

NEWS NTERTAINMENT

TUESDAY 02/11/2004 08:37:12

INQUIRY INTO 'NEEDLESS' DEATHS OF THREE CHILDREN I HOSPITAL

An independent inquiry was set up in Northern Ireland last night t investigate the deaths in hospital of three children.

It has been alleged that all died needlessly from a condition know as hyponatraemia - a shortage of sodium in the body - and that th death of one of the children was covered up.

Northern Ireland Health Minister Angela Smith MP announced sh had appointed leading QC John O'Hara to conduct an inquiry into the issues raised by the recent UTV Insight programme, When Hospital Kills.

The minister said it was very important the public had confidence the health service and in the standards of performance of all who worked in it.

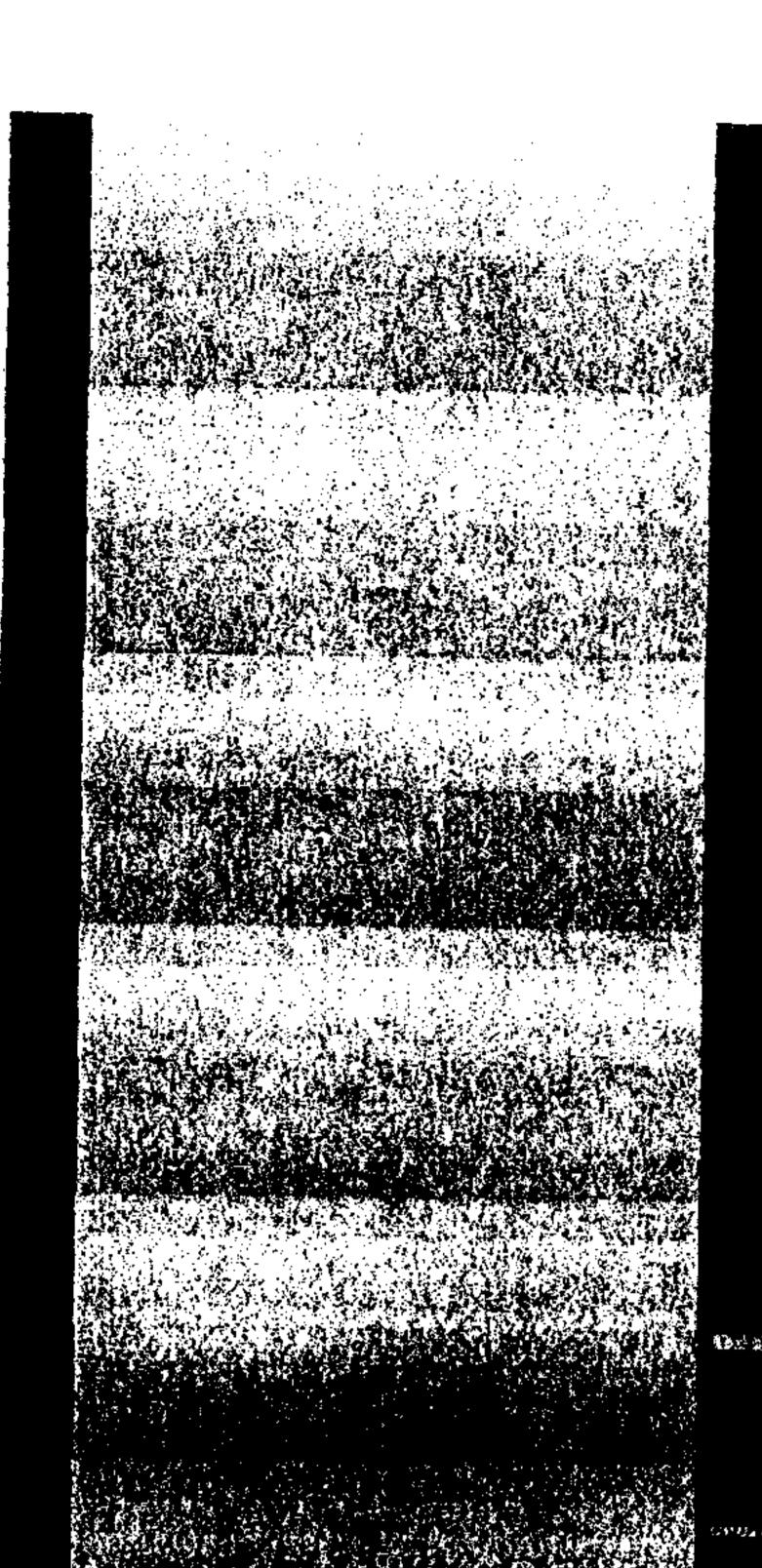
"This television programme has raised a number of serious issue and allegations which need to be investigated," said Ms Smith.

