GOVERNANCE OPENING: RAYCHEL FERGUSON

THE ORAL HEARINGS IN THE INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

Chairman: O'Hara J

Banbridge Court House, August 2013

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I. Preamble

1. This Opening will seek to set out the principal governance issues in Raychel's case in the context of the evidence gathered to date, the revised Terms of Reference and List of Issues; and to identify the main areas which the Legal Team consider requires further investigation through questioning in these Oral Hearings.

The Inquiry's Terms of Reference

2. Raychel's name was included in the original Terms of Reference for the Inquiry as published on 1st November 2004 by Angela Smith MP (then Minister with responsibility for the Department of Health, Social Services and Public Safety).[1]

3. Those original Terms of Reference were:

> *"In pursuance of the powers conferred on it by Article 54 and Schedule 8 to the Health and Personal Social Services (Northern Ireland) Order 1972, the Department of Health, Social Services and Public Safety hereby appoints Mr. John O'Hara QC to hold an Inquiry into the events surrounding and following the deaths of Adam Strain and Raychel Ferguson, with particular reference to:*
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> *1. The care and treatment of Adam Strain and Raychel Ferguson, especially in relation to the management of fluid balance and the choice and administration of intravenous fluids in each case*
>
> *2. The actions of the statutory authorities, other organisations and responsible individuals concerned in the procedures, investigations and events which followed the deaths of Adam Strain and Raychel Ferguson*
>
> *3. The communications with and explanations given to the respective families and others by the relevant authorities."*[2]

4. As you are aware the then Minister of Health Mr. Michael McGimpsey MLA, revised the original Terms of Reference on 17th November 2008 to exclude entirely Lucy Crawford's name.[3]

5. Raychel's case is otherwise being investigated in the same terms as those of Adam and Claire. The Terms of Reference require investigation into the actions of the statutory authorities, other organisations and responsible individuals concerned in the procedures

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1 Now Baroness Smith of Basildon
2 Ref: 021-010-024
3 Ref: 303-033-460

and events that followed Raychel's death, including the explanations given to Raychel's family and others by the relevant authorities.

6. This Opening will seek to set out the information that has been received by the Inquiry in relation to governance issues. To assist in appreciating the key events in Raychel's case, the Inquiry has compiled a 'Consolidated Governance Chronology.'[4] Schedule 5 of this document sets out the events that particularly pertain to Raychel's case as well as other developments that relate to governance.[5]

Documents

7. The Inquiry made initial requests for information and evidence in 2005 and the call for documents has been ongoing since the resumption of the Inquiry's work in 2008. While much of this documentation will have been considered at Oral Hearing into clinical issues, it is relevant to set out those documents that have significance for governance issues.

8. To date the Inquiry has received significant material in relation to the governance issues arising in Raychel's case, including:

   (i) Documents held by the Coroner (Depositions from the Inquest into Raychel's death and Expert Reports commissioned by the Coroner)[6]

   (ii) Western Health and Social Services Council Papers[7]

   (iii) Documents held on behalf of Raychel's family[8]

   (iv) Medical Notes and Records in respect of the care and treatment of Raychel[9]

   (v) Altnagelvin Individual Files[10]

   (vi) Altnagelvin Communication and Media Files[11]

   (vii) Altnagelvin Medical Negligence Files[12]

   (viii) The Files of Dr. Raymond Fulton[13]

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4 Ref: 325-004-038
5 Ref: 325-004-038
6 Ref: 012-001-001 to 012-074-456
7 Ref: 014-001-001 to 014-024-053
8 Ref: 068-001-001 *et seq* & 068a-001-001 *et seq* & 068b-001-001 *et seq*
9 Ref: 020-001-001 to 020-028-069
10 Ref: 021-001-001 to 021-072-168 & 022-001-001 to 022-109-338
11 Ref: 023-001-001 to 023-097-228
12 Ref: 024-001-001 to 024-019-031
13 Ref: 026-001-001 to 026-019-047

(ix) Royal Group of Hospitals Papers[14]

(x) Altnagelvin Supplementary Papers[15]

(xi) Documents from the investigations of the Police Service of Northern Ireland ("PSNI")[16]

(xii) General Practitioner Notes[17]

(xiii) Regional Neuropathology Service Papers[18]

(xiv) Directorate of Legal Service ("DLS") Inquest Files[19]

(xv) Inquiry Generated Documents[20]

(xvi) Correspondence from the Directorate of Legal Service providing responses to the Inquiry's requests for information.[21]

9. The Inquiry has been referred to numerous publications and papers by its Advisors, Experts and Witnesses. The Legal Team has carried out its own research and has added publications and papers to the bibliography for Raychel's case that to date has largely comprised clinical material. The bibliography is available on the Inquiry website[22] and is updated.

Background Papers

10. In the Clinical Opening, reference was made to the commissioning of Background Papers by Experts to provide context for consideration of the evidence. Of particular relevance to the investigation into the governance issues involved in Raychel's case are the Background Papers of:

(i) Dr. Michael Ledwith,[23] Clinical Director of Paediatrics, Northern Trust and Professor Sir Alan Craft,[24] Emeritus Professor of Child Health, Newcastle University Education on the training and

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14 Ref: 063-001-001 to 063-038-098 & 064-001-001 to 064-066-194 & 065-001-001 to 065-015-030
15 Ref: 077-001-001 to 077-005-008
16 Ref: 095-001-001 to 095-020-092 & 098-002-001 to 098-384-1132
17 Ref: 113-001-001 to 113-031-035
18 Ref: 124-001-001 to 124-063-005
19 Ref: 160-001-001 to 160-244-018 & 161-001-001 to 161-066-017
20 Ref: 312-001-001 to 312-013-021 & 317-001-001 to 317-029-009
21 Ref: 321-001-001 to 321-055-001
22 Ref: Inquiry into Hyponatraemia-related Deaths website: 'Articles Index' under heading 'Key Inquiry Documents.'
23 'A Review of the Teaching of Fluid Balance and sodium management in Northern Ireland and the Republic of Ireland 1975 to 2009' Ref: 303-046-514
24 'A Review of the teaching of fluid balance and sodium management in Northern Ireland and the Republic of Ireland 1975 to 2009' Ref: 303-047-561

continuing professional development of doctors in Northern Ireland, the rest of the United Kingdom and the Republic of Ireland over the period 1975 to 2009.

(ii) Professor Mary Hanratty,[25] former Vice-President of the Nursing and Midwifery Council and Professor Alan Glasper,[26] Professor of Children and Young Person's Nursing, University of Southampton on the training and continuing professional development of nurses in Northern Ireland, the rest of the United Kingdom and the Republic of Ireland over the period 1975 to 2011.

