HER MAJESTY'S CORONER

DISTRICT OF GREATER BELFAST

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10th February 2003

Dear Eta,

RAYCHEL FERGUSON, DECEASED

I am writing to advise you that I concluded the inquest hearing yesterday and for your information I am enclosing a copy of Form 21 which sets out the verdict.

As you are aware Dr Edward Sumner, who has recently retired as Consultant Paediatric Anaesthetist at Great Ormond Street Hospital for Children, prepared a report for me. Whilst giving evidence at the inquest he expressed praise for the new protocol that has been drawn up and commented that Northern Ireland was ahead of the rest of the United Kingdom. He agreed with me that the protocol should be drawn to the attention of the Chief Medical Officers of England and Wales, Scotland and the Republic of Ireland. I announced at the inquest that I would write to you requesting that this be done. Dr John Jenkins, Senior Lecturer in Child Health at Queen's University who also gave evidence, agreed that this would be appropriate. He stated that he concurred with all the views expressed by Dr Sumner.

Dr Fulton and Dr Nesbitt from Altnagelvin Hospital expressed the view that the protocol was not prescriptive enough and should apply to all patients – not just children. This is something you might wish to consider though I express no opinion on it.

The issue was discussed as to how medical information should be disseminated. The view expressed by a number of the medical witnesses was that journal articles alone

do not provide the solution. For whatever reason they may not be read. That being so it was felt that the Department of Health might have a responsibility in this area although what the mechanism should be no-one could say. As you are aware because the major hospitals are located in my district I often hold inquests involving complex medical issues. Certainly, I must admit that on occasions I have wondered if the results of these inquests and the evidence of independent experts have been made available for consideration by members of the medical profession. (My practice is to provide a copy of any independent expert report I have obtained to the family and the medical side prior to the inquest hearing.) Unfortunately, it would now appear that this is unlikely to have happened as there is no obvious mechanism for the dissemination of this information.

Dr Sumner described Hyponatraemia as a "Cinderella area" of medicine. The evidence given at the inquest would support this. None of the surgical team, which was responsible for Raychel and for the fluids given her, seemed aware of this condition. Mr Robert Gilliland, Consultant Surgeon, stated that he had not heard of it until after Raychel's death. Two of the nurses had some knowledge of Hyponatraemia but not sufficient to be able to link what was happening to Raychel to that condition. Those on the "medical" team did seem more alert to the dangers of Hyponatraemia and as soon as they became involved with Raychel they considered it as the likely explanation for her deteriorating condition.

You might consider whether what emerged at the inquest has implications for the training of both doctors and nurses.

I would welcome your views and if you thought I could assist in any way please do not hesitate to let me know.

With best wishes.

Yours sincerely

J L LECKEY
HM CORONER FOR GREATER BELFAST

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