Form 20

CORONERS ACT (NORTHERN IRELAND) 1959

Deposition of Witness taken on the THURSDAY the 6TH day of FEBRUARY 2003, at inquest touching the death of RAYCHEL FERGUSON, before me MR J L LECKEY, HM CORONER for the District of GREATER BELFAST as follows to wit:-

The Deposition of DR RAYMOND FULTON
of ALTNAGELVIN HOSPITALS H&SS TRUST who being sworn upon his oath, saith

I, Dr Raymond Fulton, MB, FRCP London, was Medical Director of Altnagelvin Hospitals H&SS Trust at the time of Raychel Ferguson's death on 09/06/01. I was responsible for investigating the circumstances of her death within the hospital and to make recommendations for any action to prevent recurrence.

On 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 six Action Points were agreed and circulated to all present on 13/06/01 *(see attachment 1)*.

On 14/06/01 following Action Point 1 Dr Nesbitt, Clinical Director for 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 *(see attachment 2)*.

On 18/06/01 at a meeting of Medical Directors with Dr I Carson, Medical Advisor to the CMO, at Castle Buildings I described the circumstances of

this death. There were several anaesthetists present, some of whom said that they had heard of similar situations though it was not clear if there had been fatalities. I suggested that there should be regional guidelines.

On 22/06/01 I rang the Chief Medical Officer, Dr Henrietta Campbell, and informed her of the circumstances of the death. I suggested she should publicise 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 (Regional Guidelines Group) might do this.

In Mid June 2001 I rang Dr W McConnell, the Director of Public Health at the Western Health & Social Services Board, and described the circumstances of the death. He said he would discuss the matter 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 the British Medical Journal on Hyponatraemia *(see attachment 3)*.

On 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 *(see attachment 4)*.

On 26/07/01 Mrs Burnside, Chief Executive of Altnagelvin Hospitals H&SS Trust, contacted the CMO to personally advocate a regional review *(see attachment 5)*. I remember seeing a reply from the CMO agreeing to set up a regional Enquiry Group and that Dr Nesbitt would be a member.

On 14/01/02 I arranged for the CMO to view a presentation by Dr Nesbitt on Hyponatraemia while she was visiting Altnagelvin Hospital to present accreditation to the Trust's HSDU.

On 09/04/02 I chaired a meeting of relevant clinical staff to review the Action Plan of 12/06/01 in light of the publication of Departmental Guidelines on Hyponatraemia. *(see attachment 6).*

On 01/05/02 Dr Nesbitt, who succeeded me as Medical Director, wrote to the CMO enquiring if the death of a child some years previously from hyponatraemia in the RBHSC had been reported to the Department. Dr Nesbitt had become aware of the RBHSC case whilst investigating the death of Raychel Ferguson *(see attachment 7).*

On 10/05/02 Dr Campbell replied that the Department had not been made aware of the first case either by the Royal Victoria Hospital or the Coroner. She had only become aware of the original case whilst working on developing guidelines following the death of Raychel Ferguson *(see attachment 8).*

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 Raychel's death.

Mr. Foster :

TAKEN before me this 6TH FEBRUARY 2003

Coroner for the District of Greater Belfast

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Statement about Investigation of the Death of Rachel Ferguson on 9th June 2001

I, Dr. Raymond Fulton, MB, FRCP London, was Medical Director of Altnagelvin Hospitals H&SS 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 recommendations for any action to prevent recurrence.

On 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 six Action Points were agreed and circulated to all present on 13/06/01 (*see attachment 1*).

On 14/06/01 following Action Point 1 Dr Nesbitt, Clinical Director for 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 (*see attachment 2*).

On 18/06/01 at a meeting of Medical Directors with Dr. I Carson, Medical Advisor to the CMO, at Castle Buildings I described the circumstances of this death. There were several anaesthetists present, some of whom said that they had heard of similar situations though it was not clear if there had been fatalities. I suggested that there should be regional guidelines.

On 22/07/01 I rang the Chief Medical Officer, Dr Henrietta Campbell, and informed her of the circumstances of the death. I suggested she should publicise 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 (*Regional Guidelines Group*) might do this.

In Mid June 2001 I rang Dr. W McConnell, the Director of Public Health at the Western Health & Social Services Board, and described the circumstances of the death. He said he would discuss the matter 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 the British Medical Journal on Hyponatraemia (*see attachment 3*)

On 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 (*see attachment 4*).

On 6/07/01 Mrs Burnside, Chief Executive of Altnagelvin Hospitals H&SS Trust, contacted the CMO to personally advocate a regional review (*see attachment 5*). I remember seeing a reply from the CMO agreeing to set up a regional Enquiry Group and that Dr Nesbitt would be a member.

On 14/01/02 I arranged for the CMO to view a presentation by Dr Nesbitt on Hyponatraemia while she was visiting Altnagelvin Hospital to present accreditation to the Trust's HSDU.

On 09/04/02 I chaired a meeting of relevant clinical staff to review the Action Plan of 12/06/01 in light of the publication of Departmental Guidelines on Hyponatraemia. (*see attachment 6*)

On 01/05/02 Dr. Nesbitt, who succeeded me as Medical Director, wrote to the CMO enquiring if the death of a child some years previously from hyponatraemia in the RBHSC had been reported to the Department. Dr. Nesbitt had become aware of the RBHSC case whilst investigating the death of Rachel Ferguson *(see attachment 7)*.

On 10/05/02 Dr. Campbell replied that the Department had not been made aware of the first case either by the Royal Victoria Hospital or the Coroner. She had only become aware of the original case whilst working on developing guidelines following the death of Rachel Ferguson (*see attachment 8)*.

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.

DR RAYMOND FULTON
12/11/02

attachments 1-8

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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