EXPERT BRIEF
GOVERNANCE ISSUES: RAYCHEL FERGUSON

Remit

1. We seek assistance with the following:

   (a) The provision of a detailed critique and overview of the governance issues arising from Raychel's case (excluding government or departmental level governance) whether deriving from:

      (i) An analysis of the documents, including the various statements and reports;

      (ii) Those protocols, guidelines, standards, systems or practices applicable in 2001 and which the Altnagelvin Hospital and/or the Royal Belfast Hospital for Sick Children may have been expected to note and/or comply with;

      (iii) The identification of any particular clinical governance structure, mechanism or governance policy that should have been in place;

      (iv) Consideration of the Inquiry's particular queries identified below.

   (b) You are asked to identify and (with the express approval of the Chairman) pursue any additional issues as may occur to you from the papers provided but which are not raised as specific questions in this Brief.

   (c) You are asked to advise on the following additional matters (if you think it necessary):

      - Particular lines of questioning that might be pursued with individual witnesses;

      - Specific documents that should be requested from individuals or organisations.

Queries

2. The Inquiry requires your guidance and opinion in relation to the following governance issues arising from Raychel's case.

   (a) The governance context of the case of Raychel Ferguson, and whether Altnagelvin, the Royal Belfast Hospital for Sick Children and their respective Trusts complied with the governance standards which might have been expected at the time;

   (b) The responsibilities and accountabilities of the employees of the Trusts from the Chief Executive down;

   (c) The nature of the responsibility (if any) of the Chief Executive for the quality of healthcare delivered in 2001 (prior to the introduction of statutory responsibility in 2003);

   (d) Whether there were failings in the regulatory systems of internal control and quality assurance at Altnagelvin and if so what they were;

   (e) Please include any comments you might wish to make regarding:

      (i) Raychel's transfer to the Royal Belfast Hospital for Sick Children;

      (ii) The way in which the Trust(s) managed their interaction with the Fergusons after Raychel's death (to include the sharing of information relating to the cause of death);

      (iii) The way in which the Trust(s) managed and approached the Inquest, to include the process of taking witness statements and the sharing of reports;

      (iv) The apparent failure of Altnagelvin Hospital Trust to supply Mr. and Mrs. Ferguson or HM Coroner with a copy of Dr. Warde's report or to refer to the initial reports of Dr. Jenkins and his reference in them to the need for further information in respect of vomiting and the conduct of the nurses;

      (v) The apparent failure of the Royal Belfast Hospital for Sick Children to alert Altnagelvin to their discontinuance of Solution 18 prior to the date of Raychel's death

(vi) The apparent failure of the Royal Belfast Hospital for Sick Children to communicate to Altnagelvin its assessment of the cause of Raychel's cerebral oedema and death (other than a reference by Altnagelvin Chief Executive that a PICU nurse had told a nurse at Altnagelvin that Raychel had received the 'wrong fluids');

(vii) The performance assessment of clinicians involved in the care of Raychel;

(viii) The standard and experience levels of junior doctors and nurses involved in the care and treatment of Raychel;

(ix) The standard of communication between clinicians;

(x) The system of education, training, mentoring and continuing professional education and development in operation at the time;

(xi) Staffing levels, workload, resourcing and recruitment;

(xii) The use of clinical protocols;

(xiii) The role of the Risk Management Co-ordinator in investigation, review, complaints procedures, litigation, Inquest and liaison with this Inquiry;

(xiv) Ethos, culture, experience and leadership.

Specific Questions

3. We should also be grateful if you would address the following specific questions either individually or in a broader discussion of governance relevancies and consequences:

(a) Whether adequate guidance was provided on medical care including communication between clinicians and specifically:

(i) Is there any evidence of systems being in place at Altnagelvin for the development of ward protocols (in respect of the management of post-surgical cases on ward 6) and for

monitoring, evaluating and revising any such protocols or ward practices that may have developed? What systems ought to have been in place having regard to the standards of 2001?

(ii) What guidance might have applied to junior surgical and anaesthetic staff in respect of the conduct of 'out of hours' surgery e.g. was it advisable to contact and/or confer with senior members or their respective teams before proceeding to carry out such surgery? How should the Trust have ensured compliance with any such guidance?