(iii) Dr. Bridget Dolan,[27] Barrister-at-Law and Assistant Deputy Coroner, on the systems of procedures and practices in the United Kingdom for reporting and disseminating information on the outcomes or lessons to be learned from Coroner's Inquests on deaths in hospital (involving Hospitals, Trusts, Area Boards, Department of Health and Chief Medical Officer)

(iv) Dr. J.W. Keeling, FRCPath, FRCP(Edin), FRCPCH, on the "*Dissemination of information gained by post-mortem examination following unexpected death of children in hospital.*"[28]

Expert Reports

11. In addition to the Experts retained by the Inquiry to deal with the clinical issues arising out of Raychel's case, Professor Charles Swainson has also provided a report on the governance aspects of the case.[29]

12. The Legal Team, together with the Inquiry's Advisors and Experts, have reviewed the reports of the experts engaged by the Coroner, and the PSNI namely those from:

(i) Dr. Edward Sumner[30] (Consultant Paediatric Anaesthetist at Great Ormond Street Children's Hospital) who provided a report to the Coroner on 1st February 2002[31] and provided various reports to the PSNI[32]

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25 'Chronology of Nurse Education in Northern Ireland – Comparisons with UK mainland and Republic of Ireland 1975 to date' Ref: 303-048-571

26 'A Selective Triangulation of a Range of Evidence Sources Submitted to Explain the Chronology of Nurse Education in Northern and England with Reference to the Teaching of Record Keeping and the Care of Children Receiving Intravenous Infusions 1975 to date' Ref: 303-049-674

27 'Report to the Inquiry into Hyponatraemia-Related Deaths' Ref: 303-052-715

28 Ref: 308-020-295 *et seq*

29 Ref: 226-002-001 *et seq*

30 See List of Persons Ref: 312-003-001

31 Ref: 012-001-001

32 Ref: 098-081-235, Ref: 098-081-244, Ref: 098-098-373

(ii) Ms. Susan Chapman[33] (Nurse Consultant for acute and high dependency care at Great Ormond Street Children's Hospital) who provided a report to the PSNI dated 24th September 2005[34]

(iii) Dr. Clodagh Loughrey[35] (Consultant Chemical Pathologist, Belfast City Hospital) who provided a report to the Coroner dated 24th October 2001[36]

(iv) Dr. Brian Herron[37] (Consultant Neuropathologist, Royal Group of Hospitals) who provided the Autopsy Report following post-mortem on 11th June 2001.[38]

13. The Inquiry has also had the opportunity to consider the views expressed in various medical reports obtained by the former Altnagelvin Group of Hospitals Trust from the following experts:

(i) Dr. John Jenkins[39] (Senior Lecturer in Child Health and Consultant Paediatrician) who provided reports dated 12th November 2002[40], 27th January 2003[41] and 30th January 2003[42]

(ii) Dr. Declan Warde[43] (Consultant Paediatric Anaesthetist) who provided a report dated January 2003.[44]

Witness statements

14. The Legal Team has requested and received a large number of Witness Statements from others involved in Raychel's case. The Legal Team has been informed in that task by:

(i) The Inquiry's Advisors

(ii) Medical notes, records and other contemporaneous material

(iii) Previous statements made, whether through Depositions to the Coroner, Statements taken by the PSNI or Witness Statements to the Inquiry

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33 See List of Persons Ref: 312-003-001
34 Ref: 098-092a-328
35 See List of Persons Ref: 312-003-001
36 Ref: 014-006-014 *et seq*
37 See List of Persons Ref: 312-003-001
38 Ref: 014-005-006 *et seq*
39 See List of Persons Ref: 328-001-006
40 Ref: 317-009-002 *et seq*
41 Ref: 160-215-002
42 Ref: 317-009-004 *et seq*
43 See List of Persons Ref: 328-001-006
44 Ref: 317-009-006 *et seq*

(iv) Statements from others and in some cases the evidence of others during the Oral Hearings

(v) Subsequent documents and information received from the DLS and a variety of other sources

(vi) Reports from the Inquiry's Experts.

15. The Legal Team has compiled a list of all those involved in the governance aspect of Raychel's case from the information received by the Inquiry.[45] It identifies positions held, briefly summarises roles, and indicates whether they have provided a statement and if so for whom. Additionally it also identifies those Witnesses who may be called to give evidence during the Oral Hearings.

16. As with the evidence of witnesses to the Clinical Hearing, it is entirely possible for the evidence provided in a Witness Statement to be sufficient on a given issue, particularly where it is not contradicted or where it is clear from an Expert Report that further questioning of the Witness would not be useful. Should the evidence in a Witness Statement be regarded as sufficient, then it will accepted as the evidence of that Witness. The Inquiry Witness Statement, PSNI Statement or Deposition, as the case may be, of those who are not being called will be tendered as an unchallenged account.

17. In due course the Legal Team will compile a Schedule of all those whose evidence is tendered in that way. It will be a matter for you, Mr. Chairman, whether you nonetheless wish a Witness to be called.

Oral Testimony

18. Finally, there are the accumulated Transcripts of the Inquiry's Oral Hearings.[46] For the most part it will not be necessary for that oral evidence to be set out to any great extent because, Mr. Chairman, you have already had the benefit of hearing it first hand and, in many cases, of questioning the witnesses yourself.

Defining Governance

19. The 'governance' issues arising out of the Inquiry's revised terms of reference are being considered at three 'levels':

(i) Hospital management and clinical governance

(ii) Corporate or trust level and

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45 Ref: 328-001-006

46 Ref: On the Inquiry website, under heading of 'Oral Hearings- Timetable'

(iii) Government or departmental level within the Health and Social Care (HSC).

20. In general, the Inquiry Team has interpreted 'clinical governance' as the system rendering hospitals accountable for continuously monitoring and improving the quality of healthcare and services and safeguarding standards. This system largely operates at the clinical level, with reporting lines to Directorate and Trust Directors.

21. The Inquiry Team has adopted the term 'clinical governance' to encompass the range of activity to maintain and improve the quality of the care provided to patients and to ensure full accountability. On the 'management' side, the Inquiry understands that the term embraces the leadership, procedures and systems required to maintain high quality services to patients and for which they are accountable.

22. Insofar as 'corporate' or 'Trust level' governance is concerned, the Inquiry considers that it is important to examine the governance structures and processes which existed between the clinical Directorates and a Trust board, and between the Trust, the area Health and Social Services Board and the Department of Health, Social Services and Personal Safety in Northern Ireland. This third, Departmental level of governance, will be considered separately by the Inquiry.

