HSC Business Services Organisation

Directorate of Legal Services
— Practitioners in Law to the Health & Social Care Sector —

2 Franklin Street, Belfast, BT2 8DQ
DX 2842 NR Belfast 3

Your Ref:
AD-0529-13

Our Ref:
HYP W50/1

Date:
12th April 2013

Ms Anne Dillon
Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Madam

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS – RAYCHEL FERGUSON GOVERNANCE

I refer to your letter of 18th February 2013 and in particular section 1 (a) – (z) thereof. I am instructed that the following Protocols, Guidelines, Guidance and Practice Documents were in place at Altnagelvin Hospitals H & SS Trust in and around 2001-2002 (where appropriate, I have also included details of who would have held responsibility for the implementation and monitoring of such protocols and guidance etc.):-

1a. Corporate structures
We have previously furnished the Inquiry with details of the Altnagelvin Hospital Corporate Structures for this period. I can confirm that the Structure as outlined in Inquiry letter reference AD-0526-13 is correct as per my email of 22nd March 2013 and correspondence of 26th March 2013.

The Chief Executive would have held responsibility for the implementation and monitoring of Corporate structures.

I also attach a copy of a letter dated 27th June 2005 which was originally sent to the Inquiry Solicitor, Fiona Chamberlain by Altnagelvin H & SS Trust: points 1 and 2 thereof explain the Accountability arrangements for Altnagelvin H & SS Trust.

1b. The use of Solution 18
The Trust can confirm that there were no written protocols, guidelines, guidance or practice documents in place at Altnagelvin in or around 2001-2002 regarding the use of Solution 18.

1c. Paediatric patients
Further to your email dated 28th February 2013, I confirm that the Trust is not aware of there having been any written clinical protocols in place, at that time, in relation to post-op fluid management, blood or urine testing, or other post-op management regarding paediatric patients.

1d. Complaints procedures
Please find attached copy Procedure for Handling Complaints, Enquiries and Commendations reviewed in October 1996, April 1998, March 2002 and February 2005.
The Chief Executive would have held responsibility for Complaints procedures. The Patient Advocate Department would have had responsibility for the day-to-day management of the implementation and monitoring of the Trust's Complaints procedures.

1e. Claims Management
Please find attached copies of a Claims Management Policy (undated and incomplete copy) and a Policy for the Management of Clinical Risk October 1997 which both refer to Claims Management.
The Chief Executive would have held responsibility for Claims Management Policy. The Risk Manager would have had responsibility for the day-to-day management of the implementation and monitoring of the Trust's Claims Management procedures.

1f. Administration of drugs and intravenous medicines
Please find attached copy Policy in relation to the Control and Administration of Medicines dated March 2000.
The Head of Pharmacy would have held responsibility for the implementation and monitoring of Administration of Drugs and Intravenous Medicines Protocols and Guidance.

1g. Communication between clinicians
Please refer to the section entitled 'Relationships with other Staff' at page 3 of the Junior Doctor's Handbook 2001 previously provided.
The Post Graduate Dean would have been responsible for signing off the content of information held within the Junior Doctor's Handbook.

1h. Nursing care plans
In 2001 care plans would have been managed by the individual Directors. The Trust had adopted the 'DM Nurse' computer system which was an Information Technology programme used by nursing staff to electronically record nursing care plans for individual patients. DM (DataMed) was the name of the original company who developed it. Nursing Staff were fully trained in the use of this programme.

I am instructed that the programme contained no Protocols/Guidance relating to nursing care plans themselves. It did, however, contain a library of generic care plans which could be used and adapted to suit the patient's individual needs.
There was an implementation team in place to manage the roll out of the system across the Trust.

1i. Handover
There were no written protocols or guidance regarding Handovers. Medical Handover is referred to at page 4 of the Junior Doctor's Handbook 2001 which has already been provided to the Inquiry. Nursing Handover would have been the responsibility of the Clinical Service Managers to lead on and Ward Sisters would have been involved in ensuring that this had been carried out.

1j. Surgical procedures
Please refer to pages 17 and 18 of the Junior Doctor's Handbook regarding Consent and Theatre Lists.
The Chief Executive would have held overall responsibility for Surgical procedures.

1k. Blood/electrolyte testing
There was no prescriptive written protocol for pre-operative blood testing in children, at the time. The custom and practice would have been that, where possible, sick children would have had a full blood count and electrolytes sample. However, this would have depended on the child's co-operation.

I also refer to our response to the Inquiry's letter dated 26th February (AD-0510-13) in relation to the query regarding Urine Direct Microscopy. Please also refer to page 26 of the Junior Doctor's Handbook August 2001 regarding Laboratory Services.