(iii) Whether the Trust ought to have implemented NCEPOD guidance or similar standards prior to June 2001, and if so, how ought that guidance have been applied in the circumstances of Raychel's case?

(iv) Whether the Trust ought to have had guidance in place to:

- Regulate the allocation of responsibility for the prescription of pre and post operative intravenous fluids?
- Determine the type and amount of intravenous fluids to be prescribed pre and post operatively?
- Regulate the monitoring and recording of fluid balance, electrolyte testing and observations, and for evaluating the continued appropriateness of a fluid regime?
- Monitor post-operative vomiting?
- Enable the nursing team to determine whether it was necessary to notify a surgical team about changes in a patient's condition?
- Ensure that the staff treating Raychel were familiar with any ward protocols or practices (reportedly) in place concerning fluid management, and whether any such protocols or practices were adequate?
- Assist junior surgeons in determining whether it was necessary to notify a senior colleague about changes in a patient's condition?

(v) Whether the systems that operated to regulate fluid management in Raychel's case were adequate?

(vi) What responsibilities ought to have been delegated to an on-call Consultant Surgeon at the time of Raychel's admission to the Altnagelvin Hospital?

(vii) What ought to have been the responsibilities of the Consultant Surgeon under whom Raychel was admitted, and should he have been informed of the admission, the reasons for it and significant developments?

(viii) What arrangements ought to have been in place for the purposes of:

- Allocating responsibilities within the surgical team in respect of Raychel's care and treatment, and whether there was sufficient clarity in terms of identifying who was responsible for Raychel's post-operative care and ensuring continuity of her care?

- Supervising junior members of the surgical team (such as Drs. Devlin and Curran), and for making available to them advice to assist them in their approach to Raychel's care, and whether the arrangements that were in place were adequate?

- Enabling junior members of the surgical team to notify their senior colleagues about changes in Raychel's condition, and whether the systems that operated were adequate?

- Enabling junior members of the surgical team to seek advice/input from other medical specialties in relation to Raychel's condition?

- Enabling the nursing team to notify surgical staff about any concerns they might have had in relation to Raychel's condition, and whether the systems that operated were adequate?

(ix) What was the purpose of a ward round and how and by whom should it have been carried out in Raychel's case, also considering the seniority and specialism of those who should have carried it out, the information that should have been

provided to those who carried it out, and the timing of it? Should there have been a "handover" in Raychel's case between medical teams and if so when and how should it have taken place?

(x) Was the programme of education and training provided at Altnagelvin to pre-registration and other junior doctors in relation to fluid management and post-surgical vomiting adequate by the standards of 2001 and what if any mechanism should have been in place to ensure that those trainees were achieving a satisfactory standard?

(xi) What steps ought to have been taken by the nursing team when contact with a doctor could not be established using the "bleeper" system, and what arrangements ought the hospital to have had in place to provide for a situation where the "bleeper" could not be answered by the doctor?

(xii) What was the purpose of "handovers" between nursing teams, and how should the handover of care in Raychel's case have been managed, having particular regard to the information that should have been exchanged especially when the night shift came on duty on the 8th June 2001?

(xiii) What information should have been communicated between Altnagelvin Hospital and the Royal Belfast Hospital for Sick Children prior to, upon her transfer to the Paediatric Intensive Care Unit and after her death, and the identity of those who should have been involved in those exchanges?

(b) Please comment, from a governance perspective, on the adequacy (or otherwise) of the medical and nursing notes and records with reference to contemporaneous guidance and expectation and the means available to ensure quality and completeness.

(In your report you are asked to describe the purpose and importance of making medical and nursing notes and records, and the guidance which was applicable to this task at the time. You are also asked to address whether the process of making notes and records should have been monitored within the Trust at that time, and to describe the steps that ought to have been taken to enforce compliance with professional standards. Finally, you are asked to comment on whether the notes

and records available in Raychel's case indicate any particular problem areas which the Inquiry should consider).

