Marie Dunne - Commun. Mgr

From: Marie Dunne - Commun. Mgr
Sent: 06 August 2004 10:28
To: Janet Hall (E-mail)
Subject: Insight Programme

Hi Janet - You'll recall that Altnagelvin submitted a response to questions Trevor Birney asked on the Ferguson/Crawford cases in June, a copy of which I sent to you but which I'm also attaching to this email for your convenience.

Trevor came back with further questions the next day but he wasn't in too much of a hurry so we didn't push ourselves getting the answers and he hasn't come back looking for them. However, in anticipation of this being picked up for the Autumn schedule, we've now agreed our response which I've just emailed to Colm Shannon to let the CMO have a look at. Stella also wanted Hugh to see this so I'd be grateful if you would pass it to him.

By way of background to the latest quesions and answers, I would advise that during my telephone conversation with Trevor when he posed these questions, he said that Altnagelvin "...seems to have acted properly and decisively...dotting all the 'is' and crossing all the 'ts'...". Why, he asked, did they do this? What prompted us to do this when other hospitals in "similar circumstances" did not? It is, he said "very important for the public to understand why Altnagelvin did what they did and other hospitals didn't."

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ALTNAGELVIN HOSPITALS HEALTH AND SOCIAL SERVICES TRUST

Statement for Insight Programme

15th June 2004

The following is the sequence of events following the sad death of Raychel Ferguson in June 2001.

- Raychel's unexpected collapse and sudden death on 10th June 2001 triggered the Trust's Critical Incident Investigation procedure, which has been in place since 1998.

- As the investigation developed, including a literature review, it became clear that although Altnagelvin's procedures in respect of the use of perioperative fluids in children was common practice in most hospitals at that time, there may have been a problem in relation to the use of Solution 18 for children.

- 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.

- 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.

- 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.

- On 22nd July 2001, Dr. Fulton spoke directly to the CMO about this matter and the CMO suggested that CREST (Clinical Resources Efficiency Support Team) might be involved in the development of guidance.

- On 26th July 2001, Altnagelvin's Chief Executive also contacted the CMO advocating the development of regional guidance.

- The CMO commissioned a Regional Working Party, including Dr. Nesbitt, to consider the use of fluids and the risks of hyponatraemia in children. The Working Party developed and disseminated guidance in March 2002.

- In June 2003, having become aware that hyponatraemia is also a risk for adults, CREST disseminated guidance on hyponatraemia that is applicable to both adults and children.

The Trust believes that it acted professionally and honestly following Raychel's death.

The treatment of the Ferguson family by Altnagelvin: Altnagelvin very deeply regrets the death of Raychel Ferguson. We have endeavoured at all times to treat the family with honesty and respect and it is a source of further sadness for us that they feel we have failed in this regard. The series of events in our response to the family is as follows:

- The Chief Executive wrote to Mr and Mrs Ferguson on 15th June 2001, expressing our sympathy and our sadness and offering to meet with them.
- The Chief Executive and clinical staff involved with Raychel met with Mrs. Ferguson, family members, and the family's GP on 3rd September 2001 to allow full discussion of the circumstances surrounding Raychel's death.
- In February 2003, in response to media enquiries, the Trust issued a press statement, publicly expressing sympathy to the family and offering our sincere condolences.

Was Dr Quinn acting on behalf of Altnagelvin Trust when he provided a report on the death of Lucy Crawford? Dr Quinn is a much respected and very experienced consultant paediatrician employed by Altnagelvin Trust. On 21st April 2000, Sperrin Lakeland Trust asked Dr. Quinn to carry out an initial review of notes related to Lucy Crawford. Dr. Quinn reviewed the notes and provided a report on 22nd June 2000. He was acting independently when he prepared his report for Sperrin Lakeland. The use of Altnagelvin headed paper is co-incidental and did not infringe hospital policy.

Letter from the Coroner: The Trust responded to the letter from the Coroner on 11th March 2004.

ENDS

Provided by the Communications Department, phone [redacted]

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. Fulton 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]