Medical Director Involvement in Investigation of death of Rachel Ferguson 9/6/01

12/6/01	Chaired Critical Incident Meeting - agreed Action - circulated to all present 13/6/01.
14/6/01	Received letter from Dr Nesbitt saying that solution 18 would no longer be used at Altnagevlin for surgical children.
18/6/01	Discussed case at Medical Director Meeting Castle Buildings - chaired by Dr Carson in absence of CMO - several M D Anaesthetists had heard of similar cases - I suggested Regional Guidelines needed.
22/6/01	Rang CMO. - I suggested she should publicise dangers of hyponatraemia and suggested she publish regional guidelines.
Mid June 2001	Rang Dr McConnell, (DPH, WHSSB) - he suggested bringing up case at regular CMO/DPH review. I sent him recent reprints from BMJ re: hyponatraemia.
3/7/01	Received copy of letter from Dr Nesbitt (CD Anaesthetics) to P Bateson, CD Surgery requesting surgeons all to agree, all agree that Hartmans be standard solution for surgical children.
5/7/01	Dr McConnell confirmed he had discussed case with CMO and DPHs and each DPH agreed to draw attention to paediatricians in respective boards (letter 5/7/01).
26/7/01	Chief Executive contacted CMO advocating regional review. - CMO replied agreeing and that Dr Nesbitt should be on review committee.
14/1/02	I set up meeting between CMO and Dr Nesbitt to view Dr Nesbitt's presentation on hyponatraemia.
9/4/02	I chaired meeting of nurses and doctors to revise Action Plan in view of publication of DOH Guidelines on hyponatraemia (letter from CMO dated 55/3/02).

R Fulton 10/4/02