

# **Directorate of Legal Services**

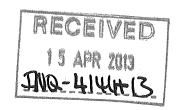
PRACTITIONERS IN LAW TO THE
HEALTH & SOCIAL CARE SECTOR

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

Your Ref: AD-0529-13 Our Ref: HYP W50/1 Date:

15<sup>th</sup> April 2013

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



Dear Madam,

#### RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS-RAYCHEL FERGUSON

I refer to your letter of 18<sup>th</sup> February 2013 and in particular section 2a – 3c thereof.

I am instructed as follows: -

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.

Please find attached job descriptions for the following:-

Director of Business – Raymond McCartney

Director of Personnel – Manus Doherty

Director of Estates - Alan Moore

Clinical Director – Surgery – Paul Bateson

Clinical Director - Pathology Referenced 14/03/2000 - Morris O'Kane

Director of Clinical Business Support - Thomas Melaugh

Director of Finance - Niall Smyth

Medical Director - Raymond Fulton

Unfortunately the Trust cannot locate Job Descriptions for the following: -

Providing Support to Health and Social Care







Stella Burnside – Chief Executive Irene Duddy – Nursing Director

## 2b. Annual Reports for the years 1999-2003

Please find enclosed photocopies of Altnagelvin Hospitals Health and Social Services Trust Annual Reports – 1998-99, 1999-00, 2001-02, 2002-03, and 2003-04.

2c. The Altnagelvin Doctors Handbook for the year 1999-2003. Presently the inquiry has only the copies issued in August 2001 & August 2002.

Please find enclosed Doctors Handbook for Period 2003. The Altnagelvin Doctors Handbook for the year 1999 is no longer available.

2d. All Public Relations/Media Interest/Corporate Affairs files pertaining to the case of Raychel Ferguson or other Hyponatraemia cases.

The Public Relations files have all been provided to the Inquiry and are on website in File 23.

2e. Files in relation to the UTV Insight broad cast.

See above 2d.

2f. Trust legal representatives files in relation to Raychel's treatment and death, her Inquest and civil action taken by her mother.

Please see separate correspondence.

2g. Trust management and staff files in relation to the above include the Risk Management Co-Coordinator's files.

All Trust files in relation to Raychel Ferguson have been provided to the Inquiry and are on the Inquiry's website in File 21 and 22.

2h. Neuropathology files.

The Trust does not hold Neuropathology files. These would be held by Pathology Services Belfast.

2i Trust Investigation/Review files.

Trust Investigation/Review files have been provided to the Inquiry and are contained within the Inquiry website in Files 21 and 22 and File 26 Dr Fulton.

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.

We have located all Trust Board Minutes for Altnagelvin Trust dated 1999-2003. These are held within 26 Lever Arch files. Staff members have been allocated the task of reviewing individual files and any relevant documentation will be forwarded in due course.

In relation to Audit Committee Minutes and documentation please find attached documentation which may be potentially relevant to the Inquiry.

#### 2k. Minutes of Critical Incident Meetings between 1999 and 2003.

The Trust launched its Clinical Incident Policy in February 2000. Details of Critical Incidents which relate to other Individuals and do not refer to Raychel Ferguson are not relevant.

#### 21. Paediatric care strategy documents.

The Trust operated in accordance with NAWCH. Please find attached The NAWCH Charter dated 1984.

2m. Clinical and Social Care Governance Reports for the years 1999-2003 Clinical and Social Care Governance Report from 1 April 2002 – 31 March 2003 was previously provided on 10 January 2012 reference BC-0073-11.

Please find enclosed Clinical and Social Care Governance Report from 1 April 2003 – 31 March 2004.

2n. Reporting to the National Confidential Enquiry into Patient Outcome and Death.

The consultant who was the NCEPOD reporter at that time has advised that paediatric deaths would not have been reported to NCEPOD. The criteria for NCEPOD reports were – "Deaths within 30 days of admission to the Hospital". NCEPOD have advised the Trust that the responsibility for reporting a death to NCEPOD lay with the Hospital in which the Patient died.

#### 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?

Please find attached a summary of accreditations which Altnagelvin had achieved from period 1999-2003. This information has been extracted from Annual Reports. The Trust is also currently seeking additional information on other accreditation.

# 3b. What medical textbooks were available on Ward 6, or any other textbooks of Paediatrics at the time?

There were two textbooks available on Ward 6 for period June 2001. These were Textbook of Paediatrics-Forfar and Arneil's 1992. And Nursing Care of Infants and children-Whaley and Wong - 1995.

### 3c. The role of the Post-Graduate Deanery (to include any and all documentation in relation to the same.

The Trust is not a Deanery. The Trust has a connection with (NIMDTA) Northern Ireland Medical and Dental Training Agency.

The Northern Ireland Medical and Dental Training Agency (NIMDTA) is responsible for funding, managing and supporting postgraduate medical and dental education within the Northern Ireland Deanery. It provides a range of services for those engaged in the delivery of postgraduate Medical and Dental education and training. This organisation allocates the Trainee Doctors to Altnagelvin Hospital.

Yours Sincerely

Joanna Bolton

Solicitor Consultant

RBCHO

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 Raychel Ferguson including:	of
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	2
2m. Clinical and Social Care Governance Reports for the years 1999-2003	
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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)	/

RF - INQ 321-004g-006