OPENING ADDRESS ON BEHALF OF

RAYCHEL FERGUSON AND THE FERGUSON FAMILY

THE ORAL HEARINGS IN THE INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

BANBRIDGE CO DOWN – 1ST FEBRUARY 2013

CHAIRMAN: MR JOHN O'HARA Q.C.

HYPONATRAEMIA INQUIRY – RAYCHEL FERGUSON

Raychel was born on the 4th February 1992, a joyful day for her parents, Raymond and Marie. She was a beautiful and loving little girl, their only daughter and she gave her parents great joy throughout her lifetime. This family would be celebrating Raychel's 21st birthday on Monday 4th February 2013, had mistakes not been made, had concerns been addressed and had someone in authority stepped back and looked at the history of deaths from Hyponatraemia in Northern Ireland during the years before Raychel's death. The day she died, 10th June 2001, remains the darkest day in the life of this family and they are battered continually by waves of grief. They have placed their faith in this Inquiry, the family has faith in the system and they look forward to hearing the analysis of the evidence and the findings of the Inquiry when all of the evidence has been heard. In order to address the terrible injustice inflicted upon the Ferguson family and the other families involved in this Inquiry we are confident that no stone has been left unturned, no file has been left unopened, no office or warehouse has been left unexplored for various documents that are integral to the workings of this Inquiry and this family are confident that they will see justice done for their daughter.

At this stage I want to thank the Inquiry legal team, particularly Ms Anyadike-Danes for putting together a Clinical Opening that traces the history of Raychel's treatment in clear and concise detail and places against each piece of the treatment and care the comments of the Inquiry experts to whom I will refer to later. I am mindful that this Inquiry does not need any further analysis of the history of this case or the comments made by the various experts who will be called to assess the performance of the medical team at Altnagelvin Hospital during early June 2001. However, some repetition from the medical reports is unavoidable, I will keep this to a minimum trusting the evidence will speak for itself. The Ferguson family would like me to deal with issues that they feel are important to a family like themselves, a family who has lost a child in totally unexpected circumstances.

We have here a series of events that all parents dread. A completely healthy child complaining of a sore stomach goes into Altnagelvin Hospital and is dead in less than 36 hours. Marie and Raymond Ferguson did what any other parents would do on that early summer's day; they took their child to the hospital because she was complaining of stomach pain. They put their trust in Altnagelvin Hospital in Derry but it is clear to them and as I will explain, that Raychel would not have died but for the treatment that she received at Altnagelvin Hospital.

It has not been easy for the Ferguson family. In the past years, since the Inquiry was established, their faith in this process has wavered. The Fergusons, and in particular Raychel's Mum, Marie, have not been shy about expressing their views. They have suffered all of the usual human emotions to date: grief, confusion, loneliness, bewilderment and, without doubt, great anger. As the evidence will reveal their anger is not without justification. The Fergusons intend to let the evidence in respect of the treatment of Raychel and the death of Raychel speak for itself. The Fergusons are confident that this Inquiry will at last reveal the true circumstances of the last days of Raychel's life and what happened afterwards. We also want to examine what went before and we cannot deal with Raychel's case without mentioning the case of Lucy Crawford. This was a little girl admitted to the Erne Hospital who died in similar circumstances on the 14th April 2000, just 14 months before Raychel. The family want to make the point, at this very early stage, that it would seem that nothing was learnt from the death of Adam Strain in 1995, nothing at all was learnt from the death of Lucy Crawford in April 2000 and it would seem that the death of Claire Roberts, because that was not defined as Hyponatraemia, was not even considered until 2004.

We should not forget that it took some brilliant investigative journalism, which is not now fashionable in this computer driven age, to reveal the truth. It was not until the UTV documentary "*When Hospitals Kill"* was aired in 2004 that this issue came into the public arena. Arising from this documentary the family of Claire Roberts contacted the Royal Victoria Hospital and this led to a full investigation into Claire's death – a full 8

years after she died. The documentary highlighted Lucy's case but it also focussed on the issue of Hyponatraemia and hopefully has been useful in preventing other deaths in the years since the documentary was broadcast and this Inquiry was set up. What the Fergusons want is for something useful to come out of this Inquiry. There are still a number of unanswered questions, there is still work to be done in relation to training of staff, the incorporation of guidelines and protocols into the Health system across all of the Boards and Trusts and perhaps, something could be done to ensure that there is some form of communal sharing of information across the various Health Trusts.