List of Governance Issues

23. The issues raised by the Terms of Reference are reflected in the Inquiry's List of Issues. The List of Issues is a working document which is updated and revised as appropriate. The current List of Issues was published by the Inquiry on 14th February 2012.[47] The governance issues arising in Raychel's case may be broadly categorised as:

(i) Investigation into the quality of the information provided to Raychel's next-of-kin whilst she was in Altnagelvin Hospital and the Royal Belfast Hospital for Sick Children ("RBHSC") in 2001

(ii) Investigation into the processes and systems of teaching/ training then available to clinicians

(iii) Investigation into the extent to which procedures and practices in Northern Ireland for the reporting and dissemination of information to the DHSSPS and the medical community in general in relation to unexpected deaths in hospital and the

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47 Ref: Revised List of Issues - Inquiry into Hyponatraemia-related Deaths website, under 'Key Inquiry Documents'.

outcome of Coroners' Inquests, had changed by the time that Raychel died in 2001

(iv) Investigation into the steps taken by the Altnagelvin to investigate the causes of Raychel's death, disseminate information about it and address the procedures for safe fluid administration, including an investigation into the information that was actually provided to the DHSSPS and the medical community in general on the death of Raychel in 2001 including:

- The steps taken by Altnagelvin to investigate the causes of Raychel's death and what conclusions were reached
- The steps taken by Altnagelvin to disseminate information about Raychel's death both internally and to other parts of the medical community, the adequacy of any steps taken and the adequacy of any information that was disseminated
- The steps taken to address the procedures for safe fluid administration in the Altnagelvin after Raychel's death, and whether the steps which were taken were adequate
- The extent to which dissemination of information relating to Raychel's death followed the procedures or practices that were in place at the time
- Those channels of communication made available by Altnagelvin to the Ferguson family so that they could learn about the cause of Raychel's death, and what were they told or learned
- Extent to which Altnagelvin provided the Ferguson family with an adequate explanation of the events which led to Raychel's death.

II. Corporate Structure

24. Organisational structure may be most effective when it supports an organisation's purpose. Structure should reflect the allocation of accountability and responsibility and be designed to support healthcare systems.

25. The Altnagelvin Hospitals Health and Social Services Trust ("AHHSST") was established by Order of Parliament on 1st April 1996.[48] Fully accountable to the Northern Ireland Department of Health

[48] Ref: 321-004gj-008

and Personal Social Services ("DHSSPSNI"),[49] in 2001 the AHHSST provided a wide range of acute hospital services in the Altnagelvin Area Hospital ("Altnagelvin") which was the major district general hospital in the North West offering *"the most comprehensive and complex range of services of any hospital outside Belfast."*[50]

26. The AHHSST's main commissioner of services was the Western Health and Social Services Board ("WHSSB").[51] The relationship between it and the AHHSST was described as one of 'Purchaser-Provider' governed by a Service Agreement.[52] While the AHHSST operated independently from the WHSSB, it maintained close links with the Board *"to ensure that the services it provides meets the needs of the resident population."*[53] In the AHHSST Annual Report for 1999-2000 the then Chairman, Mr. Denis Desmond, described the existence of a *"spirit of co-operation and partnership with colleague Trusts, General Practitioners, the Western Area Health and Social Services Council, and our commissioning partners, Western and Northern Health and Social Services Boards, to enhance the quality and quantity of care for the population."*[54] Review and oversight of the AHHSST was provided by the Western Health and Social Services Council ("WHSSC"), which was established in 1991, pursuant to Section 15 of the 'Health and Social Services Councils Regulations (Northern Ireland) 1991' the Western Health and Social Services Council ("WHSSC") was established specifically to *"keep under review the operation of the health and personal social services in its area and to make recommendations for the improvement of these services."*[55]

27. The AHHST was directed by a Board of Executive and Non-Executive Directors, which bore responsibility for setting and delivering overall policy and strategy, and maintaining the financial viability of the AHHST.[56] Mrs. Stella Burnside, Chief Executive of the AHHSST, and the *"Accountable Officer for the organisation"*[57] was *"responsible for the management and leadership of the services provided by the organisation"* and *"bore ultimate responsibility for the overall quality and quantity of the services we provided."*[58]

28. "*Trust Chief Executives reported individually and collectively through regular meetings to a Senior Officer within the Permanent Secretary's*

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49 Ref: 321-004fa-001
50 Ref: 321-004gj-008
51 Ref: 321-004fa-001
52 Ref: 321-028-002 *et seq*
53 Ref: 321-004fa-002
54 Ref: 321-004gk-004
55 Ref: WS-093/1 p.2
56 Ref: 321-004gj-010
57 Ref: WS-046/1 p.3 & Ref: 321-050-002
58 Ref: WS-046/2 p.8

department on issues within their Trusts."[59] The Chief Executive was also accountable to the General Manager of the WHSSB for the *"leadership and management of the hospital organisation, the maintenance of efficient services and effective financial management"*[60] and *"directly to the Chairman of the Trust Board."*[61] The Executive Directors were Miss Irene Duddy (Director of Nursing), Dr. Raymond Fulton (Medical Director), Mr. Raymond McCartney (Director of Business Services) and Mr. Niall Smyth (Director of Finance).[62]

29. The AHHSST Annual Report for 1999-2000 described the management structure in place during that period as *"A senior management team (Hospital Executive) [is] responsible for ensuring the implementation of the policies and strategy set by the Trust Board. At this level, the Executive Directors are joined by the Trust's Director of Personnel (Mr. Manus Doherty), the Director of Estates (Mr. Alan Moore), and the Director of Clinical Support Services (Mr. Thomas Melaugh)."*[63] Responsibility for overseeing the day-to-day operational management of the AHHSST is described as having rested with the Hospital Management Team.[64] *"This team includes a number of Clinical Directorates which are each managed by a Clinical Director and a Clinical Services Manager."*[65] The Hospital Management Team *"met each month and all the Clinical Directors and Service Managers together with Hospital Executive members would be able to discuss the issues facing the organisation."*[66]

30. It should be noted that *"The Chief Executive would have held responsibility for the implementation and monitoring of Corporate structures"*[67] and ensuring *"the development of a management system that secured accountability (Clinical Directorate model)."*[68] As an aid to understanding the corporate structure the Inquiry has produced a diagram representing the *"Organisational Structure AHHSST 2001-2002"*[69] setting out the lines of responsibility and accountability in the AHHSST at the time of Raychel's admission. There were seven Clinical Directorates: Surgery & Critical Care, Woman & Children's Care, Medical and Ambulatory Care, Pathology, Medical Imaging, Pharmacy and Hospital Sterile and Disinfecting Unit and Clinical Support Services. The two Directorates with greatest relevance to Raychel's case were the Surgery & Critical Care, and Women & Children's Care Directorates,

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59 Ref: WS-286/2 p.4
60 Ref: WS-046/2 p.5
61 Ref: WS-046/2 p.5
62 Ref: 321-004gj-010
63 Ref: 321-004gj-011
64 Ref: 321-004gj-011
65 Ref: 321-004gj-011
66 Ref: WS-035/2 p.4
67 Ref: 321-004f-001
68 Ref: WS-046/2 p.5
69 Ref: 312-014-001

which may be seen in this organisational setting. The Directors were Mr. Paul Bateson FRCS (deceased) and Dr. Denis Martin, Consultant Obstetrician and Gynaecologist, respectively.[70] The role of Clinical Director is described by Dr. Nesbitt[71] as *"primarily a leadership role within the department"* and *"issues relating to standards of care or poor performance would be directed to the Clinical Director in the first instance."*[72]

31. The Surgery & Critical Care Directorate had overall responsibility for the provision of Raychel's surgical procedure. It is unclear, however, the extent to which the Women & Children's Care Directorate was responsible for the provision of care and treatment to Raychel as a paediatric patient on Ward 6. The Paediatric Department appears to have been a sub-division of the Women & Children's Care Directorate under the supervision of Mrs. Margaret Doherty, the Clinical Services Manager.[73] However, Dr. Denis Martin has informed the Inquiry that *"I had no involvement in Paediatric clinical care as Clinical Director... I did not, as far as I am aware, have overall responsibility for the provision of Paediatric care in Ward 6."*[74] The efficacy of these structures will be a matter to be explored during the Oral Hearings.

