

8f 47/03

MINISTERIAL SUBMISSION

From: Dr M McCarthy

cc: Dr I Carson

Mr P Simpson

Mr J Hamilton

Date: February 2003

Mr K Mulhern

1. CMO
2. Des Browne

INQUEST VERDICT ON RAYCHEL FERGUSON

Issue: The recent inquest on Raychel Ferguson, a 9 year old who died following surgery in Altnagelvin Hospital on 10 June 2001.

Timing: Urgent.

Presentational: Minister may be asked to comment on the case when he visits Altnagelvin Hospital on Thursday 20th February.

Recommendation: That Minister notes information relating to the case and agrees lines to take.

Background

1. Raychel Ferguson, a 9 year old girl died on 10 June 2001 following an appendicectomy in Altnagelvin Hospital. The inquest on her death was held on 5th February 2003 and the findings concluded that she died from cerebral oedema caused by hyponatraemia (depleted sodium levels).
2. Raychel was admitted to Altnagelvin Hospital on 7 June 2001, complaining of abdominal pain. Appendicitis was diagnosed and she underwent appendicectomy the same day. Initially post-operative recovery proceeded normally. However the following day she vomited and complained of a headache. On the 9th June she suffered a series of seizures and was transferred to the Paediatric Intensive Care Unit at RBHSC where she died on the 10th June.
3. The post-mortem examination established that she died from cerebral oedema caused by hyponatraemia. The verdict at the inquest concluded that the hyponatraemia was caused by inadequate electrolyte (salt) replacement in the face of vomiting and water retention.
4. Hyponatraemia is rare but potentially extremely serious, a rapid fall in sodium leading to seizures and death. Warning signs are often non-specific and include nausea, headaches and malaise.
5. Hyponatraemia often reflects water retention and is a particular risk in patients who have just had surgery or who are vomiting, when a hormone may be released that causes the body to retain water.

Summary of Issues

6. Issues likely to arise focus on:

- **The Case:** Now that the inquest has concluded, Rachael's family may pursue legal proceedings.
- **The implications for disseminating information to health professions:** Following Raychel's death, the Chief Medical Officer established a group to draw up guidance for hospital medical and nursing staff working with children. The guidance aims to raise the awareness of hyponatraemia and provide clear and practical advice on steps required to prevent hyponatraemia. Guidance was completed in February 2002 and disseminated to Trusts. A copy of the guidance is attached (Annex A).
- **Quality of Care:** A statutory duty of Quality will soon apply across the HPPS. New arrangements including the establishment of a Health and Social Services Regulation and Improvement Authority will be put in place to monitor practice against agreed Standards.

Handling and Timing Issues

7. There has been a considerable amount of media interest in this case. The Belfast Telegraph reported on the inquest proceedings. UTV is currently recording material including an interview with the Chief Medical Officer, for an *Insight* programme due to be televised within the next few weeks. It is possible that Minister will be asked to comment on the case and its implications when he visits Altnagelvin Hospital on Thursday 20 February. Lines to take are attached (Annex B).

Recommendation

8. I recommend that you agree the lines to take.

DR MIRIAM McCARTHY

Senior Medical Officer

ANNEX B

LINES TO TAKE

My sympathy goes to the parents and family of Raychel following the death of their daughter.

I am concerned about this incident and want to make sure that the lessons we learn from this unfortunate event will prevent a similar case occurring in the future.

Guidance has already been issued to doctors and nurses involved in treating children in hospitals. This guidance raises awareness of hyponatraemia, a rare but potentially serious problem and provides clear and practical advice on how to prevent it.

We must ensure the very highest quality standards in our Health Services. From April this year new arrangements to support the Duty of Quality will be in place. These will include the establishment of a Standards and Guidelines Unit within the DHSS&PS, and an independent HSS Regulation and Improvement Authority.