It is important that the Ferguson family and all of the families involved in this Inquiry should have faith in the justice system. There are lots of imperfections in this system and in fact you may be surprised to hear that Altnagelvin Hospital still has not admitted liability for Raychel's death. In this age of openness and in the search for truth and justice, how could this hospital and the Trust responsible for that hospital still maintain that they are not responsible for Raychel's death? Even the most basic of investigations would have demonstrated to the Hospital Authorities that there were errors and omissions in the treatment of Raychel during her short stay at Altnagelvin in June 2001. Mrs Marie Ferguson, on behalf of Raychel, issued proceedings against Altnagelvin Hospital claiming, among other things, that the staff failed to properly diagnose and treat the vomiting, that they failed to provide proper nursing care, that they didn't give her the proper fluids and that they failed to carry out a blood test to check her electrolytes. The Altnagelvin Trust served a Defence to this action in November 2005 admitting that Raychel did develop a cerebral oedema and that she died on the 10th June 2001 but they denied that her death had anything to do with the negligence of any of their staff in relation to the diagnosis, the treatment and clinical care afforded to Raychel. To make matters worse for the parents, when their Solicitor asked by open letter to admit liability for the death of Raychel, a letter from the Directorate of Legal Services, who represented the Altnagelvin Trust, dated the 30th June 2005 states that, while the Trust repeats its sentiments of sorrow and regret in relation to the death of Raychel, the Trust does "*not accept that it or its staff were negligent or that if there was any failure to apply appropriate standards or that the failure caused or contributed to the death of Raychel Ferguson and therefore liability is denied.*" In this open letter the Trust then go on to state,

"*The Trust is however acutely conscious of the emotional trauma involved in any litigation and of the tragic circumstances of this particular case. Accordingly it is and remains prepared on an ex gratia basis, without admission of liability, to pay compensation to the Plaintiff. That is not an admission of liability but we do hope that the Plaintiff will be able to respond to our client's willingness to resolve this litigation on that basis, remaining safe in the knowledge that the Inquiry is going to deal with all aspects of the Trust's care and management of Raychel Ferguson*."

They didn't bring a legal action against the Trust to get money, they brought an action to get to the truth, they want the Trust to acknowledge that there was negligence on the part of the staff and that there were errors and omissions in relation to the system that was in place at the time of Raychel's death. There was an Inquest into the death in February 2003 during which a report from Dr Warde, compiled for Altnagelvin Trust into the death of Raychel, was not disclosed to the Coroner nor was he called as a witness. Was this because he identified Raychel's vomiting as "*severe and protracted"* and stated that there should have been electrolyte measurement and an accurate estimate of fluid balance [317-009-011]. Is the failure to release this report to the Coroner part of an attempted cover up by the Trust? We would like to hear the reasons why they didn't release it and, in view of the contents of that report, which they had before they denied liability in the action brought by the parents, why do they continue with such a stance?

We know that the system has now been changed; we know that Solution No .18 is no longer in use but what the parents want is an answer as to why Raychel died. We know that other children, in fact many, many children, are admitted to Altnagelvin for surgical procedures and that those procedures were totally successful. What we need to look at is why Raychel's treatment failed.

We are going to hear from a number of experts whose evidence has already been outlined by the detailed Opening that you have just heard and, with the greatest of respect, what we must not do is miss the main points and become swamped in the details. This is an Inquiry into "*Hyponatraemia-related deaths*". The main point of the investigations relate to fluid management and mis-management. Of course, there are other issues that must be developed and investigated and Mr and Mrs Ferguson welcome the fact that the Inquiry will carry out a full and thorough investigation into Raychel's death. They have already attended the Inquiry to hear a considerable amount of the evidence in relation to Adam Strain and Claire Roberts and they can see that the Inquiry has dealt with the deaths of those children thoroughly and comprehensively. Mr and Mrs Ferguson have no background in medicine or science and therefore they rely on the experts to provide an explanation of what happened, who was at fault, the problems with the system and how all of those issues can be addressed. They are acutely aware that had proper investigations been carried out, then a number of children involved in this Inquiry would not have died. Like the other families involved in this Inquiry, the Fergusons want to ensure, as far as is humanly possible, that no other family has to suffer as they have suffered in the last 12 years. They want this Inquiry to not only point the finger of blame at those individuals who should carry the blame but they also want the system addressed. They don't want just the individuals on the ground, those directly treating Raychel, to bear all the responsibility, they would also like the Inquiry to identify those in control of the system and the management structures who were ultimately responsible for the failure in the system.

