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29 November 2013

Ms Anne Dillon
Solicitor to the Inquiry
The Inquiry into Hyponatraemia-related Deaths
Arthur House
41 Arthur Street
Belfast BT1 4GB

Dear Madam

Closing Submission

We attach hereto our Closing Submission on behalf of Raychel's parents.

To keep the document as short as possible we have simply highlighted the main points which our clients have highlighted to us. We have not carried out a detailed forensic analysis of the evidence as we feel this has, and will, be carried out by the Inquiry.

We would add to the submission herein all our letters of criticism of every witness we have made, a record of which the Inquiry has. We would also repeat the evidence Mr & Mrs Ferguson gave to the Inquiry with particular reference to their own oral statement at the end of their evidence.

The belated apology and admission of liability in Raychel's case has indeed obviated the need, in particular, to carry out a detailed analysis of the expert evidence. We have focussed solely on the main clinical and governance evidence as received and prepared the submission in general summary form.

Yours faithfully

DESMOND J. DOHERTY
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THE ORAL HEARINGS IN THE INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

BANBRIDGE CO DOWN

CHAIRMAN: MR JOHN O'HARA Q.C.

CLOSING SUBMISSION
ON BEHALF OF THE PARENTS OF RAYCHEL FERGUSON

PRE-OPERATIVE CARE

1. In our Opening to the Inquiry we posed the following questions.

> *Why did a healthy 9-year-old girl die in a modern hospital with a full complement of nursing and clinical staff? Why did it happen and who was responsible? It didn't just happen, there must be reasons for it happening. We ask why?*

Through the careful scrutiny of the evidence by the Inquiry we hope that we now have the answers.

2. There was virtually complete ignorance of hyponatraemia and the proper safe management of intravenous fluids among the nursing and medical staff. The evidence supports the view that prior to June 2001 medical staff may have been aware of hyponatraemia to the extent that their university studies touched upon the issue, but there was no real practical clinical understanding and recognition of it on the evidence presented.

3. Hyponatraemia was known since at least 1992, and the medical literature has shown its rising prominence with awareness of it. This did not seem to filter through to clinical and nursing staff (if their evidence is accepted). But the very basics of fluid management, especially in children, was neither demonstrated or put into practical effect by the nursing and medical staff.

PRE-OPERATIVELY

4. As now transpires, the appendectomy operation was unnecessary.

5. The use of [cylormorph] by Dr. Kelly masked Raychel's symptoms, and may have led to unnecessary intervention by way of emergency surgery that is recognised to carry a significant statistical risk.

6. There was no referral to a senior consultant and junior surgeons took a decision without senior referral. There is therefore a lack of communication as between the treating surgeons and their senior. There was no involvement at all of Mr Gilliland as Raychel's Consultant in the decision to operate on Raychel. His lack of involvement in Raychel's care, treatment and post death assistance is disturbing and unacceptable, as far as Raychel's parents are concerned.

INTRA-OPERATIVELY

7. On the night of her admission, during her unnecessary surgical procedure, Raychel was provided with too much Hartman's Solution. This may not have been centrally causative but was un-helpful to the later over infusion of Solution 18 post-operatively.

8. The later amendment of the anaesthetist's recording [on administrative direction by Dr Nesbitt] of the intra operative fluid might be interpreted as a wilful attempt to reduce the amount of the infusion of fluids. Given the time it was carried out this changing of the records could have had no therapeutic value to Raychel and we submit could only be seen as an exercise in record manipulation.

POST-OPERATIVELY

9. The notes and records maintained failed in any meaningful sense to record the extent and frequency of Raychel's vomiting. This was a key and glaring omission. The failure to note and realise her lack of micturation was another pointer to deterioration and the development of hyponatraemia, which was missed by the nursing staff.

10. The fluid balance chart was not effectively or clearly maintained by the nursing staff. The indices of a serious problem were neither realised or properly recorded to trigger meaningful medical intervention at a stage where that might have been productive to arrest Raychel's declining condition on Friday the 8th June 2001 prior to it becoming critical, and irreversible.

