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Statement about investigation of the death of Rachel Ferguson on 9 June 2001

I was Medical Director of Altnagelvin Trust at the time of Rachel Ferguson's death on 09 06 01. I was responsible for investigating the circumstances of her death within the hospital and to make suggestions for any action to prevent recurrence. The following is the sequence of action I undertook.

12 06 01	I set up a Critical Incident Enquiry involving all relevant clinical staff to establish the clinical facts. As a result of this 6 Action Points were agreed and circulated to all present on 13 06 01 (Enclosure 1).
14 06 01	Following Action Point 1 Dr Nesbitt, Clinical Director, Anaesthetics, wrote to me saying he had found that solution 18 was currently used in several hospitals in Northern Ireland. He said he had reviewed the literature which had convinced him that Solution 18 should not be used in surgical paediatric patients. He stated that henceforth Solution 18 would not be used in these circumstances in Altnagelvin (Enclosure 2).
18 06 01	At a regular meeting of Medical Directors at Castle Buildings I described the circumstances of this death. There were several anaesthetists present some of whom said they had heard of similar situations though it was not clear if there had been fatalities. I suggested that these should be regional guidelines.
22 07 01	I rang the Chief Medical Officer, Dr Campbell, and informed her of the death. I suggested she should publicize the dangers of hyponatraemia when using low saline solutions in surgical children. I said there was a need for regional guidelines. Dr Campbell suggested that CREST (the regional Guideline group) might do this.
Mid June 2001	I rang the Director of Public Health at Western Health Board (Dr McConnell) and described the death. He said he would discuss the circumstances at his next meeting with the Chief Medical Officer and the Directors of Public Health of the three other Health Boards. I sent him reprints from British Medical Journal on hyponatraemia.
05 07 01	Dr McConnell wrote to confirm that he had discussed the case with the CMO and DPHs. Each DPH had agreed to alert the paediatricians in their respective Board areas to the hazards of hyponatraemia (Enclosure 3).
26 07 01	Mrs Burnside, Chief Executive, Altnagelvin, contacted the CMO to advocate a regional review (Enclosure 4). I remember seeing a reply from CMO agreeing to set up a regional Enquiry Group and that Dr Nesbitt would be a member.

14 01 02 I arranged for the CMO to view a presentation by Dr Nesbitt on hyponatraemia while she was visiting Altnagelvin to present accreditation to the Hospital HDSU.

09 04 02 I chaired a meeting of relevant clinical staff to revise the Action Plan of 12 06 01 in view of the publication of guidelines on hyponatraemia. A new Action Plan is being agreed between surgeons, anaesthetists, paediatricians (to follow).

Throughout this process I was struck by the wish of all concerned to learn from this death which is unique in their experience. I received full co-operation from all clinical staff who are extremely distressed by Rachel's death.

I feel our response was rapid and directed towards specific action to prevent recurrence. The documentation attached details the action.

Dr R Fulton

11/04/02

Encs