1l. Vomiting in paediatric patients
See response to 1(c) above, in relation to 'other post-op management regarding paediatric patients .'

1m. Fluid balance and observations
As per 1(c) above.

1n. Weighing of paediatric patients
It was (and still is) hospital policy that all paediatric patients were weighed on admission. Each individual clinician was responsible for their own practice to ensure that weighing of paediatric patients was carried out on admission.

1o. Division of responsibility within the hospital, including responsibilities of senior clinicians
See response 1(a) above.
The Chief Executive would have held overall responsibility for the implementation and monitoring of the division of responsibility within the hospital, including the responsibilities of senior clinicians.

1p. Records/record keeping
There are no written protocols/guidelines on records/record keeping for staff above JHO Level. For JHO staff, please refer to page 14 of the Junior Doctor's Handbook August 2001. We shall forward copy Guidance for nurses on record keeping, upon receipt of same from our Client.

1q Adverse clinical incident/critical incident reporting, audit, review and investigation
I attach a copy of the Clinical Incident Policy (February 2000). I also attach copy document dated 7th September 1998 entitled 'Proposed Strategy for Implementing Clinical Governance'.

The Chief Executive would have held overall responsibility for the implementation and monitoring of adverse clinical incident/critical incident reporting, audit, review and investigation.
The Risk Management Co-ordinator would have had responsibility for the day-to-day management of the implementation and monitoring of the Trust's adverse clinical incident/critical incident reporting, audit, review and investigation.

1r. Clinical risk management
Please find attached the Trust's Policy for the Management of Clinical Risk dated October 1997 and Proposed Strategy for Implementing Clinical Governance.
The Chief Executive would have held overall responsibility for the implementation and monitoring of Clinical Risk Management.
The Risk Management Co-ordinator would have had responsibility for the day-to-day management of the implementation and monitoring of the Trust's Clinical Risk Management Policy.

1s. Audit/consent
The Trust had no written Protocols, Guidelines, Guidance or Practice documents in relation to Clinical Audit.
Clinical Audit information has already been provided to the Inquiry (see response 2j of our letter of even date relating to section 2 of AD-0529-13). Regarding Consent, the Trust is satisfied that it operated in accordance with the Management Executive Circular relating to Consent (Inquiry reference 306-058-002). It is clear from the Medical Records that the

Consent form used in relation to Raychel was identical to that which appears at Appendix A (1) of the Circular.
The Chief Executive would have held overall responsibility for the implementation and monitoring of Audit and Consent.

1t. Assessment/appraisal of clinical performance
There were no written Policy, Protocols or Guidelines Assessment/appraisal of clinical performance, as this was the professional responsibility of each individual clinician.
I would ask you to note that, by virtue of Departmental Circular HSS (TC8) 3/01, medical appraisal for Consultant Staff was introduced into Northern Ireland in April 2001.

For Junior staff guidance on the importance of appraisal was included in pages 6 and 7 of the Junior Doctor's Handbook August 2001 (already provided to the Inquiry). Please also can you refer to the Job Description provided (in response to question 2 of request AD-0529-13) for the role of Clinical Director in relation to the assessment/appraisal of clinical performance.

The Trust also instructs me that it complied with the Department of Health Guidance 'Confidence in the Future'- Management of Consultant Performance in Northern Ireland. I also refer to the letter dated 27th June 2005 to the Inquiry referenced at 1(a) above.
Please find attached a copy of 'Confidence in the Future'- Management of Consultant Performance in Northern Ireland.

1u.Transfer of patients between hospitals
There was no Altnagelvin Hospitals H & SS Trust written policy in existence in 2001 for the Transfer of Patients between hospitals.

1v. Mortality/morbidity meetings and reviews
There were no written Protocols, Guidelines, Guidance and Practice documents in place at Altnagelvin Hospitals H & SS Trust in and around 2001-2002 in relation to mortality/morbidity meetings and reviews.
These meetings were professionally led within Departments, with initially only Medical staff in attendance, then over time the meetings included other Clinical staff. The frequency of the meetings varied within Departments and were normally held at least monthly. Patient information was anonymised.

The Clinical Director of each Department would have held responsibility for the implementation and monitoring of mortality/morbidity meetings and reviews.

1w. Communication with parents of deceased patients
There were no written Protocols, Guidelines, Guidance and Practice documents in place at Altnagelvin Hospitals H & SS Trust in and around 2001-2002 in relation to the communication with parents of deceased patients.
However, there were many examples of established good practice within the Hospital, for example, the A&E Department where Senior Staff offered to meet with families when a sudden/unexpected death had occurred. Also, certain Consultants individually wrote letters of sympathy with invitations to meet with the family.