32. The Clinical Directors of these Directorates would have been *"responsible and accountable to the lead Clinical Director for all resources within his/her Specialty whether human, financial or physical and for all outcomes from the deployment of these resources both in terms of quantity and quality."*[75]

33. The Medical Director of the AHHSST at the time of Raychel's admission was Dr. Raymond Fulton, whose *"Principal Responsibilities"* were:

- *"To secure wide input to medical policy and strategy through the Chairmanship of a Clinical Directors forum*
- *In conjunction with the Director of Nursing to promote the development of clinical audit within the Trust as a means of examining the outcomes of care provided by the Trust*
- *To facilitate effective communication between the clinicians and management*

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70 Ref: 312-014-001
71 Clinical Director in Anaesthesia and Critical Care and, subsequently, Medical Director, AHHSST
72 Ref: WS-035/2 p.4
73 Ref: 321-022-001
74 Ref: WS-335/1 p.3
75 Ref: 321-004gd-001; Job Description

- *To advise the Trust on medical workforce policy including staffing levels, changes in working patterns and skill mix which will ensure the delivery of effective and efficient clinical services to the patient*

- *To ensure that professional standards are maintained in the provision of medical services within the general guidance issued by the Department of Health and Social Services and within the terms of contracts with purchasers*

- *To promote a multi-disciplinary approach to clinical services."*[76]

34. Dr. Fulton has explained that he was "*responsible to the Trust for monitoring the quality of medical care at Altnagelvin."*[77] He led the team tasked with investigating any serious clinical incidents[78] and advised the Trust Board on medical issues, complaints, clinical incidents, disciplinary action against doctors (including appraisal), and provided medical advice on litigation.[79] The role of Medical Director was "*an evolving one but essentially consisted of elements relating to corporate responsibility, leadership and clinical governance*"[80] and involved liaison "*between the medical workforce and management.*"[81] Dr. Nesbitt succeeded Dr. Fulton in this role in March 2002.[82]

35. In 1998-1999 Miss Irene Duddy, as Director of Nursing, assumed responsibility for the Department of Nursing and Risk Management to reflect an evolved clinical governance agenda[83] and held meetings with the Clinical Services Managers on a monthly basis.[84] Together with the Medical Director, Miss Duddy was accountable to the Board for clinical audit, quality of care and overall risk management[85], although it was the Risk Management Co-ordinator ("RMCO") Mrs. Therese Brown, who was charged with management responsibility for "*Trust wide risk management culture with the co-ordination of risk identification, analysis, control and audit activity.*"[86] From 2003, in her subsequent post of Risk Management Director, Mrs. Brown became "*operationally responsible for the management of clinical incidents, clinical negligence claims and inquests... [and] therefore aware of any Trust wide learning which arises from any of these sources... she is responsible for ensuring that the information is communicated within the Trust.*"[87] Mrs. Anne Witherow served as the

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76 Ref: 321-004gh-005-7
77 Ref: WS-043/1 p.3
78 Ref: WS-043/1 p.3
79 Ref: WS-043/1 p.3
80 Ref: WS-035/2 p.4
81 Ref: WS-035/2 p.4
82 Ref: WS-035/2 p.3
83 Ref: WS-323/1 p.2
84 Ref: WS-323/1 p.4
85 Ref: WS-323/1 p.3
86 Ref: 321-004fg-004
87 Ref: 321-004fa-006

Clinical Effectiveness Co-ordinator, responsible for leading on standards and guidelines and managing the Audit team.[88]

36. It is of note that, at a Hospital Management Team meeting held on 10th April 2001 *"Mrs. Burnside suggested that as it is now six years since the directorate structure was created, it would be worthwhile to now review this to assess if the structure is appropriate for its purpose and if it aids delivery of Trust objectives"*[89] and advised that she *"would like views from Hospital Management Team in relation to relationships, structures, performance, educational/developmental standards, accountability etc."*[90] Detailed responses were requested by 27th April 2001. Whether the structures were assessed as adequate for purpose, and whether changes could and should have been made in the months before Raychel's admission, will be matters further explored during the Oral Hearings.

III. Clinical Governance Context: June 2001

37. The DHSSPSNI set out its proposals for new clinical governance arrangements in its 'Best Practice – Best Care' Consultation paper in April 2001. It suggested *"a system of clinical and social care governance, backed by a statutory duty of quality"* noting that *"governance arrangements are already in place to ensure overall probity, transparency and adherence to public service values."* It proposed a system of *"clinical and social care governance [that] will bring together all the existing activity to the delivery of high quality services for example, education and research; audit; risk management and complaints management."*[91]

38. Anticipating these developments the AHHSST had announced in its Annual Report for 1998-1999 that *"From 1st April 2000 Chief Executives will be responsible for not only the financial performance of the Trust but will have clear accountability for quality in the clinical setting. In preparing to meet these responsibilities a clinical governance strategy has been developed at Altnagelvin which details the structures and processes required to ensure that patients will receive the highest quality of care with the best clinical outcomes."*[92]

39. As Professor Swainson, the Inquiry's Expert on governance, notes: *"Clinical governance has been part of the professional codes of conduct of doctors, nurses and midwives and other regulated healthcare professionals for many years predating these events although not specifically named as such."*[93]

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88 Ref: WS-322/1 p.5
89 Ref: 316-006e-005-6
90 Ref: 316-006e-005-6
91 Ref: WS-068/1 p.14
92 Ref: 321-004gi-044
93 Ref: 226-002-001

40. The AHHSST was experienced in clinical governance requirements. In 1999, it had entered into a Service Agreement to provide the WHSSB with acute hospital services and thereby undertook to devise a structured clinical governance programme within the AHHSST.[94] It had accepted that *"clinical governance raises clearly defined duties and responsibilities on healthcare organisations and individuals within them; to be effective, a clinical governance programme must include key elements such as processes for recording and deriving lessons from untoward incidents, complaints and claims; a risk management programme; effective clinical audit arrangements; evidence based medical practice and a supportive culture committed to the concept of lifelong learning."*[95] Clinical governance was to remain *"a standing item"* in discussions between Board and Trust.[96]

41. Additionally the AHHSST was to share details of its *"quality framework"* with the Board and to *"set out the various professional guidelines and policies being adhered to, together with details of internal arrangements in place in respect of key activities such as... medical, nursing and clinical audit, procedures for handling complaints, relevant staff training/development programmes [and] any other relevant quality initiatives."*[97]