The system undoubtedly failed Raychel and they want a full and frank investigation of how that occurred and who is responsible for that failure. They already recognise, as the Chairman of this Inquiry stated on day 47 to Dr O'Hare, that the position in Northern Ireland has changed largely because of the death of Raychel Ferguson. This led the Department of Health to establish a working party which came up with new guidelines.

The parents want me to state that they want to remember how Raychel lived and not how she died but they do take solace in the fact that lives have undoubtedly been saved as a result of Raychel's untimely, unnecessary and totally avoidable death. To demonstrate the failures in the system at around the time when Raychel died let us look at the following quote:

> *"There is also a mistake in the calculation of the ongoing cumulative fluid which the patient received. This would be understandable if it had occurred after the emergency at 3 o'clock, but in fact the inaccuracies precede that emergency. There is no obvious indication as to suggest that the nursing staff were under excessive pressure and excessive workload up to that point. If they were, then the staffing of the ward would be need to be addressed."*

That was written almost a year before Raychel died. It is, of course, very relevant to Raychel's case but it is not about Raychel. That comment in fact comes from the Lucy Crawford files and can be found at 043-062-126. It is a letter from Dr Anderson, the then Clinical Director of Sperrin Lakeland Trust to Mr Fee, the Director of Acute Hospital Services at Tyrone Hospital (dated 17th July 2000).

Had this investigation been properly followed up Raychel may have been celebrating her birthday on Monday.

THE FAMILY'S APPROACH TO THE INQUIRY

The family appreciate the thoroughness of the investigations carried out by the Inquiry Team. They, as ordinary people, dealing with a massive volume of documentation see the case in simpler terms. The issues that they feel are relevant are:

1. Should Raychel have had surgery at all? This issue is fully covered in the report from Mr George Foster, MD, FRCS, expert in General Surgery and a qualified Paediatric Surgeon. He has been retained by the Inquiry to give evidence on this and a number of other issues. Some might say that this Inquiry is only about

fluids and that this is a side issue. We say that this is an area of concern in that a general anaesthetic leads to the use of opiates that may cause vomiting that could lead to electrolyte imbalance and thereafter the mismanagement of fluids that could lead to death. It certainly did in Raychel's case. The bottom line is that he is critical of the fact that Raychel was the subject of surgery at midnight on the 7th June 2001. He raises a number of issues that we say will be very difficult to rebut. In a nutshell he says that Raychel should not have had surgery. I will expand on this later.

2. Why was Raychel not seen by a Consultant or a Senior Doctor? She was in the hospital from the early evening of the 7th June until she was beyond help in the early hours of the morning on the 9th June. She was admitted under the care of Mr Gilliland, the Surgical Consultant. However, he never saw her at any time during her stay at Altnagelvin, it would seem that he was never informed that she had been admitted under his care and he didn't even know she had died until the 11th June. To make matters worse, he didn't attend the meeting of the 3rd September 2001 when the family met Trust representatives to enquire about Raychel's death. He confirms that he was informed about the meeting but didn't attend as he did not think he could materially contribute. Well, as it turns out, perhaps he couldn't contribute, as Mr Foster now makes the point that Mr Gilliland was not aware of the danger of infusing hypotonic fluid in children who had prolonged vomiting.