11. The nursing staff on Friday the 8th June 2001 failed to appreciate that the pathway to recovery was totally askew, with the number of vomits and frequency of same added to the volume of same. This perspective was in fact maintained through the nursing evidence heard by this Inquiry, that such extent and extensive vomiting had been consistent with their experience and children in recovery. This is at odds with, for example, Mr. Gilliland who has said that even a second vomit should have provoked the summoning of an SHO at an early stage on the mid morning of 8th June 2001. Such an intervention, if meaningful,

could have re-routed the direction of the horrendous events of that day for Raychel.

12. There was clearly inadequate communication between the nursing staff at handovers during the 8th June 2001. These handovers were compromised by the lack of proper note keeping and also an accurate interpretation of the seriousness of Raychel's vomiting. There was a failure and neglect to listen to the parents' concerns. In fact, their genuine, and as it turned out, well-founded, worries were dismissed out of hand by the nursing staff.

13. The severe headaches that Raychel experienced on the evening of 8th June 2001 should have been understood by the nursing and all medical staff to be caused by the pressure being exerted within Raychel's skull because of the fluid infusion and overload.

14. There was complete ignorance of the electrolyte balance and a failure to order a blood test for Raychel until after her seizure, when it was too late. This was a gross failing. The evidence received allows a conclusion that this omission displayed a central failure on the part of the nursing staff, and thereby the medical staff, to appreciate what was happening to Raychel until Raychel was beyond saving.

15. In the early evening of Friday the 8th June 2001 the involvement at Drs. Devlin and Curran was entirely ineffectual, given their inexperience, lack of information and their deference to senior nursing staff.

16. The rate and type of the infusion of Solution 18 was and should have been recognised as entirely inappropriate. There was no understanding of the difference between a maintenance and a replacement fluid, with the continued over supply of the former. The electrolyte imbalance, which worsened during Friday 8th June, was never corrected and was not recognised for the dangers it presented. The record keeping, particularly the fluid charges and the anti-sickness medication notes, were not of a proper standard and contributed to a want of accurate information being gathered about Raychel.

Information transmission/communication

17. It is plain from the evidence that there was a lack of care and disregard for Raychel's well being. Our clients do not believe that anyone set out to harm Raychel, but then why did she die when her death was totally preventable?

Inexperienced surgeons and JHOs

18. Ignorance through poor recording, combined with the ignorance of JHO'S who were poorly informed. Their inexperience at pivotal moments around 5pm and 10pm lead to two opportunities to engage in a corrective course of action to retrieve Raychel in time being squandered.

19. Nurses were individually and collectively wedded to a recovery path that was clearly not happening in spite of the plain observation of severe and excessive vomiting and the parents' reports of vomiting, headache and lethargy.

20. The continued use of Solution 18. As the Inquiry will appreciate this is a maintenance fluid and not replacement. In essence, it's continued transfusion into Raychel and at the rate and amount made a bad situation fatal.

21. Failure to inform, to take blood tests and of the known fact of hyponatraemia.

22. Arrogance in governance: There was a failure to take on board the parents' concerns and communications with the staff. There was a failure to acknowledge a lack of senior involvement in the surgical procedure. Moreover Mr Gilliland's non-attendance at the 3rd September 2001 meeting was unfortunate to say the least and could be interpreted as arrogance or, alternatively, an uncaring attitude towards the events surrounding Raychel's death.

23. There was a failure to communicate or absorb or disseminate information between the parents and nursing staff, the nurses themselves and the clinical staff.

24. There was a consequent failure by all the medical staff to trigger senior involvement in Raychel's treatment that may have saved her life. There was never an adequate answer offered for this failure and it is a failing that applies to both nursing staff and doctors.

POST-SEIZURE

25. There was a failure to actively communicate to the parents the gravity of the situation. Further, the journey to the RBHSC with Dr Nesbitt lead to the active creation of an un-realistic false hope to the parents. At that stage circumstances were clearly dictating that Raychel's position would never improve. There was a failure to be realistic with the Ferguson's in a manner that would have begun to prepare them for the worst. When it did transpire that no recovery was possible this added to the anguish immeasurably.

