[redacted]

From: Aiden Duffy <[redacted]@[redacted]>
To: Therese Brown <[redacted]@[redacted]>
Sent: 28 March 2002 11:28
Attach: Ferguson Inquest.doc
Subject: Re: Rachel Ferguson (Deceased)

332

Marie ~ Claire
can you ring DS urgently
in regard to this action.

29/03

Ring Theresa . 09:30
re wording.

Aidan urgent
Please e-mail to typist and
get these amendments done
amended letter
a e-mail to GMcA.

"Dear Sir,

M-E

Re: Inquest into the death of Rachel Ferguson (Deceased).

I am writing in relation to the hearing of the Inquest into the death of Rachel Ferguson (Deceased) which is listed for hearing on ~~11th~~ 10th and ~~12th~~ 11th April, 2002. As you are aware, Mr Coroner, the Central Services Agency will be representing the Altnagelvin Hospitals Health and Social Services Trust at the hearing of this matter.

333

Firstly, Mr Coroner, I wish to thank you for furnishing your list of proposed witnesses together with the reports prepared by Dr Brian Herron, Consultant Neuropathologist, Dr Clodagh Loughrey, Consultant Chemical Pathologist, and Dr Edward Sumner, Consultant Paediatric Anaesthetist. These reports have been considered in depth by the senior medical staff at the Altnagelvin Area Hospital in consultation with Counsel retained on behalf of the Trust in this matter and as a result of these deliberations, I have been directed by Counsel to write to you on behalf of the Trust in relation to the contents of these reports and, in particular, the report prepared by Dr Edward Sumner, Consultant Paediatric Anaesthetist and to raise with you the issue of the proper nature and scope of an Inquest held in the case of the death of a patient in hospital as the result of a medical accident in light of Article 2 of the European Convention on Human Rights and the decisions of the European Court of Human Rights in the cases of *Calvelli and Ciglio -v- Italy* and *Powell -v- United Kingdom.*

At the outset, the Trust wishes to make it clear that it fully accepts that the cause of death in this case was cerebral oedema due to hyponatraemia. The Trust also accepts that hyponatraemia occurred in this case as a result of a combination of factors. It is wholly accepted that, particularly in children, the stress of surgery can result in the increased secretion of anti diuretic hormone which has the effect of inhibiting the excretion of excess free water resulting in a reduction in the

concentration of sodium in the extracellular fluid. It is also accepted that the vomiting experienced by the Deceased was a contributory factor in that it would have contributed to some extent to the net sodium loss from the extracellular fluid. Further, it is accepted that the use of Solution 18 (1/5 strength saline solution) in order to provide post-operative maintenance and replacement fluids was a contributory factor in bringing about a reduction in the concentration of sodium in the extracellular fluid.

334

Prior to this incident it had been the practice in Paediatric Units in Altnagelvin Area Hospital and most other major hospitals in Northern Ireland to use Solution 18 for the purposes of maintenance and replacement fluids in children post-operatively where pre-operative blood electrolyte analysis had not revealed any significant abnormality. Following the tragic death of Rachel Ferguson, the Altnagelvin Trust immediately commenced an investigation into the circumstances of her death. This investigation was led by Dr Nesbitt, Consultant Anaesthetist and now Clinical Director of the Trust. This investigation concluded that the use of Solution 18 (1/5 strength saline) for the purposes of maintenance and replacement fluids in the circumstances in which it had previously been used should be stopped and that Hartman's Solution (containing approximately 133 mmol/L of Sodium) should instead by used for the purpose of maintenance and replacement fluids in such circumstances. In addition to bringing about a change in practice in Altnagelvin Area Hospital, the Trust advised the Department of Health of the conclusions of its investigations and requested the Department of Health to issue general guidance on this matter for all the Trusts in Northern Ireland. It is understood that the Chief Medical Officer is in the process of drawing up guidelines which will be issued in the near future.