3. **Severe Vomiting:** There is no doubt that Raychel suffered from severe vomiting throughout the 8th June. This is one issue that Mr and Mrs Ferguson are extremely upset about. It would seem that the records, for what they are, didn't record a number of vomits reported by the parents, particularly those at 11am and 12 noon, neither was the vomit observed by Dr Devlin at sometime between 17:30 and 18:00 hours recorded. Again, a vomit noticed by Nurse Bryce at 00:35 hours on the 9th June was not recorded. Seven vomits were recorded on the

Fluid Balance Record. However, to make things totally clear, Mrs Ferguson personally recalls vomiting at 11:00 hours, 12:00 hours, two further vomits between 12:00 hours and 15:00 hours and two vomits after 15:45 hours. We also have the vomits observed by Dr Devlin and Nurse Bryce. That would mean that there were eight vomits that were not recorded. The notes are a complete disgrace. The recording of vomits is totally inadequate. But the main point is that no one on the staff, I repeat again – no one on the staff – seemed to be aware that, when a child is vomiting, the electrolyte and fluid balance needs to be rapidly addressed and the type of fluid reassessed. The fluids that she was receiving and the rate of infusion was totally and completely wrong in the circumstances. In fact, the surgical team had got it right when they prescribed Hartmann's Solution initially, but it would seem that they were talked out of this prescription by the nursing staff who told them that solution no .18 was the solution of choice in the Paediatric ward. There seems to be a complete and utter lack of understanding about fluid balance and choice of fluids at this time. Even though Mr Gilliland, the Surgical Consultant was not called to attend Raychel, he has stated that, if a child vomited more than twice, then the SHO in surgery should be contacted. No attempt was made by the nursing staff to do this. However, the most worrying situation is that Dr Gilliland, as a Senior Consultant, also states that he was not aware, in 2001, of the danger of infusing hypotonic fluid in children who had prolonged vomiting (WS 044/2 page 34). Does this mean that the man in charge of the surgical team does not possess the basic knowledge of fluid balance? Mr Foster comments on this statement: "*I really don't believe he means this*". Does that sum it up? This issue needs to be thoroughly investigated.

4. **Fluid Rate:** I have no doubt that this Inquiry will find that it was completely wrong and negligent to continue to infuse solution No .18 into a child who was constantly vomiting. This should have been recognised by the ward staff and the fluid should have been changed to Hartmann's Solution or some other suitable fluid. None of the experts have challenged that conclusion. However, there is

another problem in the case in that it would also seem to be totally and absolutely clear that the infusion rate was also wrong. The Inquiry experts Mr Foster, Dr Haynes, Consultant Anaesthetist and Ms Ramsay, Nursing Expert, have all concluded that setting a rate of 80 ml / hr is in excess of Raychel's maintenance requirement of 65 ml / hr. The calculation is set out in page 30 of the Inquiry Opening. Raychel's total daily fluid requirement was 65 ml / hr not the 80 ml / hr that she was given. To make matters worse Mr Foster holds the view, and no one has demurred from that stance, that post-operatively Raychel should have been receiving fluids at a rate of about 52 ml / hr. Therefore, on my calculations Raychel was getting 54% more than her calculated requirements in the form of hypotonic saline. When you couple this with electrolyte loss from vomiting, this would accelerate the haemodilution and the onset of electrolyte changes. For ease of reference this is fully set out and explained on pages 44 and 45 of the Inquiry Opening. Mr Foster has calculated that she is getting almost a third more than the accepted rate, whereas the true calculation is 54% more than the accepted rate. Therefore, not only was she getting the wrong fluid, she was being infused at a rate of 54% more than she should have had, in effect, Raychel had no chance. We will hear that a number of Doctors attended Raychel on the 8th, including Drs Devlin, Curran, Butler and Zafar but none of the Doctors or Nurses noted the mistake in the infusion rate.

5. The parents feel very strongly, that they were not told the whole truth about Raychel's death. They feel that Raychel was killed by the hospital. They attended a meeting on the 3rd September 2001 but they got nowhere near the truth. The Consultant, Mr Gilliland, didn't even bother to attend the meeting. Those who did attend denied that they or their colleagues had done anything wrong. We should note that this is still the formal stance of the Hospital Trust notwithstanding all that we now know. What they did do was completely ignore the fact that Raychel was suffering from severe and protracted vomiting and it would seem that no one had the required level of knowledge to change to the correct type of fluid, or enough sense to alter the fluid rate. Clearly, this was negligent. Infusion of the wrong type of fluid at an excessive rate led to Raychel's death. Of course, everyone points the finger at someone else, but the parents

have carefully read Dr Foster's report and, even as people with no prior knowledge of science or medicine, they can see that mistakes have been made and that staff have been criticised. I intend to briefly analyse Dr Foster's report and his recent addendum, with a view to "*pointing up"* those criticisms.