(c) Whether communication with the Ferguson family was appropriate at both Altnagelvin and the Royal Belfast Hospital for Sick Children, given the nature of Raychel's condition and her care needs, including whether the information given to the family was adequate during or in relation to:

(i) The diagnosis of appendicitis;

(ii) The taking of consent for the appendicectomy, including whether abnormal urine tests should have been discussed;

(iii) Care plans, treatment and prognosis at the time of admission and throughout the course of her treatment in Altnagelvin Hospital in the period from 7th June to the 9th June 2001, particularly at the times when Raychel was examined by nursing and medical staff;

(iv) The vomiting experienced by Raychel during the course of the 8th June 2001, the cause of that vomiting, its significance, severity and duration, together with comment as to how parental expression of concern about Raychel's condition should have been managed;

(v) Her seizure/collapse;

(vi) The decision to transfer Raychel to the Paediatric Intensive Care Unit ('PICU') of the Royal Belfast Hospital for Sick Children and the purpose of the transfer, particularly the possibility of surgical intervention there;

(vii) The period of admission in PICU (at the Royal Belfast Hospital for Sick Children) and at the time of her death;

(viii) The reasons for Raychel's deterioration and the cause of her death, and in particular the reasons and explanation (in the light of the information gleaned by the Critical Incident Review Investigation) given to the Ferguson family during the meeting convened by the Chief Executive of the Altnagelvin Trust on the 3rd September 2001;

(In your report you are asked to comment with reference to any guidance which was applicable at that time, on the general importance of communication between nursing/medical staff and the parents of a child who admitted to hospital, including the significance of listening to parents, and whether there was any requirement or good practice which indicated that nursing and medical staff should have been provided reasoned explanations to the parents in relation to the child's condition, treatment and care).

(d) Having regard to the importance of risk management and of any obligation to learn lessons from adverse incidents, whether the procedures adopted by the Altnagelvin Trust after Raychel's death were adequate, with particular reference to the Critical Incident Review undertaken at the Altnagelvin Hospital, including:

(i) The adequacy or otherwise of the Review undertaken at the Altnagelvin Hospital including the scope of the Review, the manner in which it was conducted, the personnel who participated in it, the methodology adopted, the expert analysis relied upon, the method of recording/minuting contributions and statements, the overall independence thereof, the sufficiency of the Action Plan, the examination of the broader systems and context of any failings, shortcomings or deficiencies, the absence of a written report, and the provision of' follow-up' to evaluate compliance with the Action Plan;

(ii) Whether the Review should have been informed by any discussion with the clinicians at Royal Belfast Hospital for Sick Children;

(iii) The extent to which Raychel's parents might have been involved in the Review process and informed as to its findings;

(iv) Whether all of the issues of concern which might have been identified arising out of Raychel's case were in fact identified, or whether additional issues of concern should have been identified and dealt with;

(v) In addition to the Critical Incident Review which was carried out, whether any other form of inquiry or investigation was necessary in order to comply with applicable guidance or good practice, including whether a formal audit was required, and

whether steps ought to have been taken to address the conduct or the competence of staff;

(In your report you are asked to explain the importance which regulatory bodies attached to the Critical Incident Review (or other form of review or investigation, and if applicable, an audit) at the time of Raychel's death, the manner in which such a Review should have been conducted, and by reference to any applicable guidance, a description of the standards to be complied with. You are also asked to address the question of whether the Royal Belfast Hospital for Sick Children ought to have examined this case with a view to learning lessons, and if so, identify the steps that should have been taken within that Hospital).

4. Whether appropriate steps were taken to disseminate relevant information arising out of the death of Raychel in order to:

(a) Advise staff in Altnagelvin/Royal Belfast Hospital for Sick Children as to the issues of concern which had been identified as arising from Raychel's treatment and death, and the lessons to be learned from her case;

(b) Assess and develop the competence of staff involved in Raychel's treatment at Altnagelvin, and other staff members who were likely to encounter similar circumstances in the course of their work;

(c) Inform HM Coroner;

(d) Communicate outcomes and lessons learned externally (i.e. to the wider Northern Ireland health community);

(e) Provide information to Trust management, the Western Health and Social Services Board and the Department of Health and Social Services and Public Safety and/or medical community;

(Arising out of these issues you are asked to explain the importance of disseminating information and lessons learned both internally and externally, the manner in which this should have been done, and by reference to any applicable guidance, a description of the standards that should have been complied with at the time. You are also asked to consider whether any other external organisation, such as the

National Confidential Enquiry into Perioperative Deaths, should have been notified of the circumstances of the death).

