Directorate of Legal Services

Directorate of Legal Services
Central Services Agency
25 Adelaide Street
Belfast
BT2 8FH

Tel: [redacted]
Fax:
E-Mail: dls[redacted]

To G M°Auenden Esq BL

Of Bar Library

Fax No [redacted]

From [redacted]

Date 08/04/02

Direct Line / Ext 90[redacted]

URGENT ✓

For Information

Please Phone

Please Reply

No of Pages (inc cover sheet) 4

Message Re: Rachel Ferguson

I refer to your recent conversation with Mrs. Scott and have enclosed correspondence from the Department dated 25/03/2002 entitled 'Prevention of Hyponatraemia In Children' along with a report from Mr Zafar dated 03/04/02. (2)

Practitioners in Law to the Northern Ireland Health and Social Services Sector

NORTHERN IRELAND HEALTH & SOCIAL SERVICES
csa
CENTRAL SERVICES AGENCY

Department of Health, Social Services & Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

From The Chief Medical Officer:
Dr Henrietta Campbell CB

Castle Buildings
Upper Newtownards Road
Belfast BT4 3SJ

Telephone: [redacted]
Fax:

E-Mail: henrietta.campbell[redacted]

Medical Directors of Acute Trusts
Directors of Nursing in Acute Trusts
Consultant Paediatricians
Consultant Surgeons
Consultant Neurosurgeons
Consultant Anaesthetists/Intensivists
Consultants in Plastic Surgery/Burns
Consultants in A&E Medicine
Consultant Pathologists

25 March 2002

Dear Colleagues

PREVENTION OF HYPONATRAEMIA IN CHILDREN

Guidance on the Prevention of Hyponatraemia in Children has been published and will be forwarded to you under separate cover. It has been prepared as an A2 sized poster and I ask you to ensure that the posters are prominently displayed in all units that may accommodate children. The Guidance has been developed by a multidisciplinary working group established by the Department and the work has been supported and endorsed by CREST.

Hyponatraemia can be extremely serious and has in the past few years been responsible for two deaths among children in Northern Ireland. Hyponatraemia is a problem of water balance and most often reflects the failure to excrete water. Stress, pain and nausea are all potential stimulators of the antidiuretic hormone ADH which inhibits water excretion.

Any child receiving IV fluids or oral rehydration is potentially at risk of hyponatraemia. The administration of excess or inappropriate fluid to a sick child may result in serious or life threatening hyponatraemia. There is a particular concern about the use of 0.18% Sodium Chloride in Glucose among children as it has been implicated in cases of hyponatraemia. While it may pose a risk because of the relatively low sodium content no specific fluid is without risk. This has been emphasised in a recent letter received from the Medicines Control Agency which stated that while hyponatraemia is a risk with 0.18% Sodium Chloride, electrolyte imbalance is a risk with all intravenous solutions.

The Guidance emphasises that every child receiving intravenous fluids requires a thorough baseline assessment, that fluid requirements must be calculated accurately and fluid balance must be rigorously monitored. Following this simple advice will prevent children from developing hyponatraemia.

The Guidance is designed to provide general advice and does not specify particular fluid choices. Fluid protocols should be developed locally to complement the Guidance and provide more specific direction to junior staff. This is particularly important in subspecialty areas such as renal medicine, burns units and

neurosurgery. It will be important to audit compliance with the guidance and locally developed protocols and to learn from clinical experiences.

I would like to extend my thanks to all members of the multidisciplinary group who have worked together to provide clear and practical guidance to improve the care of sick children. The Guidance is also available on the Departmental website www.dhsspsni.gov.uk.

Yours sincerely

HENRIETTA CAMPBELL (Dr)

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Statement re: Rachael Ferguson Deceased

I Mr MH Zafar, was employed as a Surgical SHO in Altnagelvin Hospital in June 2001.

I visited Ward 6 to do a ward round on 8th June 2001. I saw Rachel Ferguson. Rachel had an appendectomy operation on 7th June 2001.

On my ward round she was free of pain and apyrexial. The plan was for continuous observation.

At approximately 3.15.p.m. I was beeped by the Surgical JHO and asked to attend to Rachel Ferguson who had a fit. I was asked to come to see the child. I advised the JHO that I was in Casualty with another patient and would come to the Ward as soon as possible.

When I arrived on the ward the child was being resuscitated.

Mr M H Zafar
3-4-2002

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