6. **The medical notes:** The meeting of the 3rd September 2001 and the issues regarding the notes are probably best left to the Governance section of this Inquiry but I feel that something has to be said in this Opening to allow a full and frank investigation of those notes to be carried out and for them to be assessed in relation to the clinical issues. The bottom line is that there are no notes worth talking about. It is hard to believe that during the 8th June 2001, when Raychel was desperately ill and continually vomiting, that only one sentence of notes appear in the clinical records. The only note in the clinical file prior to Raychel having a fit at 3 o'clock on the morning of the 9th June is an untimed and barely initialled one sentence note made by Mr Zafar (Surgical SHO).

"Post appendicectomy free of pain, apyrexial, continue observations."

Eight words. That's it for the whole day – eight words. The next note is an urgent note made at 3:15am on the 9th June by Dr Johnston who had been summonsed when Raychel suffered a fit. It seems that we will now hear from Mr Zafar that he gave verbal instructions. Why did he not note those instructions? If they were given then why did the nurses not note them? Why did the other Doctors who were called during the day to examine Raychel and administer drugs because of her continued vomiting not make any notes on the Clinical Records? It is clear that there is a complete and utter lack of training, a lack of care and a lack of appreciation of proper note taking at Altnagelvin Hospital. The nursing notes are a little better and in relation to requests for assistance from the nurses to the Doctors, at page 13 of his report Mr Foster says "*I cannot find any written confirmation on any contemporaneous nursing record of these requests for medical assistance, their timings or outcomes. There is uncertainty regarding the time of Dr Devlin's visit ..... When Dr Devlin wrote up the odansetron (020-017-034) no time was recorded and he made no note at all in the clinical file".* To make matters worse Dr Devlin has stated that when he saw her

in late afternoon he was told that Raychel had been vomiting but had been drinking fluids, when he saw her he recalled her to be *"actively vomiting"*, but there is no record in the Fluid Balance Chart of this vomit. There is no evidence that Dr Devlin looked at the Fluid Balance Chart or considered it necessary to consult a senior colleague about what was now at least five episodes of vomiting plus the vomiting that he himself was witnessing. Finally, Mr Gilliland accepts that prior to June 2001 there was no formal advice given to new members of the surgical team regarding Hyponatraemia, post-operative fluid management or record keeping. (See Para 10.17 of Mr Foster's addendum report: Ref 223-003-017.)

7. This brings me, finally, to one of the most important issues: why were no blood tests carried out? This is central to the issue of Hyponatraemia. By means of a simple blood test the drop in sodium would have been immediately revealed and Hyponatraemia recognised as a problem. The very sad truth is that had anyone had the sense to order a blood test at any time on the 8th June 2001 then Raychel could probably have been saved. It wasn't until the blood test was taken after she fitted in the early hours of the morning that her drop in sodium was revealed. We know that Dr Curran arrived on the ward at 22.15 hours and prescribed Cyclizine which was administered at once [020-017-034] but of course there is no nursing record to confirm the Doctor's visit, its timing and the action taken. Dr Curran himself made no note of it at all in the clinical pages of the file. The only confirmation we have is the statement from Nurse Gilchrist. The whole course of treatment and nursing care was a complete and utter inadequately documented shambles. If the child was suffering from excessive vomiting, as Raychel undoubtedly was, then someone should have ordered a blood test. It was clearly negligent not to do so. No one took control of the situation, the parents' pleas about excessive vomiting were ignored. Despite the fact that Raychel was given drugs to stop her vomiting, no one thought of the more dangerous implications of that condition.