The death of a child is tragic and is something which my Department takes very seriously."

esterday, Ms Smith personally rang the parents of the children, Lucy Crawford, Raychel Ferguson and Adam Strain, to tell them she was setting up the inquiry and to assure them it would be a "fully independent investigation".

Her announcement was welcomed by Sinn Fein spokesman. Assembly member John O'Dowd.

He said he had contacted the Minister after the TV programme to urge she set up an inquiry.



"That the three children's deaths from hyponatraemia could have been avoided remains a source of major concern and worry

"I am sure that many people will want to see all the facts surrounding these cases properly investigated," he said. The inquiry was needed "to ensure that mistakes which may have been made are not repeated".

It was essential the inquiry dealt with all the circumstances leading to the deaths and also investigated allegations of a cover up, said Mr. O'Down

Hyponatraemia is a severe shortage of sodium which can be due to dilution of blood excessive water retention or other factors.

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TUESDAY 02/11/2004 17:31:28

FAMILIES WELCOME INQUIRY INTO CHILD DEATHS

Families of three young people who died in hospitals in Northern Ireland, from a condition known as hyponatraemia, have welcome a government commitment to hold an inquiry in response to a UT Insight programme.

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However, they say it must be a public inquiry.

One mother has already questioned the independence of the investigation.

The Health Minister ordered the investigation as a result of last week's UTV Insight programme 'When Hospitals Kill', which suggested the three children had died needlessly.

Making the announcement, Angela Smith said she had appointed Mr John OHara QC to head up the investigation.

The Minister said: "I regard it as very important that the general public should have confidence in the health service and in the standards of performance of all who work in it.

"This television programme has raised a number of serious issue and allegations which need to be investigated."

The Health Minister also said she had already spoken to the families involved in the Insight programme and had told them the will be a fully independant investigation.

However, the familes have already said that while they welcome the inquiry, it must be public.

Despite announcing its decision 24-hours ago, the Department of Health said this evening that it still was not ready to answer speci questions on the nature and scope of the inquiry.

Meanwhile, the police says its investigation into the childrens' deaths is continuing and a spokesman said the PSNI have not been told of the terms of reference of the inquiry.

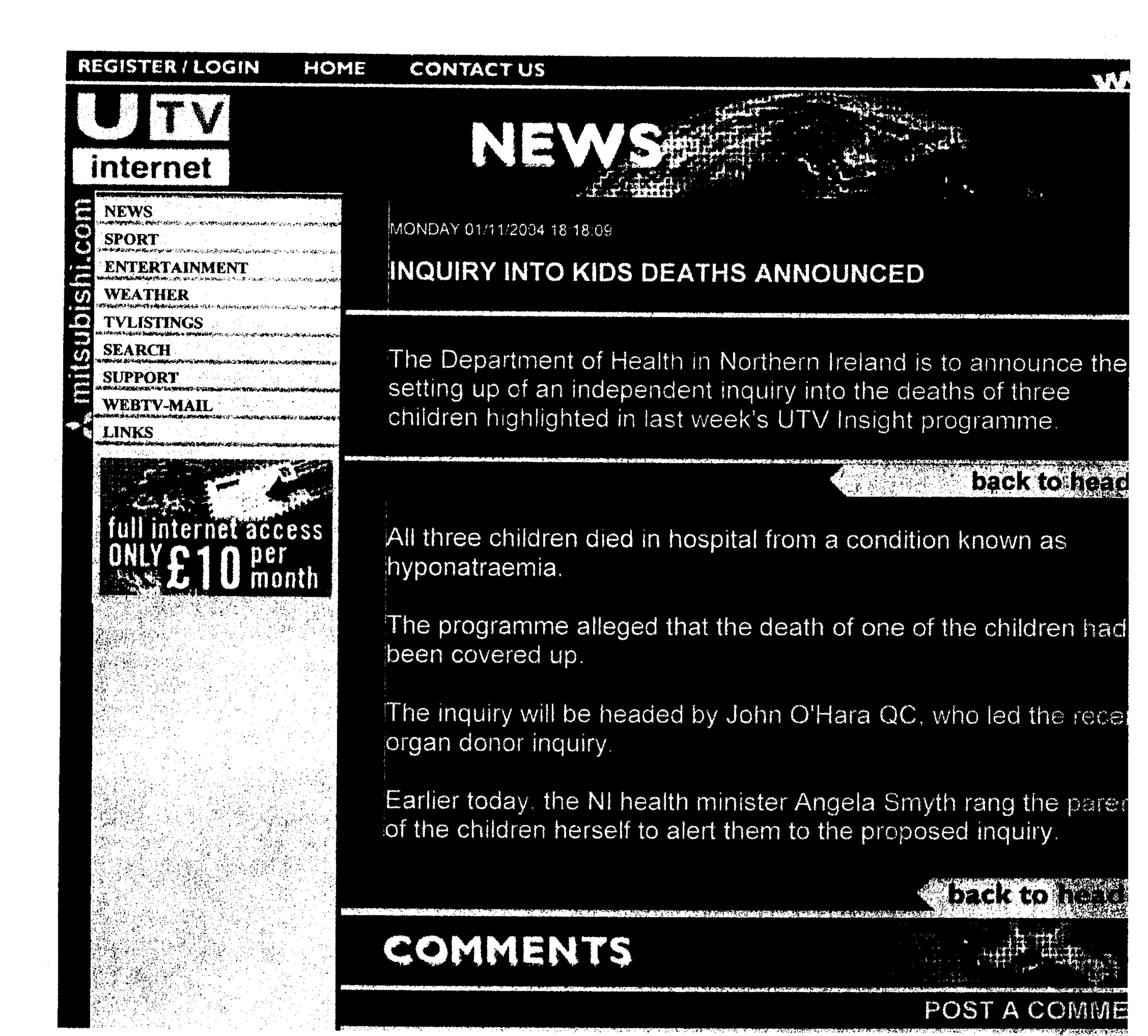
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01/11/2004 18 18:09 - Inquiry into kids deaths announced