42. The HPSS had emphasised *"better practice"* in its Management plan for 1995/96 – 1997/98 indicating that improvements in practice necessitate a strategy for *"continuing quality improvement."*[98] This was a broad clinical governance approach requiring hospitals to *"ensure that there is a clear policy on; clinical audit as part of a programme to improve all aspects of service quality not just clinical outcomes [together with] support and evaluation of quality improvement programmes; and multi-disciplinary approaches to the development of best practice in service delivery."*[99]

43. The AHHSST's Annual Report for 1999-2000 recorded that *"whilst clinical governance is not yet a statutory requirement in Northern Ireland, Altnagelvin Trust has decided that the imperatives implicit within clinical governance are the basis for development and implementation of the Trust's quality and risk management strategies. A clinical governance committee has been established and will provide assurance to the Trust Board that procedures relating to... Clinical effectiveness and quality; Risk Management; and Education and Training are in place within the Trust and are functioning effectively."*[100]

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94 Ref: 321-028-002
95 Ref: 321-028-004
96 Ref: 321-028-004
97 Ref: 321-028-010
98 Ref: 306-083-001
99 Ref: 306-083-017
100 Ref: 321-004gj-042

44. A *"Clinical Governance Steering Group was established in 2001."*[101] The transactions of both the Clinical Governance Committee and the Clinical Governance Steering Group remain unknown despite requests for disclosure of the relevant records.

45. When finally, the 'Clinical and Social Care Governance' Circular HSS (PPM)10/2002 was effected- it did not introduce a completely new system but rather drew upon the existing clinical governance structures and approaches, to consolidate them and create organisations within which the final accountability for clinical governance and quality rested with the Chief Executive.[102] This responsibility was accorded the weight of statutory duty by Article 34 of The HPSS (Quality Improvement and Regulation) Northern Ireland Order 2003.[103]

46. The foundations of clinical governance were therefore in place at Altnagelvin in June 2001 when Raychel was admitted. In order to assess what the AHHSST might reasonably have been expected to know and practise in respect of the core principles of clinical governance risk management at that time, reference may be made to *"A survey of risk management in the HPSS organisations - a report by Healthcare Risk Resources International of February 1999."*[104] This Survey was commissioned by the DHSSPSNI[105] and assessed the 26 HPSS bodies in Northern Ireland against 12 specific risk management methods. Applying the same clinical governance criteria to Altnagelvin in June 2001, it should be possible to gauge the general level of risk management control and quality assurance in place at that time. The survey *"provided each of the organisations with an assessment of their position against the average performance on each of the factors in the survey."*[106] This assessment has not been furnished to the Inquiry.

47. Following the same order of requirements and issues as set out in the Survey the following may be observed of Altnagelvin in 2001:

    (i) The AHHSST had produced a 'Proposed Strategy for Implementing Clinical Governance' in September 1998 which concluded that *"Altnagelvin Hospital is committed to the success of clinical governance within the Trust"*[107]

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101 Ref: 321-004grt-008
102 Ref: 306-119-001
103 Ref: www.legislation.gov.uk
104 Ref: 317-035-001
105 Ref: WS-062/1 p.4
106 Ref: WS-062/1 p.4
107 Ref: 321-004fg-001

(ii) It had produced a 'Policy for Management of Clinical Risk' in October 1997[108] and was using guidance from the textbook 'Clinical Governance – Making it Happen' edited by Lugon and Secker-Walker.[109] Written materials were available to guide the AHHSST, not least the 'Risk Management in the NHS' Manual (December 1993) which was issued to all Northern Ireland NHS Organisations[110]

(iii) The AHHSST had produced a 'Policy for Reporting Clinical Incidents' in February 2000[111] which it further supplemented by a Critical Incident Protocol[112]

(iv) It had produced written guidance on 'Patients Case Note Standards' in May 1996.[113] Considerable guidance on records and record keeping was available at that time from the Royal Colleges such as the Surgeons[114] and from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting ("UKCC").[115] The GMC's 'General Medical Practice' stipulated specific responsibilities for doctors in respect of patient records.[116] It is not clear if any system was in place for the routine audit of compliance with these standards *"but record keeping was a recurring theme of many audits using hospital records as a source."*[117] In addition *"during 1999 and 2001... a large multidisciplinary audit of nursing and medical records"* was reported[118]

(v) Clinical audit was provided and overseen by a re-organised *"Multi-disciplinary Clinical Audit Committee."*[119] The Annual Report for 1998-1999 records a designated Clinical Audit Coordinator and a Clinical Effectiveness Coordinator who also undertook uni-professional audit.[120] An annual Audit Report was produced.[121] Peer review was to be driven by *"monthly morbidity and mortality meetings"*[122]

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108 Ref: 321-004fd-001
109 Ref: 317-034-001
110 Ref: 211-005-002
111 Ref: 321-004ff-001
112 Ref: 022-109-338
113 Ref: 321-014c-001
114 Ref: 210-003-1048
115 Ref: 202-002-052
116 Ref: 314-014-002
117 Ref: WS-043/3 p.8
118 Ref: WS-329/1 p.12 (10g)
119 Ref: 321-004gi-044
120 Ref: 321-004gi-044
121 Ref: 321-004gi-044
122 Ref: WS-046/2 p.19

(vi) The AHHSST had published its 'Procedure for Handling Complaints' in 1996.[123] It could, in any event, have relied upon the 'Complaints – Listening... Acting... Improving Guidelines on Implementation of the HPSS Complaints Procedure.'[124] The AHHSST underwent 'Patient Charter' monitoring.[125] The 'Patient Charter' encompassed complaints handling.[126] "*Analysis of complaints to Patient's Advocate and recommendations from Patient user Committees*"[127] contributed to the Altnagelvin's systems for quality assuring the safe provision of patient care[128]

(vii) The DLS have advised that "*the Trust is not aware of there having been any written clinical protocols in place, at that time, in relation to post operative fluid management, blood and urine testing or other post operative management regarding paediatric patients.*"[129] The 1999 risk management Survey stressed "*the importance of up to date, easily understood, clinical and other policies, procedures, guidelines, treatment protocols and agreed standards [which] cannot be over emphasised in relation to risk reduction.*"[130] A comprehensive Trust policy for the 'Control and Administration of Medicines' was published in its 4th Edition in March 2000.[131] An 'Accident and Emergency Handbook' and a 'Hospital Formulary' were also available.[132]

(viii) It is not known to what extent the AHHSST had developed a communications strategy to communicate with other Healthcare Organisations, whether by managed networking between professionals, or otherwise. Guidance as to communications with patients and other clinicians was contained in the 'Junior Doctor's Handbook' and the GMC's 'Good Medical Practice Guide' and "*as part of the hospital's efforts to improve communications a staff 'hotline' was introduced in 1998.*"[133] The AHHSST did, however, operate a Communications Department which managed press releases and public relations operations.