I can also advise you, Mr Coroner, that in addition to directing that a more concentrated saline solution should be used to provide maintenance and replacement fluids in such circumstances, the Trust has also stipulated that blood electrolyte analysis should be carried out regularly when such a patient is

which it would intend to issue in the event of press inquiry

receiving maintenance and replacement fluids. The Trust understands that this will also form part of the guidance to be issued by the Chief Medical Officer.

The Trust has taken this tragic incident very seriously and has fully and promptly investigated the matter and has implemented new practices and procedures to ensure that such an incident cannot happen again. Further, it has taken these steps in advance of the Chief Medical Officer issuing official guidance on this subject. The Trust ~~also proposes to issue a~~ has drafted a press release following the conclusion of this Inquest, ~~which~~ The draft Press Release in addition to containing expressions of sympathy and regret, sets out in brief the fact that the Trust has put in place new practices and procedures in order to ensure that such a tragic incident does not recur again. A copy of the said press release is enclosed herewith. One of the purposes of this press release is to ensure that public confidence in the public health care system can be maintained.

335

I now wish to turn to certain specific matters set out in the report of Dr Sumner, Consultant Paediatric Anaesthetist, with which the Trust has certain concerns both in relation to the accuracy of certain statements and the appropriateness of certain opinions expressed therein in the context of the hearing of an Inquest.

Firstly, it is the Trust's contention that there are certain timing inaccuracies in Dr Sumner's report based on a misinterpretation of the records. In page 3 of his report in the fifth paragraph, the time 0630 is incorrect. The correct time is 4.15 a.m. In page 3 of the report in the seventh paragraph, the time 0830 is incorrect. The correct time is 4.30 a.m.

In relation to Dr Sumner's reference to "AMT (150ml every hour)" in page 3 of his report in the third paragraph, this simply refers to the amount of 150 ml of fluid which is drawn down into the burette every hour. In other words, the burette was checked every hour to ensure that 150 ml of fluid was present in it.

Another issue which is of concern to the Trust is Dr Sumner's conclusions in page 4 of his report in the comments numbered 2 and 5 that the Deceased suffered very severe and prolonged vomiting. This conclusion is strongly disputed by the Trust. The nurses who were caring for the Deceased during the relevant period have been interviewed in detail about this matter and they are all of the opinion that the vomiting suffered by the Deceased was neither severe nor prolonged. However, it would appear that it id not proposed to call any of the Nursing Staff at the hearing of this Inquest so that the opinion of Dr Sumner based on his perusal of the Notes and Records will not be balanced or countered by the oral testimony of the Nursing Staff who cared for the Deceased during the relevant period. I would respectfully suggest that if such expressions of opinion are to be permitted to be given at the hearing of the Inquest, then the Nurses who were caring for the Deceased should have the opportunity to present their contrary oral evidence on such an important matter.

336

On a general point, the Trust is concerned that the statements of opinion set out in page 4 of Dr Sumner's report in the comment numbered 4, go well beyond that which is appropriate in the context of an Inquest. These statements of opinion refer to certain steps and procedures which it is alleged the doctors and nurses employed by the Trust should have carried out. These statements of opinion do not directly relate to the central issues of how, when and where the Deceased came by her death but are directed more to attributing fault and blame and are in essence expressions of opinion on issues of civil liability.

It is the considered view of the Trust that even in light of Article 2 of the European Convention on Human Rights, the scope of an Inquest in the case of a medical accident has not been broadened to such an extent as to permit opinion evidence of such a nature to be given. The European Court of Human Rights has stated in the *Calvelli* case (Judgment given on 17th January, 2002) that in the case of death resulting from a medical accident where the "infringement of the right to life or to personal integrity is not caused intentionally, the positive

obligation imposed by Article 2 to set up an effective judicial system does not necessarily require the provision of a criminal-law remedy in every case. In the specific sphere of medical negligence the obligation may for instance also be satisfied if the legal system affords victims a remedy in the civil courts, either alone or in conjunction with a remedy in the criminal courts, enabling any liability of the doctors concerned to be established and any appropriate civil redress, such as an order for damages and for the publication of the decision, to be obtained. Disciplinary measures may also be envisaged." 337