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THURSDAY 06/02/2003 17:37:07

GIRL'S DEATH CAUSES HOSPITAL POLICY CHANGE

A fluid given to a young girl who died following surgery at a Londonderry hospital is no longer prescribed for children recovering from operations there, an inquest heard today.

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A consultant anaesthetist at Altnagelvin Hospital told an inquiry in the death of Raychel Ferguson that the solution she received was no longer given to post-operative children.

The inquest earlier heard Raychel could have survived if she was put on a saline drip after undergoing surgery to remove her appendix.

Belfast Coroner's Court heard that Raychel continually vomited after an operation at Altnagelvin Area Hospital in June 2001.

The child was then rushed to Belfast's Royal Victoria Hospital after suffering a seizure and swelling to the brain, and died on June 10

The inquest heard that Raychel was a normal, healthy child befor complaining of stomach pains on her return home from St Patrick Primary School in Pennyburn, Londonderry on June 7.

Her mother then took her to hospital from their Benview Estate home in Coshquin where her appendix was removed that night.

Dr Bernie Trainor, a paediatrician who was called to treat Rayche after she suffered a seizure, told the inquest today that surgeons were responsible for prescribing fluids to children after operations

She said that when she saw Raychel in the early hours of June 9 she looked "very unwell" and had a rash on her face, neck and upper chest which was consistent with vomiting.

Dr Trainor noted that Raychel had thrown up seven times followir

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The inquest also heard that the two surgeons who attended Raychel, including Dr Ragai Reda Makar who prescribed the fluid which were administered before and after the operation, would not be appearing.

Coroner for Greater Belfast John Leckey said Dr Makar had beer written a letter and sent a witness summons to attend the hearing but he had no explanation as to why he had not attended.

The court later heard he was on two weeks leave from another hospital where he now works. The other surgeon, Mr Zafar, was excused by the coroner as he is currently sitting exams.

Paul Foster, a barrister acting on behalf of the Ferguson family, instructed by Kelly and Corr solicitors, expressed concern that thi could leave a gap in the evidence of the events which led up to Raychel's death.

However, Mr Leckey said he would wait to see if the other witnesses could provide a full picture of the circumstances prior to death.

Dr Edward Sumner, who was a consultant paediatrician at Great Ormond Street Children's Hospital in London for almost 30 years said yesterday that Raychel could have survived if she had received saline after the operation.

Dr Sumner, who carried out a report for Coroner for Greater Belfa John Leckey, said hospital staff should have measured the fluid loss from her stomach and in her urine.

He added: "There should have been fluid supplement administered."

Dr Raymond Fulton, who was medical director of Altnagelvin Hospitals Trust in June 2001, told the inquest an action plan had been drawn up less than a week after Raychel's death.

It said children should be monitored regularly after surgery, all urine output should be measured and recorded, and the charts which document a patient's fluid input and output should be reviewed.

Mr G Nesbitt, a consultant anaesthetist, said after the hospital carried out its own inquiry into Raychel's death, Solution 18, the fluid which Raychel received after surgery, was no longer given to children recovering from operations.