(ix) A system of supervision of junior staff may be inferred from the Altnagelvin 'Junior Doctor's Handbook' which emphasised that "*as a junior member of medical staff you are a vital link in a clearly*

123 Ref: 321-004fb-001
124 Ref: 314-016-001
125 Ref: 321-004gj-042
126 Ref: 306-085-014
127 Ref: WS-043/3 p.9
128 Ref: WS-043/3 p.9
129 Ref: 321-004f-002
130 Ref: 317-035-002
131 Ref: 321-004-004
132 Ref: 316-004g-024
133 Ref: 321-004fk-001

defined chain of responsibility. Part of the responsibility for your actions will ultimately rest on your supervising consultant."[134] There was a system whereby each Pre-registration House Officer was *"assigned to a supervisor. This is a consultant (either medical or surgical) with whom you should meet on a regular basis throughout the year to discuss problems and career plans."*[135] Dr. Curran recalled *"I was aware that there was a nominal figure who would be, in perhaps, a supervisory capacity, but I have no- I am pretty sure that my only contact with that person would have been at the end of the six months to sign the form to say 'you've done your pre-reg surgical six months.'"*[136] There does not appear to have been a written procedure for enabling clinical staff to gain ready access to the advice and support of their seniors. This is not to imply that such processes were not in place. The 1999 risk management Survey observed *"this is a particularly vulnerable area in the context of clinical risk and needs more focused attention."*[137] The AHHSST's 'Proposed Strategy for Implementing Clinical Governance' 1998 referenced the Kings Fund publication *"Clinical Supervision– an Executive Summary"*[138]

(x) In respect of review of individual staff performance the DLS has advised that *"there were no written policies, protocols or guidelines [for] assessment appraisal of clinician performance as this was the professional responsibility of each individual clinician."*[139] The Postgraduate Clinical Tutor for Altnagelvin has advised that *"regular appraisal for trainees was introduced in 1997 and was taking place regularly by 2001. Compliance was checked annually by NIMDTA and JCHMT. This did not extend to involve other groups."*[140] Appraisal of consultant staff was introduced into Northern Ireland by Departmental Circular HSS (TC8) 3/01 in April 2001.[141] The DHSSPSNI published its consultation document 'Confidence in the Future- on the Prevention, Recognition and Management of Poor Performance of Doctors in Northern Ireland' in 2000.[142] It set out recommendations, not only for performance appraisal, but also for audit, education, adverse incident reporting and responsibility for supervision. Chief Executive, Mrs. Burnside, was a member of the Working Party responsible for the document.[143] The DLS have advised

134 Ref: 316-004g-004
135 Ref: 316-004g-010
136 Ref: Transcript of the Oral Hearings 7th March 2013, p.24 line 8
137 Ref: 317-035-003
138 Ref: 321-004fg-006; 1994
139 Ref: 321.004f-005
140 Ref: WS-328/1 p.12 (23k)
141 Ref: 317-030-001 *et seq*
142 Ref: 321-004fi-001 *et seq*
143 Ref: 321-004fi-032

that *"the Trust... instructs that it complied with the DOH Guidance 'Confidence in the Future."*[144] The GMC, in its 'Management in Healthcare – the Role of the Doctor' published in December 1999 set out the requirement that *"all doctors, who have management roles should do their best to ensure that, for the teams for which they are responsible... appraisal systems for doctors and other staff are established and maintained and mechanisms are in place for dealing with any problems which appraisals bring to light."*[145] The 1999-2000 Annual Report notes as a *"key achievement"* that the staff appraisal system had been agreed.[146] The Director of Nursing, Miss Duddy, advises that appraisals of nursing staff were conducted annually with reviews of both performance and training requirements[147]

(xi) A Trust 'Health & Safety Policy' had been published and was in place in June 2001[148]

(xii) Amongst the key achievements claimed in the *"Clinical Governance and Quality"* section of the 1998-1999 Annual Report is the *"agreed policy for the management of clinical risk which includes the arrangements for the management of legal claims."*[149] The guidance given in this Policy in respect of claims management is limited. Additional general advices on the basic organisation of claims handling was issued by the DHSSPSNI by way of *"Clinical Negligence Claims: Claims Handling (Circular HSS (F) 20/98)."*[150] There was a Clinical Negligence Scrutiny Committee.[151] There was no specific policy for engagement with H.M. Coroner or an inquest.

48. The AHHSST achieved various Charter standards and awards obtaining *"full CPA accreditation in all Departments in 2001-02."*[152] Its 'Proposed Strategy for Implementing Clinical Governance' (1998) referred to *"the work ongoing in application for... Kings Fund accreditation."*[153] Engagement with the Kings Fund programme would have given access to a broad range of benchmarked guidance and standards. Guidelines and recommendations, both binding and merely persuasive, were published by the Royal Colleges, UKCC, GMC, National Confidential Enquiry into Perioperative Deaths ("NCEPOD"),

144 Ref: 321-004f-005
145 Ref: 317-031-005
146 Ref: 321-004gj-044
147 Ref: WS-323/1 p.8
148 Ref: 321-014a-001
149 Ref: 321-004gi-045
150 Ref: 317-039-001
151 Ref: WS-323/1 p.14
152 Ref: 321-004gt-001
153 Ref: 321-004fg-003

DHSSPSNI, Working Groups, Inquiries, Medical Journals and via the internet. The Director of Nursing describes how *"a cascade system of dissemination was used e.g. when guidance was received by me as Director of Nursing, from the UKCC or HPSS etc. which was relevant at individual Ward/Department level, then it would be sent to the Clinical Services Managers for dissemination to their staff, discussion at relevant meetings, identifying training needs and monitoring through the Staff Appraisal System."*[154]

49. *"Additionally a senior nurse facilitated the HOSQIP development and undertook additional exercises in quality assurance through 'Monitor' and 'Essence of Care' projects on nursing standards."*[155] Hospital Quality Improvement Programme ("HOSQIP") was an approach to achieving quality by setting standards deriving from the Royal College of Nursing and patient experience of healthcare. MONITOR was *"a nationally developed quality assurance tool and endorsed by the DoH... as part of the nursing quality improvement programme."*[156] The Director of Nursing recalls that *"the MONITOR exercise carried out in 2000 showed improvements across all categories since the previous one in 1989."*[157] The Clinical Effectiveness Co-ordinator, Mrs. Anne Witherow remembers that *"a system of peer review did take place in a number of wards when Monitor was being used- staff from Sperrin Lakeland Trust and Altnagelvin staff did cross over and review the other facilities but I cannot say if this happened with the Ward 6 review."*[158] A nurse representative from each Paediatric unit in Northern Ireland attended the NI Paediatric Benchmarking Group to compare practice against best practice statements with the object of improvement and standardisation of care. Amongst the issues considered by this group was the *"Transfer of the Critically Ill Child."*[159]

50. Altnagelvin's role as a Teaching Hospital should have made it imperative that the knowledge and skills of its clinical and nursing staff were kept up to date. Associations with other Teaching Hospitals and the exchange of personnel should all have contributed to the dissemination of information on clinical effectiveness.

