical Resources Efficiency Support Team) might be involved in the development of guidance.

- On 26th July 2001, Altnagelvin's Chief Executive also contacted the CMO advocating the development of regional guidance.

- The CMO commissioned a Regional Working Party, including Dr. Nesbitt, to consider the use of fluids and the risks of hyponatraemia in children. The Working Party developed and disseminated guidance in March 2002.

- In June 2003, having become aware that hyponatraemia is also a risk for adults, CREST disseminated guidance on hyponatraemia that is applicable to both adults and children.

The Trust believes that it acted professionally and honestly following Raychel's death.

The treatment of the Ferguson family by Altnagelvin: Altnagelvin very deeply regrets the death of Raychel Ferguson. We have endeavoured at all times to treat the family with honesty and respect and it is a source of further sadness for us that they feel we have failed in this regard. The series of events in our response to the family is as follows:

- The Chief Executive wrote to Mr and Mrs Ferguson on 15th June 2001, expressing our sympathy and our sadness and offering to meet with them.
- The Chief Executive and clinical staff involved with Raychel met with Mrs. Ferguson, family members, and the family's GP on 3rd September 2001 to allow full discussion of the circumstances surrounding Raychel's death.
- In February 2003, in response to media enquiries, the Trust issued a press statement, publicly expressing sympathy to the family and offering our sincere condolences.

Was Dr Quinn acting on behalf of Altnagelvin Trust when he provided a report on the death of Lucy Crawford? Dr Quinn is a much respected and very experienced consultant paediatrician employed by Altnagelvin Trust. On 21st April 2000, Sperrin Lakeland Trust asked Dr. Quinn to carry out an initial review of notes related to Lucy Crawford. Dr. Quinn reviewed the notes and provided a report on 22nd June 2000. He was acting independently when he prepared his report for Sperrin Lakeland. The use of Altnagelvin headed paper is co-incidental and did not infringe hospital policy.

Letter from the Coroner: The Trust responded to the letter from the Coroner on 11th March 2004.

ENDS

Provided by the Communications Department, phone [redacted]