## Stella Burnside - Chief Executive

**From:** Marie Dunne - Commun. Mgr
**Sent:** 01 August 2004 21:39
**To:** Stella Burnside - Chief Executive
**Cc:** Theresa Brown - Risk Management
**Subject:** Insight Interview

Stella - Further to your email correspondence with Dr. Carson, find attached amended draft response.

Was speaking to Colm Shannon last week and he thinks the programme may run during September. He's still keen to get reps of all Trusts involved together to share both the questions we have been asked and the responses we have given or are planning to give.

Marie

Raychel - additional questions...

Marie - See *? Should it not be Dr Fulton?

Glad to share this with Colm Shannon —

CMO, Hugh Mills

**RF – ALTNAGELVIN**

023-028-067

## Additional questions from Trevor Birney received 16th June 2004

(1): In the statement, you say:

"Dr. Geoff Nesbitt, then Clinical Director for Anaesthetics in the Trust personally telephoned colleagues in several hospitals in Northern Ireland to alert them to the circumstances of Raychel's death."

**Question**: Whom exactly did Dr. Nesbitt telephone? I asked Dr. Nesbitt this question when I met him in spring 2003, and he wasn't able to remember. Can he now recall?

**Answer: In a letter dated 14th June 2001 to Dr. Raymond Fulton our Medical Director at the time, Dr. Nesbitt reports that he telephoned a number of hospitals, specifically naming the Royal Belfast Hospital for Sick Children, Craigavon Area Hospital and the Ulster Hospital, to alert them to this death and discuss fluid management.**

(2) In the statement, you say:

"On 18 June 2001, the Trust's then Medical Director, Dr Raymond Fulton, met with Dr. Ian Carson, Deputy CMO and Medical Directors from other Northern Ireland Trusts. Dr. Fulton described the circumstances of Raychel's death and it was agreed that there was a need for regional guidelines."

**Question**: Who were the other Medical Directors who attended this meeting?

**Answer: At the time, these meetings were informal and ad-hoc designed to provide an opportunity for Medical Directors to network and share experiences or concerns. Brief notes of the proceedings were taken but these were not routinely retained so it is not possible be sure precisely who attended this particular meeting.**

(3) Again, in the statement, you say:

"The matter was also raised by Dr Fulton with Dr. W. McConnell from the Western Health and Social Services Board who advised that he would speak to Dr. Henrietta Campbell, CMO. On 5th July 2001, Dr. McConnell confirmed that he had notified the CMO."

**Question**: Why was it necessary for Dr. McConnell to advise Dr. Fulton that he would speak to Henrietta Campbell given that Mrs. Burnside had spoken to her directly in the days following Raychel's death and Dr. ~~Nesbitt~~ had attended a meeting chaired by the Deputy CMO, Dr. Ian Carson?

**Question**: There seems to have been a huge emphasis on contacting the CMO – why?

**Answer: As part of Altnagelvin's learning environment and our system of clinical governance, unexpected clinical incidents, 'near misses' and unexpected deaths are all reported to the Trust's Risk Management Department. These incidents are then reviewed.**

**The unexpected collapse and sudden death of Raychel Ferguson precipitated such a review and that review revealed literature on post-operative hyponatraemia, which was not common knowledge. As a result, Dr Geoff Nesbitt, then Clinical Director in Anaesthesia, Dr Raymond Fulton, then Medical Director, and Stella Burnside, Chief Executive, believed it was essential to disseminate this information as widely as possible.**

**Given that the information was applicable to a number of Trusts, it was felt that a regional approach to the provision of guidance was the most appropriate way forward, thus the CMO was alerted. Notifying the Western Board's Consultant in Public Health, Dr. W. McConnell, and the Deputy CMO, were further opportunities to emphasise the importance of this issue and ensure the widest possible dissemination of guidance.**

**We do not know what arrangements exist in other hospitals for responding to this type of incident. All we are able to say is that our system of review of clinical incidents identified a post-operative problem with a fluid (Solution 18) that was in common use in Northern Ireland and other parts of the UK. We believed it imperative that this was brought to the attention of our colleague Trusts to prevent similar clinical incidents.**
ENDS

Date

Provided by: Communications Department, phone [redacted]