51. Five years elapsed between the publication of the AHHSST 'Strategy for Implementing Clinical Governance' and its first 'Clinical and Social Governance Report' in 2003. Time had therefore been available for the development of clinical governance structures. Financial resources may not have been. The Minutes of the Hospital Management Team

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154 Ref: WS-323/1 p.19 (21)
155 Ref: WS-046/2 p.18
156 Ref: WS-329/1 p.5 (4e)
157 Ref: WS-323/1 p.23
158 Ref: WS-329/1 p.8 (7f)
159 Ref: WS-056/3 p.2 (1c)

Meeting for 12th March 2002 note *"that clinical governance (in terms of improving risk management, audit and research) had yet to be included in the service development bids."*[160]

52. This, albeit limited, overview allows some of the strengths and weaknesses of Altnagelvin's extant Clinical Governance system to become discernable. The extent to which policy was translated into good practice and clinical governance mechanisms into quality control and assurance, is a matter for evidence, and ultimately you, Mr. Chairman.

IV. Education & Training

53. Effective systems for education and training are central to the quality of healthcare. Education and training provided by Hospital Trusts should aim to be informed, up-to-date and continuous, and conducted in relationship with educational institutions and professional and statutory bodies.

54. Doctors were subject to registration with the GMC and nurses with the NMC. These organisations set standards for post-graduate education and training, ensuring that the appropriate degree of clinical training had been completed by trainees, and that, once registered, they were safe to practise.

55. The Service Agreement between the WHSSB and the AHHSST[161] recognised *"staff training/development programmes"* as being one of Altnagelvin's *"key activities."*[162] The AHHSST, in its Annual Report 2001-2002 listed as a *"Key Achievement"* the *"ongoing delivery of a comprehensive programme of education and training covering clinical effectiveness quality, risk assessment and the health and safety of both staff and patients"*[163] and included as a *"Target"* the *"Launch of the Professional Development Plan for Nursing."*[164] A further target was *"a comprehensive education programme for all staff."*[165]

56. Mrs. Burnside has informed the Inquiry that *"The Trust had a range of education and training providers who offered expertise... when education or training issues were identified the appropriate programmes were organised in liaison with either University, Westcare or In Service Nursing education... The Trust had an active programme of in house development training."*[166]

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160 Ref: 316-006o-004
161 Ref: 321-028-002 *et seq*; June 1999
162 Ref: 321-028-009-10
163 Ref: 321-004gk-044
164 Ref: 321-004gk-044
165 Ref: 321-004gk-045
166 Ref: WS-046/2 p.13

Medical Education

57. In 2001, Altnagelvin was a Teaching hospital.[167] In fulfilling its hospital teaching functions, a clear distinction was drawn between the education provided to doctors and that given to nurses. Dr. Phillip Gardiner was the Educational Supervisor/Post-graduate Tutor for doctors in 2001, and whilst he was charged with overseeing the medical education and training provided at Altnagelvin[168] he *"did not have any clear list of responsibilities."*[169]

58. The Medical Director had principal responsibility to *"co-ordinate and promote high standards at all stages of medical education"* including *"undergraduate education in association with the Dean of the Faculty of Medicine... postgraduate education in association with the Postgraduate Dean... and continuing medical education and development where appropriate in association with other clinical professions."*[170]

59. Mr. Gilliland was the Undergraduate Surgical Tutor (1998-2008), Postgraduate Surgical Tutor (1999-2003), and College Tutor (2000-2008) at Altnagelvin and therefore had responsibility for the training and education of doctors at the time of Raychel's admittance. It is therefore noteworthy that he is recorded as having told the Coroner that he only became aware of hyponatraemia after Raychel's death.[171] Mr. Foster, the Inquiry's expert on paediatric surgery, stated that he could *"scarcely believe this as Mr. Gilliland was a well qualified and respected consultant surgeon."*[172] Mr. Gilliland has sought to correct this impression by stating that he was referring to *"dilutional hyponatraemia."*[173] It is to be noted that Dr. Fulton described the continuing medical education and professional development of doctors as the responsibility of the *"NI Postgraduate Dean and delegated to Post Graduate Tutor at Altnagelvin."*[174]

60. Mr. Gilliland further informed the Inquiry he was unaware of the 1989 NCEPOD recommendations that junior doctors operating on children should not do so without senior advice[175] and was not aware of the danger of infusing hypotonic fluid in children who had prolonged vomiting.[176] Mr. Foster, addressing the latter point, stated *"I really don't believe he means this. It is well known that hypotonic fluids may cause dilution. In my hospital... the first tutorial I always gave was one on fluid*

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167 Ref: WS-044/1 p.8
168 Ref: 321-026-001
169 Ref: WS-328/1 p.3
170 Ref: 321-004gh-006
171 Ref: 012-038-178
172 Ref: 223-003-017
173 Ref: WS-044/3 p.6
174 Ref: WS-043/3 p.6
175 Ref: WS-044/2 p.6
176 Ref: WS-044/2 p.34

balance and the use of intravenous fluids... The matter was also quite fully covered in the basic textbooks."[177] It is worth noting that the inaugural meeting of the Western Anaesthetic Society, which included Altnagelvin, was held on 30th September 1998 at which Dr. Anthony Chisakuta gave a talk on 'Recent Advances in paediatric Anaesthesia'[178] dealing with the issues raised in Arieff's 1998 paper 'Postoperative hyponatraemia encephalopathy following elective surgery in children'.[179] At the time Dr. Chisakuta was a consultant paediatric anaesthetist at RBHSC, having only recently moved there from Altnagelvin.[180]

61. The AHHSST had a *"connection with Northern Ireland Medical and Dental Training Agency (NIMDTA)"* which was *"responsible for funding, managing and supporting postgraduate medical and dental education within the Northern Ireland Deanery... This organisation allocates Trainee Doctors to Altnagelvin Hospital."*[181] The training of junior doctors was determined by NIMDTA in conjunction with Dr. Gardiner who was *"jointly accountable to both the Trust and to the Deanery for the provision of postgraduate medical education."*[182] The Postgraduate Dean in NIMDTA and the Chief Executive shared ultimate responsibility for postgraduate education.[183] Dr. Nesbitt informed the Inquiry that the *"Royal Colleges and the Post Graduate Medical Education and Training Board (PMETB) visited the Trust to provide external scrutiny"*[184] but were not accountable to Dr. Gardiner.[185] Queens University Belfast organised an annual review of Pre-Registration House Officer ("PRHO") teaching, the results of which were *"discussed with the Chief Executive... at our hospital 'Medical Education Committee.'"*[186] Dr. Gardiner has informed the Inquiry that *"reports from education visits and trainee educational feedback reviews often praised the quality of training and educational supervision."*[187]