POST-DEATH GOVERNANCE

26. The holding of an early Critical Incident Review (CIR) may have been a credible response to Raychel's death. The rapid gathering of information about the unsatisfactory nature of the infusion of Solution 18 as a maintenance fluid may draw some credit. The immediate steps taken to change this practice, both the fluid itself and how it was administered may be viewed as a positive step. This may have saved lives, though the transmission of information to the Fergusons in September 2001 of this alteration in procedure may [and we submit should] draw criticism from the Inquiry.

27. The June 2001 CIR pre-figures and puts in a very poor light however the entirely misleading meeting with Mrs Ferguson and her relatives on the 3rd September 2001. The knowledge gathered in June 2001, immediately after Raychel's death, was not passed to the family who then would have had a clear and plain explanation of how Raychel came to die in Altnagelvin Hospital. As far as Raychel's parents are concerned, their daughter was killed as a result of the treatment she received at Altnagelvin Hospital, or to put it another way, Raychel would not have died, but for, her treatment at Altnagelvin Hospital, all of which arose out of unnecessary surgery.

28. The lack of effective preparation and availability of information hamstrung the meeting in September 2001, and stripped it of any effectiveness. The Patient Advocate was not properly trained, and therefore did not recognise her role as having an interface with the family. This nullifies, to an immense extent, any gains of the June 2001 Critical Incident Review, and the realisations which were not shared with Mrs Ferguson and her family. There were decisions taken not to disclose the CIR perspective to them.

29. This lack of disclosure to the family of relevant information by the Altnagelvin Trust is impossible to defend. The Altnagelvin Trust were aware in June 2001 of the issues and problems but the September 2001 presentation to Mrs Ferguson, her family and support is made even more appalling by the gap in transmission of information to the family of what the Chief Executive knew from June 2001.

30. Mrs Burnside belatedly acknowledged she did not follow the established protocols following Raychel's death. No good, or any reason, for this was advanced to the Inquiry in the evidence received. In fact, she admitted that she failed to follow the protocol she had devised and put in place; a failure of the highest order.

31. The meeting on 3rd September 2001 demonstrates, through the unchallenged note of the Patient Advocate, that a full divulging of information to the parents and family of Raychel, did not take place. The clinical staff failed Raychel but why did the grievance procedures fail the family? This suggests that there was a failure to provide full and frank disclosure and the Ferguson family would like comment, and if necessary, action on this issue.

32. There was no good reason in the evidence received why this was so. The value of the Critical Incident Review as a possible positive aspect is therefore tarnished and compromised because the Trust authorities knew accurately what had happened, but did not reveal same in any accurate and meaningful way to the family.

33. The use of Patient Advocate as a note taker, without any adequate preparation or understanding of her role, together with lack of facilities provided to the family, in an environment which was plainly militating against the proper sharing of information with them, was a very unhelpful way for matters to be dealt with.

34. The fact that the meeting contemporaneously was recognised as not having gone at all well, mystifyingly did not lead to any offer of a follow up of another meeting or a series of meetings. No letter was written or other communication made. The purpose of the only meeting offered could only be wondered at since the family did not leave it with any clear explanation of how and why Raychel died. The Inquiry might conclude on the evidence that the meeting was not just incompetent but was conducted in a way to confuse and obfuscate so the family were not given any clear insight into the responsibility for Raychel's death.

35. The conduct of the DLS and the Trust at Raychel's Inquest and the hiding Dr Warde's report and thereafter claiming privilege further demonstrates a desire not to share accurate information with the family or the Court. The conduct of the Defence of the litigation by the DLS and the Trust was and remains appalling. The denial of liability until 30th August 2013 is indicative of a defensive culture and a failure to take responsibility at an earlier and more meaningful stage. This causes further immense distress and is a waste of public time and money.

36. The Inquiry will have observed how it has been explained why Dr Warde's report was not made available to Mr Leckey, the Coroner, at Inquest and the impact of Dr Warde's clear and effective report would have had supplementing the report of Dr Sumner. The evidence of Mr Leckey on this issue and what he had expected in terms of the sharing of evidence with him by the Directorate of Legal Services (DLS) will be in the forefront of the Inquiry's mind, reflecting on this aspect of the evidence.