Conclusion

5. It is central to the workings of this Inquiry that it should receive clear advices on the matters raised in this Brief. Your report may form the basis for additional witness statement requests which the Inquiry may direct to those who had responsibility for the governance matters associated with Raychel's care. Moreover, you are liable to be questioned in relation to the contents of your report at the public hearings of the Inquiry. If any issue which has been raised with you falls outside of your area of expertise you should say so within the body of your report.

6. If any of the issues raised in this Brief cannot be addressed in a comprehensive fashion at this stage (for whatever reason) please explain the position and identify that which you require to furnish a final opinion.

7. The Inquiry has a large volume of materials available to it in relation to Raychel's case. An Appendix of the material provided to you is included with this Brief. If you believe that you require any additional class of documentation the Inquiry will attempt to obtain the same.

APPENDIX

Documents

1. We attach the following documents to provide a context and information for the preparation of your Report:

   (i) DVD of 'When Hospitals Kill' – UTV documentary that was shown in 2004;

   (ii) Inquiry Opening on the clinical aspects of Raychel's case - 1st February 2013;

   (iii) Opening on behalf of the Family - 1st February 2013;

   (iv) Coroner's Papers (File 12);

   (v) Altnagelvin Case Notes (File 20);

   (vi) Altnagelvin Individual File 1 (File 21);

   (vii) Altnagelvin Individual File 2 (File 22);

   (viii) Altnagelvin Communications and Media File (File 23);

   (ix) Altnagelvin Medical Negligence File (File 24);

   (x) Dr. Fulton's File (File 26);

   (xi) Royal Group of Hospitals' file for the Coroner (File 64);

   (xii) PSNI Witness Statements (File 95);

   (xiii) Additional PSNI papers (File 98 vol.1 and vols.2&3);

   (xiv) Expert Reports of Drs. Jenkins & Warde for the Trust (File 317);

   (xv) Expert Report- Simon Haynes (File 220);

   (xvi) Expert Report- Robert Scott-Jupp (File 222);

   (xvii) Expert Report- George Foster (File 223);

(xviii) Expert Report- Sally Ramsay (File 224);

(xix) DLS Correspondence- Governance (File 321);

(xx) DLS Correspondence (File 316).

2. Inquiry generated documents:

- Raychel Ferguson List of Persons;
- Chronologies – Clinical & Governance;
- Time line;
- Trainee doctors education and training;
- Nurses education and training.

3. Inquiry Witness Statements:

- Sister Elizabeth Millar (Ward Sister Altnagelvin) - WS/056/1 & WS/056/2;
- Staff Nurse Ann Noble – WS-049/1 & WS-049/2 & WS-049/3;
- Dr. Brian McCord (Consultant Paediatrician, Altnagelvin Hospital) – WS-032/1 & WS-032/2;
- Dr. Geoff Nesbitt (Consultant Anaesthetist and Medical Director, Altnagelvin Hospital) - WS-035/1;
- Dr. Raymond Fulton (Consultant Dermatologist and Medical Director, Altnagelvin Hospital) – WS-043/1 & WS-043/2;
- Mr. Robert Gilliland (Consultant Colorectal/General Surgery Altnagelvin Hospital) – WS-043/1, WS-044/2 & WS-044/3;
- Mr. John Orr (expert Paediatric surgeon for the Trust) - WS-320-1;
- Mrs. Stella Burnside (Chief Executive Altnagelvin HHSST) – WS-046/1;
- Dr. Dara O'Donoghue (Consultant Paediatrician/PICU Royal Belfast Hospital for Sick Children) - WS-040/2;
- Mr. John Leckey (HM Coroner) - WS-090/1;
- Dr. John Jenkins – WS-059/1
- Mr. Stanley Millar (Chief Officer Western Health & Social Services Council) - WS-093/1.

Documents issued to Prof Swainson subsequent to brief.