1x. Bereavement
The Trust is not aware of the existence of a Bereavement Policy for Altnagelvin Trust for June 2001. The only relevant document found is the Altnagelvin Trust 'Protocol for Performance of Last Offices'(MAPCKT 3/1997) but it does not contain guidance for staff on the death of a child. Please find a copy of same attached, for your information.

1y. Whistleblowing
There were no written Protocols, Guidelines, Guidance and Practice documents in place at Altnagelvin Hospitals H & SS Trust in and around 2001-2002 in relation to Whistleblowing. However, the Trust did have a 'hotline' in place which allowed staff to anonymously raise concerns.

1z. Competences of new nurses and doctors from outside UK
Please refer to the attached letter from the Trust to Fiona Chamberlain dated 27th June 2005, point 4 of which deals with the competences of new nurses and doctors from overseas working at Altnagelvin Hospitals Health and Social Services Trust. The competency of overseas doctors is the responsibility of the GMC. You may wish to contact the GMC regarding this point.

A response will follow from our Ms Bolton in relation to point 2 of your above-referenced letter.

Yours faithfully

AM Crawford

Angela Crawford
Solicitor

Encs.

AM-0529-13

1. All protocols, guidelines, guidance or practice documents in place at Altnagelvin in or around 2001-2002 (to include information regarding who would have held responsibility for the implementation and monitoring of such protocols etc) in relation to	
1a. Corporate structures;	✓
1b. The use of Solution 18;	✓
1c. Paediatric patients;	✓
1d. Complaints procedures;	✓
1e. Claims management;	✓
1f. Administration of drugs and intravenous medicines;	✓
1g. Communication between clinicians;	✓
1h. Nursing care plans;	✓
1i. Handovers;	✓
1j. Surgical procedures;	✓
1k. Blood/electrolyte testing;	✓
1l. Vomiting in paediatric patients;	✓
1m. Fluid balance and observations;	✓
1n. Weighing of paediatric patients;	✓
1o. Division of responsibility within the hospital, including responsibilities of senior clinicians;	✓
1p. Records/ record keeping;	✓
1q. Adverse clinical incident/critical incident reporting, audit, review and investigation;	✓
1r. Clinical risk management;	✓
1s. Audit; consent;	✓
1t. Assessment/appraisal of clinical performance;	✓
1u. Transfer of patients between hospitals;	✓
1v. Mortality/morbidity meetings and reviews;	✓
1w. Communication with parents of deceased patients;	✓
1x. Bereavement;	✓
1y. Whistleblowing;	✓
1z. Competencies of new nurses and doctors from outside UK.	✓

2. All AHHSST documentation and/or files pertaining to the case of Raychel Ferguson including:	
2a. Job descriptions of all those involved in the care and treatment of Raychel Ferguson, including all Clinical Directors and individuals sitting on the Hospital Executive	
2b. Annual Reports for the years 1999-2003	
2c. The Altnagelvin Doctors Handbook for the years 1999-2003. Presently the Inquiry has only the copies issued in August 2001 & August 2002.	
2d. All Public Relations/Media Interest/Corporate Affairs files pertaining to the case of Raychel Ferguson or other hyponatraemia cases	
2e. Files in relation to the UTV Insight broadcast	
2f. Trust legal representatives files in relation to Raychel's treatment and death, her Inquest and the civil action taken by her mother.	
2g. Trust management and staff files in relation to the above, to include the Risk Management Co-Ordinator's files.	
2h. Neuropathology files	
2i. Trust Investigation/Review files	
2j. All relevant minutes of Board Meetings and committees meetings (to include the Medical Records and Audit Committees) which took place during the period 1999-2003	
2k. Minutes of Critical Incident Meetings between 1999 and 2003	
2l. Paediatric care strategy documents	
2m. Clinical and Social Care Governance Reports for the years 1999-2003	
2n. Reporting to the National Confidential Enquiry into Patient Outcome and Death	
3. Additionally please confirm:	
3a. Whether Altnagelvin Hospital or the AHHSST had obtained accreditation in 2001 and if so from whom. If not, please confirm the stage, if any, the hospital or Trust was in the accreditation process. Who was responsible for the inspection and supervision of this process?	
3b. What medical textbooks were available on Ward 6, or any other textbooks of Paediatrics at the time?	
3c. The role of the Post-Graduate Deanery (to include any and all documentation in relation to the same)	