   What the Ferguson family will have to hear is a continuous stream of evidence along the lines that Raychel could have been saved if anyone had had the good

sense to order a blood test. Not only that, there were numerous opportunities to recognise that Raychel was slipping away and someone should have done something about it. By the time she had the fit in the early hours of the morning it was probably too late but even then there may have been some emergency action that could have saved her life, if not all of her faculties.

CONCLUSIONS REACHED BY MR FOSTER

We would submit that Mr Foster has dealt with Raychel's treatment history and tragic unnecessary death by applying his medical expertise but he has discussed it in a factual way that is easy to understand. Therefore, I deal with the issues that Mr and Mrs Ferguson and the family circle see as relevant for the Inquiry to address. The following issues could be proposed as a list of questions that the Ferguson family have for the Inquiry that arise both out of Mr Foster's report and out of their own analysis of the papers and recollection of events.

The first point is that Dr Foster in concluding his report has addressed a number of areas in which he says that the surgical care of Raychel "*fell below a satisfactory standard*". There are ten general points where the care fell below a "*satisfactory standard*" and thirteen specific points where the care fell below a "*satisfactory standard"*.

Dr Foster is clear in stating that there is no criticism of the actual surgical procedure that was carried out. The appendectomy was carried out satisfactorily and successfully, in that the appendix was removed and Raychel was returned to the ward. The parents do wonder why it took so long for her to come back. Perhaps the Inquiry should look at the drugs given before and during the surgery and the length of the recovery period. More importantly, the parents want to address the fact that Mr Foster has the decision to operate when she attended A&E on the 7th June. There was a very short history of symptoms and as there were no signs of inflammation on blood testing (white cell count

normal), no temperature and no rise in pulse rate [223-002-006], therefore it is questionable as to whether or not surgery should have been done. Further, Raychel had been given a strong painkiller and by the time she got to surgery she was no longer in pain. It is more questionable given that the decision to operate was made at Senior House Officer level without consultation with a Senior Doctor which is contrary to the National Confidential Enquiry into Peri-Operative Deaths (NCEPOD). This is a 1989 report which states "*Consultant supervision of trainees needs to be kept under scrutiny. No trainee should undertake any anaesthetic or surgical operation on a child without consultation with their Consultant".* This is even more relevant when one considers that there is some doubt as to whether or not the appendix had anything wrong with it and it should be recalled that the final Histology Report confirmed "*An entirely normal appendix"*. So, the appendix was normal. It would therefore seem it is likely that Raychel didn't require an appendectomy; that this surgery was done without consultation with a Senior Doctor and it was contrary to the NCEPOD recommendations. Mr Foster concludes, on page 6 of his report, "*To conclude this section I believe that the decision to operate here was made by a Junior Surgeon without good evidence and without consultation. On balance I cannot help but conclude that this operation was unnecessary and if deferred would likely have never been performed."* [223-002-078]

The Inquiry is impelled to investigate this decision and also why:

(a) Dr B Kelly who first examined Raychel in the A&E Department, a relatively inexperienced Doctor, decided to administer intravenous Cyclimorph (a commonly used combination of morphine and Cyclizine). This is a powerful analgesic and would likely cause difficulties in evaluating symptoms and findings later on. Why didn't he prescribe simple Paracetamol?

(b) Why did Mr Makar decide to operate given all of the relevant circumstances? Mr Makar described the appendix as obstructed but the Inquiry expert, Mr George Foster, dismisses that stating, "*I believe Mr Makar was using it retrospectively to justify operating on a child with a very short history of pain. After all one should bear in mind that Raychel was in a hospital where repeated examinations and vital*

sign recording could be done. Blood tests (all initially normal) could be repeated when required and imaging done if necessary. Proteinuria had been noted and urine microscopy should have been performed." [See page 7 of the addendum report at reference 223-003-007.]

The lawyers in the room may look at this subject and comment that it is not really relevant to a Hyponatraemia investigation. However, the public at large, and particularly the Ferguson family, see this as a very relevant issue and they want the actions of Mr Makar fully investigated. It is also relevant that out of this issue two other very relevant topics arise:

- In his latest statement Mr Makar has averred that he did in fact discuss his plan for Raychel's surgery in the course of two conversations with the General Surgical Registrar on call, Mr Zawislak. Mr Zawislak emphatically denies that he was contacted by anyone to discuss Raychel's case and states that he definitely would have remembered such an event had it occurred. This is an issue that must be thoroughly investigated by the Inquiry as there is a direct conflict between Mr Makar who said that he contacted Mr Zawislak but Mr Zawislak emphatically denies that he was ever contacted in such terms.

