Witness Statement Ref. No. 090/1

NAME OF CHILD: Raychel Ferguson

Name: Mr John Leckey

Title: H.M. Coroner for Greater Belfast

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-December 2004]

None relevant to the Inquiry.

Particular areas of interest
[Please attach additional sheets if more space is required]

1. **Describe in detail your concerns when you were informed of the death of Raychel Ferguson.**

I had been advised that Raychel had developed cerebral oedema which could be related to fluid management/ hyponatraemia. I remembered the circumstances surrounding the death of Adam Strain.

2. **Give details of your communications with the DHSSPS both before and after the Inquest you held into the death of Raychel Ferguson.**

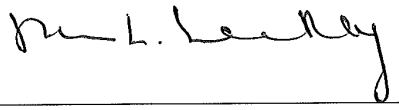
I spoke by telephone to Dr Miriam McCarthy of the office of the Chief Medical Officer about the death and the probability that fluid management was a key factor on 14th December 2001 and 22nd March 2002. On each occasion I was advised of the work of a Hyponatraemia multi-disciplinary working party established by the Chief Medical Officer to develop guidelines on a fluid management "best practice" protocol. My understanding was that Dr Sumner would be asked for his views on what was being developed.

I wrote to the Chief Medical Officer, Dr Henrietta Campbell, on 7th November 2002 about her role, whether such deaths should be formally notified to her and the dissemination of information. I indicated that I had expected that the death of Adam Strain would have resulted in changes being made to the fluid management of children. Dr Campbell replied to me on 13th November 2002 indicating that she would welcome an opportunity to discuss these issues with me and that her deputy, Dr Ian Carson, is taking the lead on clinical negligence.

After the conclusion of the inquest I wrote to Dr Campbell on 11th February 2003 on the issue of the dissemination of information on fluid management, the Hyponatraemia protocol and the lack of knowledge within the medical profession about this area of medicine. Later I wrote to her on 22nd March 2004 about a number of related issues including ones that arose out of a TV programme on the deaths of Raychel and Lucy Crawford. On 28th June 2004 Dr Campbell wrote to me a general letter about recent developments in fluid management for children, and on 6th October 2004 she sent me a copy of a letter she had received from Professor Maurice Savage relating to the teaching of this area of medicine.

Other points you wish to make including additions to any previous Statements, Depositions and or Reports
[Please attach additional sheets if more space is required]

A formal interface should be established (by legislation if necessary, otherwise by protocol) between coroners and Chief Medical Officers. Consideration should be given to what the role and responsibilities of a Chief Medical Officer should be and whether their existing powers are adequate. Consideration should be given also to whether it is desirable for children to be treated in adult wards rather than in a dedicated paediatric unit.

Signed:  **Dated:** 15/7/05