Name	Witness Ref No	Date Issued
Brian McCord	WS-032/1	30-Apr-13
Brian McCord	WS-032/2	30-Apr-13
Brian McCord	WS-032/3	17-Jul-13
Geoff Nesbitt	WS-035/1	30-Apr-13
Geoff Nesbitt	WS-035/2	09-Jul-13
Peter Crean	WS-038/3	09-Jul-13
Raymond Fulton	WS-043/1	30-Apr-13
Raymond Fulton	WS-043/3	09-Jul-13
Robert Gilliland	WS-044/1	30-Apr-13
Robert Gilliland	WS-044/2	30-Apr-13
Robert Gilliland	WS-044/3	30-Apr-13
Robert Gilliland	WS-044/4	09-Jul-13
Stella Burnside	WS-046/1	30-Apr-13
Stella Burnside	WS-046/2	09-Jul-13
Ann Noble	WS-049/1	30-Apr-13
Ann Noble	WS-049/2	30-Apr-13
Ann Noble	WS-049/3	30-Apr-13
Ann Noble	WS-049/4	09-Jul-13
E T Millar	WS-056/1	30-Apr-13
E T Millar	WS-056/2	30-Apr-13
E T Millar	WS-056/3	09-Jul-13
John Jenkins	WS-059/2	09-Jul-13
Stanley Millar	WS-093/1	30-Apr-13
Mr John Orr	WS-320/1	30-Apr-13
Threse Brown	WS-322/1	09-Jul-13
Irene Duddy	WS-323/1	09-Jul-13
Dr Parker	WS-324/1	09-Jul-13
Ann Doherty	WS-325/1	09-Jul-13
K Doherty	WS-326/1	09-Jul-13
J Hutchinson	WS-327/1	09-Jul-13
P Gerdiner	WS-328/1	09-Jul-13
Ann Witherow	WS-329/1	09-Jul-13
Dr Taylor	WS-330/1	09-Jul-13
Dr Carson	WS-331/1	09-Jul-13
Dr Ashenhurst	WS-333/1	09-Jul-13
Dr Melaugh	WS-334/1	09-Jul-13
Dr Denis Martin	WS-335/1	11-Jul-13
Margaret Doherty	WS-336/1	12-Jul-13
Dr Warde	WS-339/1	09-Jul-13
Dr Hicks	WS-340/1	09-Jul-13
Mr AP Walby	WS-341/1	09-Jul-13
Dr O'Hare	WS-343/1	10-Jul-13
Dr O'Hare	WS-343/3	10-Jul-13
Margaret Dooher	WS-344/1	22-Jul-13
Kathryn Little	WS-345/1	16-Jul-13
Mary McKenna	WS-346/1	17-Jul-13
Dr Anand	WS-347/1	16-Jul-13

FILE NO	CONTENT	Date issued
47	SLT – Mr Kevin Doherty, Westcare Litigation Manager	30-Apr-13
12	Coroners Papers	30-Apr-13
20	Altnagelvin – Raychel Ferguson Hospital Notes	30-Apr-13
21	Altnagelvin – Raychel Ferguson – Individual File 1	30-Apr-13
22	Altnagelvin – Raychel Ferguson – Individual File 2	30-Apr-13
23	Altnagelvin – Communications/Media File	30-Apr-13
24	Altnagelvin – Medical Negligence	30-Apr-13
26	Altnagelvin – Dr Fulton's File	30-Apr-13
63	Royal – Raychel Ferguson Contacts, Chronology of Care and Casenotes	14-Jun-13
64	Royal – Raychel Ferguson Papers Collated for Coroner	30-Apr-13
113	Raychel Ferguson – GP Notes (Only doc 008)	04-Jul-13
160	DLS Inquest File	30-Apr-13
161	DLS Inquest File Brangam & Co	
202	202 - Sally Ramsay – Expert	05-Aug-13
220	Dr Simon Haynes – Expert Paediatric Anaesthetic	30-Apr-13
222	Dr Robert Scott-Jupp – Paediatrician	30-Apr-13
223	George Foster – Expert Paediatric Surgeon	30-Apr-13
224	Sally Ramsay – Expert Nursing	30-Apr-13
251	Expert Governance – Prof Scally (Doc 002)	21-May-13
305	Inquiry Generated DLS Correspondence - Governance	05-Aug-13
306	Adam Strain Inquiry Generated Documents	05-Aug-13
312	Inquiry Generated Documents	30-Apr-13
314	Claire Roberts - Adhoc Governance Documents	05-Aug-13
317	Ad hoc Documents	30-Apr-13
321	DLS Correspondence - Governance	30-Apr-13