- Not only is there criticism of the notes the notes were added to after the event. This is probably a matter that should be dealt with in more detail during the Governance hearings but the family are very upset when they consider that Dr Geoff Nesbitt, the then Clinical Director of Childcare and the Consultant Anaesthetist at Altnagelvin directed the Assistant Anaesthetist involved in Raychel's surgery, Dr Clare Jamison, to add to the anaesthetic notes after Raychel's death. That retrospective note dated 13th June 2001 [020-009-016] records that Raychel received 200ml of Hartmann's Solution during the surgery. The retrospective note is properly signed and dated. However, the Ferguson family want to know why Dr Nesbitt made such a direction, when he was not involved in Raychel's care and want to test Dr Jamison's recall of this given that she left the operating theatre before the surgery concluded

and in her statement to the Coroner initially stated that Raychel received 300 ml [064-054-165].

(c) There was an incorrect calculation of intravenous fluid volumes. I have already pointed out that Raychel was receiving approximately 54% more fluid than was appropriate. There were a number of Junior Doctors called to examine Raychel and stop her vomiting. There was Dr Joe Devlin, Dr Michael Curran, Dr Butler and Mr Zafar (who did the ward round) and all of the nurses who were in charge of Raychel. Why did no one check the intravenous fluid rate which remained uncorrected for more than 24 hours?

(d) The use of intravenous hypotonic solutions in a vomiting patient is highly dangerous. However, the danger of this was not recognised by the nursing staff or the Junior Doctors. Even her Consultant seems to have a problem in understanding this issue. How could this point have escaped their basic training and we await the findings and recommendations of the Inquiry to hopefully ensure that this doesn't happen again?

(e) In spite of the frequency and the volume of vomiting no blood tests were done throughout the 8th June. Had a blood test been done, particularly in the late afternoon, it would probably have shown that Raychel's sodium level had dropped to a dangerous level. When blood tests were carried out in the early hours of the morning the sodium level had dropped to 119 at 3.30am and 118 at 4.35am. This was well below an acceptable level and represented a grave danger to Raychel. She was at this stage suffering from Hyponatraemia. The situation at that stage was probably irretrievable. Why did none of the staff reorder a blood test particularly in view of the excessive vomiting.

(f) It seems that there were no attempts made to measure the estimated volume of vomit and in fact there was absolutely no effort made to measure the volume of any liquid such as urine that was lost. How could basic training have missed this point?

(g) Why did the Junior Doctors or the nurses not send for more senior staff at an earlier stage? Mr Foster is highly critical of the staff on this issue. We say this failing should be thoroughly investigated.

(h) When Raychel suffered a fit at around 3am in the morning she was examined by the Paediatric Doctors, she was given prompt attention and they recognised that there probably was brain stem damage. This was a critical event and the child was about to be transferred to Belfast but it took 1½ hours for the Surgical SHO and Registrar to appear. During this time the resuscitation team comprising of a Junior House Officer in Surgery and Paediatricians up to Consultant level (Dr McCord) and a full anaesthetic team were in place. Mr Foster comments that the Surgeons should have been present to give support to the team. Where was the Consultant Surgeon? Mr Foster states "*I cannot believe"* that Mr Zafar and Mr Bhalla did not contact the On Call Consultant. He states that this is a "*very serious issue"*. It is a serious oversight by those Doctors.

(i) The ward round that was conducted on ward 6 by Mr Zafar – his note was extremely brief. He allowed Raychel to continue to receive both solution No .18 and at an infusion rate of 80 ml / hr.

