ALTNAGELVIN HOSPITALS HEALTH AND SOCIAL SERVICES TRUST

MEDIA STATEMENT

The staff involved in the care of Raychel Ferguson were deeply saddened by the tragic circumstances of her death

While it is of little comfort to her parents and family, it is important to emphasise that the clinical practices used during Raychel's care, following her operation, were at that time accepted practice in all other area hospitals in Northern Ireland.

Following Raychel's death, Altnagelvin Hospital immediately implemented its critical incident procedure and introduced changes to help ensure nothing similar happens again in the hospital. In addition, the hospital's Medical Director met with the Chief Medical Officer for Northern Ireland to initiate a review. As a direct result, new guidance from the Chief Medical Officer was issued to all hospitals in Northern Ireland and is now available to the wider medical community.

We again offer our most sincere condolences to Raychel's parents and family on their very sad loss. We feel it is inappropriate for us to make further comment on this sad death, or on any other deaths in other hospitals that may, or may not, be related to the practices to which we refer.

ENDS

Date

Provided by Communications Department, phone [redacted]

Notes to editors:

1. Altnagelvin's Critical Incident Procedure has been in place since 1998. Its purpose is to review incidents or events resulting in unexplained deaths, or incidents with the potential to have resulted in serious damage, injury or death of a patient. All staff are required to formally notify such incidents and the procedure is implemented as a matter of urgency on receipt of that notification. As part of the process, the care provided will be critically reviewed and action taken as required to amend practice so as to prevent, or at least minimise, similar incidents occurring in the future.

2. The sequence of events following the sad death of Raychel Ferguson is as follows:

• Date of Raychel's death:	9/6/2001
• Date potential cause of death identified:	10/6/2001
• Critical incident meeting held:	12/6/2001
• Letter of condolence sent to family	15/6/001
• Notification to Public Health (Dr. McConnell)	Mid-June 2001
• Notification to other Medical Directors	18/6/2001
• CMO notified by Altnagelvin Medical Director	22/6/2001
• Follow up with CMO by Altnagelvin Chief Exec	26/7/01
• Meeting with family to discuss cause of death	3/9/2001
• Guidance on hyponatraemia issued by DHSSPS	March 2002
• Altnagelvin discussed with Western Area Council	19/02/03
• Further DHSSPS guidance relating to adults issued	June 2003

Marie Dunne - Commun. Mgr

From: Marie Dunne - Commun. Mgr
Sent: 26 October 2004 11:47
To: Diane Brennan - CSM Medical
Subject: RE: Insight Prgramme

Thanks Diane.

M.

-----Original Message-----
From: Diane Brennan - CSM Medical
Sent: 26 October 2004 11:15
To: Marie Dunne - Commun. Mgr
Subject: RE: Insight Prgramme

Marie,

Having spoken to Raymond Jackson this am (Monday) - apparently no calls over weekend.

Diane

-----Original Message-----
From: Marie Dunne - Commun. Mgr
Sent: 22 October 2004 16:50
To: Marie McGeehan - Nigh Services Mgt; Patricia McDowell - Night Services Mgr; Raymond Jackson - Night Services Mgt; Diane Brennan - CSM Medical; Kate McDaid - Directorate Manager; Bernie McCrory - Directorate Manager, Surgery
Cc: Irene Duddy - Dir of Nursing
Subject: Insight Prgramme

Hello. You will probably be aware of the Insight Programme broadcast on UTV last night (Thursday 21st).

At the time of writing this email, we have not received any media calls about the programme. However, in the event there would be calls over the weekend, please take brief details of the nature of the enquiry, plus a telephone number, and contact myself or Miss Duddy. Our contact details are with switchboard.

I would be grateful if you would ensure that this information is passed to whoever will be carrying the bleep over this weekend.

Thank you.

Marie