Such remedies are clearly available in this jurisdiction. Having regard to this decision and the earlier *Powell* decision, it is clear that the State's obligation under Article 2 of the Convention is to carry out an effective investigation into the circumstances surrounding the death. The Court in the *Powell* case stated that it considered "that the procedural obligation as described cannot be confined to circumstances in which an individual has lost his life as a result of an act of violence. In its opinion, and with reference to the facts of the instant case, the obligation at issue extends to the need for an effective independent system for establishing the cause of death of an individual under the care and responsibility of health professionals and any liability on the part of the latter."

It is the Trust's contention that the remit of the Coroner's Court is to establish the cause of death of the Deceased whereas the remit of the Civil Courts is to adjudicate upon the civil liability of the health professionals involved in the provision of treatment to the Deceased.

In relation to the statements of opinion set out in page 4 of Dr Sumner's report in the comment numbered 4, the Trust is particularly concerned by the suggestion made by Dr Sumner, a Consultant Paediatric Anaesthetist, that it would have been appropriate in this case to insert a nasogastric tube to drain the Deceased's stomach in order to allow gastric losses to be adequately quantified. It is the opinion of ~~Dr McCord, a highly experienced Consultant Paediatrician~~ highly experienced Consultants at the time, that this

would certainly not be a routine procedure and would be one which would only be done in the presence of an intestinal obstruction. This is an example of a clear difference of opinion on a medical matter which does not directly bear on the central matters to be addressed at the Inquest. The question which must be addressed both in the context of this Inquest and in future Inquests involving the deaths of patients as a result of medical accidents is whether it is the function of the Inquest to adjudicate upon such differences of medical opinion.

338

The Trust wished me to bring these matters to your attention well in advance of the hearing of this Inquest rather than air them for the first time at the hearing. If there are any matters which you wish me to address further, I will only be too happy to oblige.

Yours faithfully,"

"Dear Sir,

Re: Inquest into the death of Rachel Ferguson (Deceased).

I am writing in relation to the hearing of the Inquest into the death of Rachel Ferguson (Deceased) which is listed for hearing on 10th and 11th April, 2002. As you are aware, Mr Coroner, the Central Services Agency will be representing the Altnagelvin Hospitals Health and Social Services Trust at the hearing of this matter.

339

Firstly, Mr Coroner, I wish to thank you for furnishing your list of proposed witnesses together with the reports prepared by Dr Brian Herron, Consultant Neuropathologist, Dr Clodagh Loughrey, Consultant Chemical Pathologist, and Dr Edward Sumner, Consultant Paediatric Anaesthetist. These reports have been considered in depth by the senior medical staff at the Altnagelvin Area Hospital in consultation with Counsel retained on behalf of the Trust in this matter and as a result of these deliberations, I have been directed by Counsel to write to you on behalf of the Trust in relation to the contents of these reports and, in particular, the report prepared by Dr Edward Sumner, Consultant Paediatric Anaesthetist and to raise with you the issue of the proper nature and scope of an Inquest held in the case of the death of a patient in hospital as the result of a medical accident in light of Article 2 of the European Convention on Human Rights and the decisions of the European Court of Human Rights in the cases of *Calvelli and Ciglio -v- Italy* and *Powell -v- United Kingdom.*

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concentration of sodium in the extracellular fluid. It is also accepted that the vomiting experienced by the Deceased was a contributory factor in that it would have contributed to some extent to the net sodium loss from the extracellular fluid. Further, it is accepted that the use of Solution 18 (1/5 strength saline solution) in order to provide post-operative maintenance and replacement fluids was a contributory factor in bringing about a reduction in the concentration of sodium in the extracellular fluid.

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I now wish to turn to certain specific matters set out in the report of Dr Sumner, Consultant Paediatric Anaesthetist, with which the Trust has certain concerns both in relation to the accuracy of certain statements and the appropriateness of certain opinions expressed therein in the context of the hearing of an Inquest.

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