He said: "It's stopped in Althagelvin and as far as I'm aware in mo other hospitals in Northern Ireland."

Mr Nesbitt said half-strength saline was now given to children afte surgery.

He said there was a place for Solution 18 but it was "not the appropriate solution" for children recovering from surgery.

The court heard there had only been one previous death in Northern Ireland attributed to brain swelling due to hyponatraemia excess water and low sodium levels in the bloodstream.

Raychel's death prompted Chief Medical Officer for Northern Ireland, Dr Henrietta Campbell, to formulate the new guidelines to raise awareness of the condition in the medical community.

They said: "Any child receiving intravenous fluids or oral rehydration is potentially at risk of hyponatraemia."

It added: "The guidance emphasises that every child receiving intravenous fluids requires a thorough baseline assessment, that fluid requirements must be calculated accurately and fluid balanc must be rigorously monitored.

"Following this simple advice will prevent children from developin hyponatraemia."

The inquest was adjourned until tomorrow when one doctor will give evidence.

The testimony of the nursing staff will be heard next week.

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WEDNESDAY 05/02/2003 18:27:00

CHILD COULD HAVE SURVIVED, INQUEST TOLD

A nine-year-old girl who died after undergoing surgery could have survived had she been given a saline solution by medical staff at Londonderry hospital, an inquest heard today.

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Belfast Coroner's Court heard Raychel Ferguson continually vomited after having her appendix removed at Altnagelvin Area Hospital in June 2001.

Raychel was then rushed to Belfast's Royal Victoria Hospital afte suffering a seizure due to brain swelling and died on June 10.

The inquest heard that Raychel was a normal, healthy child befor complaining of stomach pains on her return home from St Patrick Primary School in Pennyburn on June 7.

She was admitted to hospital that evening where her appendix was removed.

Dr Edward Sumner, who was a consultant paediatrician at Great Ormond Street Children's Hospital in London for almost 30 years said Raychel suffered "very severe and prolonged vomiting" in th hours after the operation.

He pointed to five occasions throughout the day when the little gi had thrown up and added: "I think that would have saved the day we had given her saline to cover the vomiting."

Dr Sumner, who carried out a report for Coroner for Greater Belfa John Leckey, said hospital staff should have measured the fluid loss from her stomach and in her urine.

He added: "There should have been fluid supplement administered."

Raychel's mother, Marie, told the court that her little girl complained of hunger pains after arriving home from school on June 7.

However, after she ate her dinner the pains remained and her mother rushed her to the Accident and Emergency Ward of Altnagelvin Hospital after her face turned grey.

On arrival, a doctor told Mrs Ferguson the pains could be due to a problem with her appendix and that it may have to be removed.

The court heard Raychel arrived back in the children's ward following an operation to remove her appendix just after 2am on June 8.

Mrs Ferguson left the hospital at around 6am to get her two sons ready for school. However, she received a phonecall just three hours later informing her that Raychel had been sick.

Raychel's mother told the court that when she arrived at the hospital, her daughter looked "really well" and threw her arms around her and said: "Guess what mummy? I threw up."

However, after 10.30am that day, Mrs Ferguson said Raychel we very quiet, adding: "She was just lying on the bed."

Mrs Ferguson said she told nurses: "Raychel doesn't look too we However, she said she was given no advice on how to look after her.

She said she carried Raychel to the toilet twice because her little girl "didn't look too well".

"She was very weak, she was lying on the bed, I kept talking to her."

Mrs Ferguson said she left the hospital just before 3pm that day to collect her two boys from school and when she came back at 4pm a woman visiting another child in the ward told her Raychel had restopped vomiting.

She said that later in the day when she expressed concern that Raychel had vomited a bile-like substance, a nurse told her: "She won't throw up again now her stomach's clear."

Mrs Ferguson said she was in the hospital for around 11-12 hour that day and that her little girl had lain in bed for most of that time vomiting occasionally.

She added: "I had said to the nurse that Raychel's not well but all

the nurse said was 'that's natural after an operation'."

The court heard there had only been one previous death in Northern Ireland attributed to brain swelling due to hyponatraem the medical term for a lack of sodium in the bloodstream.

After Raychel's death the Chief Medical Officer for Northern Ireland, Dr Henrietta Campbell distributed guidelines to raise awareness of the condition.

These were subsequently circulated throughout the medical community.

They said: "Any child receiving intravenous fluids or oral rehydration is potentially at risk of hyponatraemia."

It added: "The guidance emphasises that every child receiving intravenous fluids requires a thorough baseline assessment, that fluid requirements must be calculated accurately and fluid balancements be rigorously monitored.

"Following this simple advice will prevent children from developin hyponatraemia."

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