37. The role of the DLS calls for special attention in terms of the central causative role of the lawyers in the withholding of the Warde report, the attempt to assert privilege and the refusal of their client to admit liability. For ten years the DLS were possessed of all the information to have allowed their client "*on advice"* to admit fault and thereby ended an aspect of the parents' anguish and distress. This must be a matter of profound concern. Whose interest were the DLS serving? Dr Warde's report was commissioned from public funds for the purposes of a public hearing at a Coroner's Inquest. It was not commissioned in answer to civil litigation. Our clients believe and submit that the DLS were not serving the public interest and that they were involved with their client, the Trust, in a cover-up in relation to the death of their daughter. Our clients have

made their consistent position on this clear for many years to the DLS and the Inquiry. Having heard all the evidence at the Inquiry our clients remain unshakeable in their view that the DLS and the Trust attempted to cover up the truth in relation to Raychel's untimely death – and nearly got away with it. Had it not been for some expert investigative journalism leading to the UTV documentary which ultimately led to the setting up of this Public Inquiry, they probably would have got away with it.

38. It may well be that the DLS have a duty to their clients that conflicts with their client's (the doctors) duty to the public; this must be addressed and clarified in light of the refreshing attitude of openness and honesty that has now been adopted and expressed by the various Trusts.

Conclusions

(a) The explanation of how a healthy 9 year-old girl died in a modern hospital only 12 years ago requires addressing. Generally the failure to disseminate information appropriate and accurately as between medical staff and to the family lies at the core of the mismanagement and failing, which led to Raychel's utterly unnecessary death. The absence by the medical and nursing professionals at Altnagelvin of listening to the parents on the 8th June 2001 was a contributory factor. The clear discounting of their views as to the severity of Raychel's headaches and vomiting does not do the nursing and medical staff any credit. The concoction of a version of events and its continuance through the Inquest and this Inquiry, while transparently false, is a throwback to their failure to clearly understand and communicate in writing in the notes and verbally what was happening to Raychel on Friday 8th June 2001.

(b) The minimising of the frequency and severity of vomiting with inadequate recording is central as to how Raychel died. The absence of referral of accurate primary evidence of a child who was not following a safe and recognised recovery path to those on the medical staff who might have ascertained what it meant and thereby acted in time to save Raychel was not accidental but arose from a series of collective and individual nursing decisions to disregard obvious symptomology.

(c) The information regarding hyponatraemia was available from the Arrief paper in 1992 and other well documented sources. Moreover, Lucy Crawford's tragic death the year before in the same Board area, which was investigated by Dr Quinn from Altnagelvin, demonstrates a culpable failure to learn, absorb mistakes and retrain staff where necessary. The lack of any Inquest into Lucy and the failing of the Royal Hospital for Sick Children in that regard attract and should attract censure. It was inexcusable and the failures to learn the lessons of Lucy's death and disseminate them directly lead to Raychel's death, which was preventable.

(d) The involvement of Dr Quinn in the preparation of his now discredited report is a further crass failure, causative of the tragedy of Raychel's death. This is especially so since Dr Quinn worked for the Altnagelvin Trust. The link in our submission could not be plainer.

(e) One of the central and most important issues in the case is the absence of senior staff in the decision-making process such as Mr. Gilliland. There was a failure to share accurate information which led to Raychel's death by reason of ignorance, misunderstanding, and lack of intervention. There was an absence of availability of those who had or should have had the knowledge to make a difference at the critical points such as Mr. Gilliland, the consultant surgeon, under whose care Raychel was entrusted to. He was entirely absent from not only the care of Raychel while she was alive but absented himself from meeting the family on 3rd September 2001 or at anytime thereafter. Mr Gilliland could and should have made arrangements to at least speak with Raychel's parents but he did not do so. His contact with the GP could only be described as deplorable.

(f) The paradigm of Raychel's death as having been caused by ignorance and the absence of those who were responsible for her was, and is, wilful.

(g) There was a litany of failings by the medical, nursing and administrative staff of the Altnagelvin Trust. We must ask the question:

What did Altnagelvin do right in terms of the care of Raychel from the 7th to the 9th June 2001?

It is difficult to see what the medical and nursing staff at Altnagelvin did do right and therefore we are left with very little to reflect positively upon. An unnecessary operation was carried out. Had it not been carried out at all, with the events which then unfolded, Raychel Ferguson would still be alive. Her death was an avoidable tragedy. It was not an accident, or a series of accidents. Raychel's death was not attributable to only systemic failure, but the culpable failings of a series of individuals in the nursing and medical staff at Altnagelvin, which was and remains inexcusable.

