Stella Burnside - Chief Executive

From: Campbell, Dr Henrietta [Henrietta.Campbell[redacted]
Sent: 03 June 2004 16:13
To: Stella Burnside - Chief Executive
Subject: RE:

Importance: High

Dear Stella
Thank you for this.I am not sure how much further the media will want to take this. Let me know if you are approached.
Kind regards, Etta

-----Original Message-----
From: Stella Burnside - Chief Executive
[mailto:SBurnside[redacted]
Sent: 03 June 2004 12:56
To: henrietta.campbell[redacted]
Subject:
Importance: High

Etta

Having looked at the draft transcript of your interview, which was sent, I am concerned that there may be some ambiguity over facts regarding Altnagelvin.

The following are the facts:-

1. Altnagelvin heard a "rumour" from Paediatrics Intensive Care Unit that the "wrong fluids" had been used. This "rumour" emerged from a nurse in Paediatrics Intensive Care Unit responding to an enquiry from Altnagelvin's Ward Nurse on the child's state, on the Sunday.

2. In keeping with our own procedures, we carried out a Critical Incident Investigation. The child's unexpected collaspe and subsequent death would trigger a Critical Incident Investigation, which has been our procedure since 1998.

3. A literature search on fluids was undertaken simultaneous to the Critical Incident Investigation.

4. Dr Nesbitt personally telephoned colleagues in several Hospitals regarding the use of perioperative fluids in children and informed them of the death of a child in Altnagelvin who had received no. 18 solution.

5. On 15/06/01 I wrote to the family offering my condolences and a meeting.

6. On 18/06/01 at a meeting with Dr Carson and other Medical Directors, Dr Fulton described the circumstances of the death and it was agreed that there should be regional guidelines.

7. In Mid June 01, Dr Fulton raised the matter with Dr McConnell who informed him he would speak to you about it. (On 05/07/01, Dr McConnell confirmed the discussion with you).

8. On 22/07/01 Dr Fulton spoke to yourself and informed you of the death. You suggested that CREST might review the guidelines.

9. On 26/07/01 I contacted you (via email) to personally advocate a regional review, following your conversation with Dr Fulton on 22/07/01.

10. On 03/09/01 I met with the family to describe the circumstances surrounding the death.

11. In January 02 whilst on a visit to Altnagelvin, Dr Nesbitt arranged for

you to view a presentation on Hyponatraemia.

12. On 01/05/02 Dr Nesbitt wrote to you enquiring if the death of a child some years previously from hyponatraemia in the RBHSC had been reported to the Department.

13. On 10/05/02 you replied that the Department had not been made aware of the first case either by the Royal or the Coroner.

I hope this is helpful.

Best Regards
Stella