(j) The recurring theme throughout the expert's reports is that Raychel could probably have been saved had she been reviewed by an experienced competent Doctor. This gets to the crux of the matter. Had the nurses and Junior Doctors realised that Raychel was in deep trouble as evidenced by the headaches and listlessness (as well as the vomiting) then they would probably have asked for a review from a more senior member of staff. It is evident that no one took control. There is a complete lack of authority. If a blood test had been carried out, her electrolytes would have been checked and it would have been observed that her sodium level had dropped. Of course, we now know that the surgical team did not answer their bleeps. This is totally and completely unsatisfactory and has been heavily criticised by the experts. We must also criticise the nursing staff, the Junior Doctors cannot take all of the blame as they were only called to answer emergencies and to administer drugs. It was the nursing team who were observing Raychel constantly on the ward. When Dr Curran saw Raychel later in

the afternoon he should have been informed that Raychel had been vomiting "*coffee grounds"* which is a serious condition and which would immediately alert a Doctor that further investigations were required. It would seem that Dr Devlin acted appropriately but that Dr Curran should have recognised the problems and taken matters further, though it seems he was hamstrung by the nurses' failure to make a full report on the vomiting.

(k) There can be no doubt that Raychel was very ill as not only the family confirm this but the friends and neighbours who visited such as the Duffys, the McCullaghs and her Godmother, Margaret Harrison all comment on her lack of vitality and response. They also comment on the level of vomiting. Mr and Mrs Ferguson don't accept the nurses' position on this matter. Sister Millar, Nurses Roulston, Gilchrist, Bryce, Noble and McAuley can't be correct when they indicate little concern about Raychel's demeanour. The Nurses should have recognised the need for medical intervention after the second vomit. This is supported by a number of experts who have commented on this including Dr Haynes, Mr Foster and Ms Ramsay. What happened later demonstrates that the nurses' assessment was wrong. Even if their assessment of her demeanour was correct, they still should have called for assistance after the second vomit. They were negligent not to do so. Raychel's life could have been saved if anyone had taken time to look at her case and recognise that she had a serious problem. On page 40 of his report, at 223-002-042 Mr Foster states "*Personally I believe that in a specialised Paediatric ward such as this the nursing staff themselves should have told the Doctors of their concerns. I cannot understand why they regarded multiple episodes of vomiting as the normal post-operative course of a mild appendix case. There was obviously confused communication between the nurses and each other and a mindset that did not seem to accept that a serious problem was occurring. Dr Curran I believe should, on his own initiative, have approached a senior colleague but Dr Devlin did all that could have been expected of him."*

(l) The note taking, the record keeping and the communication between staff and parents was a complete and utter mess. There seems to be a complete lack of training, direction and coherence.

- Mr Makar took a history and wrote an operation note only.

- Mr Zafar took a very brief recording of his visit on the morning of the 8th and Mr Foster states that these notes were "*barely adequate"*. There will now be an issue as to what he verbally told the nurses about the care that was required.

- Dr Devlin: Apart from a Drug Chart entry, Dr Devlin made no notes in the clinical file and this, according to Dr Foster, is "*unacceptable practice".*

- Dr Curran: Apart from a Drug Charge entry, Dr Curran made no note in the clinical file, this is "*unacceptable practice"*.

- There are also issues in relation to the lack of any nursing note or record that relates to the request to bleep Mr Zafar and relating to the visits of Drs Butler, Devlin and Curran together with the timings of the visits. It would seem that the level of note taking and communication was unacceptable.

- Not only is Mr Foster critical of the note taking and communication between the staff, he also records that he is "*disappointed at the communication that took place between the surgical team and Raychel's parents. When Raychel suffered a fit and it was obvious that she was very seriously ill the Consultant on call should have attended and seen Mr and Mrs Ferguson urgently. The surgical team should also have been present at the meeting with the family in September 2001."* [223-002-48].

<u>Mr Foster finishes his report by stating</u>

> *"As I think I have demonstrated in this analysis of this case the system in place in June 2001 had <u>serious flaws</u>."*

The Inquiry expert, Mr Foster, may have concluded his report highlighting those serious flaws yet Altnagelvin Hospital still deny in the civil action brought by the parents that there was anything wrong with their system; they deny that their staff were negligent

and deny that they contributed to Raychel's death. How can this be? 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?

The Ferguson family now want the full unexpurgated truth about their daughter Raychel's avoidable death to come out. The truth unadulterated, the complete truth plain and simple, painful for them as it may be.