(h) The clear realisations and modifications put quickly in place in June 2001 in the wake of Raychel's death may be laudable but throw into sharp relief the subsequent behaviours of the medical, nursing and administrative staff of Altnagelvin towards the Fergusons to mislead and cover up what had happened from them, and indeed the Coroner. This knowingly added to the prolonged agony of Raychel's parents and family. The callousness of this, as disclosed in the evidence to this Inquiry, deserves particular and severe censure. It added further to the hurt and distress inflicted upon our clients.

(i) The parents of Raychel contend that matters could have been handled better. For the future, the Inquiry may well prescribe a more satisfactory way of handling the interaction between a Trust or Hospital and the relatives where it is

the case that something catastrophically fatal has gone wrong with the treatment of a relative.

(j) The evidence that the Inquiry has received supports the view that the opinions and reactions of parents of a sick or ailing child should be taken very seriously, and factored into the analysis of the medical and nursing staff. It seems incontrovertible that this did not happen in Raychel's case. The concerns of, for example, Mr Raymond Ferguson in the early evening of the 8th June 2001 that Raychel had a very severe headache were not taken on board by the nursing or medical staff. Had they been then this might have provided a reason to change tack and analyse why Raychel was not following the expected recovery path. Ignoring Mr Ferguson's concerns and what Raychel was saying to him, led to a direct disregard of information that could have led to a reversal of the downward spiral in Raychel's condition.

(k) The Critical Incident Review disclosed the reasons that led to Raychel's death; vis, use and overuse of a maintenance rather than a replacement fluid. The prompt action and awareness of this has drawn some credit to the Trust. However, that must, as indicated herein, be set against the utterly unsatisfactory meeting of the 3rd September 2001 where Raychel's mother and family were not accurately or adequately informed. It was not explained to them what had transpired on the 7th to the 9th June 2001 at Altnagelvin. The failure of this meeting and the omission to offer a further meeting with the Ferguson family is to be deplored. The evidence this Inquiry has received supports the view that further efforts to institute proper communication, mindful of the grief and stress the family suffered should be explored. A series of meetings may well be required in whatever format of whatever personnel will allow appropriate and accurate communication. The preparation for such a meeting and the availability of the responsible parties who had the care of a patient are a clear pre-requisite. It may well be that the format might be adjusted and that a smaller number of individuals are in the room initially, but that others can be called in to explain or speak to particular issues of which they were present or had authority to speak upon. There should be an allowance for adjournments and breaks for family members to withdraw and confer with an advisor/advocate, who is entirely independent of the administrative section of the hospital. There should be access to the medical notes and records and information that allows same to be explained and understood. That would provide a better basis for a useful and a helpful meeting with family members, and thereby allow them to understand much better what has transpired.

(l) Another opportunity to have a clear and efficacious communication was after the Coroner's Inquest. Sworn evidence was given to the Coroner and the family listened to that evidence hoping to understand what caused Raychel's death. The Inquest did not provide answers. A suitable structure of a meeting to allow the parties to reflect upon the sworn evidence, in a non-adversarial context, away

from the Coroners' building perhaps, in the days or weeks thereafter, may provide an opportunity for clear and accurate explanation and clarification.

(m) It is to be regretted that Dr Nesbitt in accompanying Raychel to Belfast was interpreted by Mr and Mrs Ferguson as creating hope that transpired to have been inaccurate. This directly led to anticipation on their part that more could be done for Raychel than was apparently possible. The training of such individuals, to give only realistic and accurate evaluations to very anxious relatives, is essential. There was no hope of recovery for Raychel after her arrival at Belfast. Her parents should not have been left feeling misled or further damaged in their experience by false hope having been engendered.

(n) The defensive legal culture as implemented by the Directorate of Legal Services requires to be examined and, perhaps, modified so that a different culture can emerge where the aggressive negativity of the legal advisors utilising legitimate legal stratagems can give way to better communication so that a tragedy, such as the Fergusons suffered, is not exacerbated and lengthened.

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Dated this 29th day of November 2013