62. The PRHO's place was "*primarily a training and apprenticeship year*"[188] under the control of Queens University Belfast[189] whereby each PRHO was assigned a supervising consultant responsible for the assessment

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177 Ref: 223-003-017
178 Ref: WS-283/3, p.4
179 Ref: 070-023h-235; Paediatric Anaesthesia 1998; 8:1-4. This paper makes specific reference to the earlier, 1992 paper, by Arieff et al, 'Hyponatraemia and death or permanent brain damage in healthy children', Ref: 220-002-201
180 Ref: 315-012-001
181 Ref: 321-004g-004
182 Ref: 321-004fa-004
183 Ref: WS-328/1 p.4
184 Ref: WS-035/2 p.10
185 Ref: WS-328/1 p.5
186 Ref: WS-328/1 p.5
187 Ref: WS-328/1 p.5
188 Ref: 316-004g-010
189 Ref: WS-328/1 p.4

of their training with the assistance of the overall Educational Supervisor.[190] Attendance at the PRHO induction course was mandatory[191] and attendance at the PRHO forum - an organised programme of weekly talks - encouraged.[192] *"The Clinical Education Centre was used by medical staff to provide courses, seminars and updates."*[193]

Education as to Fluids

63. From 1995, a doctor's training at Altnagelvin included *"teaching sessions timetabled each year on fluid balance and electrolyte disturbance within the medical division teaching and training programme."*[194] Such training was delivered during the lunchtime teaching programme and *"lectures on fluid balance [were] given by an anaesthetist and the lecture on abnormal biochemical tests including electrolyte disturbance by our clinical biochemist."*[195] *"Prior to the late 90s a specific session was allocated to fluids and electrolytes as part of a rolling training package"* and in the late 1990s a paediatric course for all SHOs *"incorporated a lecture on fluids and electrolyte disturbances and their management."*[196] Dr. Gardiner has confirmed that he set up an educational teaching programme for PRHOs which included instruction on fluid balance and sessions on electrolyte disturbances.[197] Each *"specialty had a 'Royal College Tutor' in place that was responsible for facilitating teaching in that specialty"*[198] however *"at that time (2001) there was little or no supervision of the educational programmes within individual departments."*[199]

64. Dr. Simon Haynes, the Inquiry's Expert on paediatric anaesthesia and fluid management, is of the *"opinion that there was ignorance at all levels about the management of fluids and electrolytes amongst all staff at Altnagelvin in 2001."*[200] He further states that: *"Before Raychel's death the nursing staff had no training on fluid and electrolyte management, and the junior house officers did not have the necessary knowledge... Intravenous fluid therapy is one of the commonest interventions in a wide range of hospital patients, especially around the time of surgery."*[201]

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190 Ref: 316-004g-010
191 Ref: 316-004g-011
192 Ref: 316-004g-010
193 Ref: WS-328/1 p.4
194 Ref: 316-004e-001
195 Ref: 316-004e-001 & Ref:316-004e-004: *"Wednesday, 16th Nov., '94, at 1.20 p.m. 'FLUID BALANCE'"* & Ref: 316-004e-005: *"Wednesday, 16th Aug., '95 at 1.00 p.m. 'FLUID BALANCE, PRE AND POST OPERATIVE CARE'"* & Ref: 316-004e-016: *"Wednesday, 9th Aug., 2000 at 12.30 p.m. Management of Fluid Balance by Dr. B. Morrow.""*
196 Ref: 316-004e-002
197 Ref: WS-328/1 p.5
198 Ref: WS-328/1 p.5
199 Ref: WS-328/1 p.8
200 Ref: 220-003-014
201 Ref: 220-003-014

65. Mr. Foster, when asked whether Drs. Curran and Devlin should have recognised the possibility that Raychel was suffering from hyponatraemia, stated that *"it is to be regretted that these very junior doctors apparently did not recognise or consider this possibility. However, they would have had little training in surgical physiology and postoperative care and this I believe to be a serious governance issue."*[202] He further notes that the *"physiological fact"* that post-operative fluids should be restricted due to the secretion of anti-diuretic hormone *"is core knowledge and should be understood by any appropriately trained doctor or nurse. It is taught as part of the medical curriculum in the UK and Ireland and reinforced during teaching for examinations in surgery."*[203]

66. Dr. Gardiner has informed the Inquiry that *"at the time the funding to organise postgraduate teaching in Altnagelvin hospital was at a very low level, so the provision of postgraduate teaching was based largely on goodwill and professionalism"* and *"in many specialties there was a lack of clarity or detail around the curriculum for teaching."*[204]

67. Dr. Robert Taylor, Consultant Paediatric Anaesthetist, RBHSC has confirmed that *"Occasionally the paediatric anaesthetists facilitated requests from consultant anaesthetists in other NI hospitals to visit theatres and update their clinical skills."*[205] Dr. Peter Crean, Consultant Paediatric Anaesthetist, RBHSC, has stated that whilst he was not *"aware of any formal role that RBHSC had in dissemination of learning and good practice... Anaesthetists in RBHSC fostered informal links with consultant anaesthetists in the Area Hospitals. For example, we have always made it clear that any consultant anaesthetist from an Area Hospital was welcome to spend time in the RBHSC for a 'refresher' in paediatric anaesthesia."*[206] Mrs. Margaret Doherty, Clinical Services Manager, has advised that *"when I encountered a problem that I couldn't resolve with help from the Ward area I would contact the Children's Hospital in Belfast who was very helpful."*[207]

68. Dr. Taylor founded the Sick Children Liaison Group (SCLG) in or about early 2000.[208] He states[209] that the SCLG *"met 2-3 times per year at Antrim Area Hospital"* and that its *"main purpose was to improve the quality of care to critically ill infants and children being transferred to the Paediatric ICU mainly by better communication"*. It provided a forum where fluid management issues might be discussed. It produced '*Guideline for Investigation and Treatment of Meningococcal Disease in*

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202 Ref: 223-002-041
203 Ref: 223-002-011
204 Ref: WS- 328/1 p.4
205 Ref: WS-330/1 p.8
206 Ref: WS-038/3 p.3
207 Ref: WS-336/1 p.5
208 Ref: 093-035-110n; Following a memorandum dated 9th February 1999 circulated to the consultant paediatricians and anaesthetists at a number of hospitals including Altnagelvin.
209 Ref: WS-008/1, p.9

Children'[210] and within a fortnight of Raychel's death, Dr. Taylor *"presented several papers which indicated the potential problems with the use of hypotonic fluids in children"*.[211]

69. Additionally, Dr. Crean *"set up the Paediatric Anaesthetic Group in 1999 to provide a forum for discussion amongst those involved in anaesthetising children in the Provence [sic]."*[212] He describes that he initially *"had fears that some anaesthetists may have concerns that these meetings would involve the Regional Centre telling the Area Hospitals what to do, as opposed to being a forum for discussion."*[213] Such a forum would, nonetheless, have been an appropriate vehicle for sharing information relevant to clinical effectiveness, including details of any change in the use of Solution 18 for paediatric patients.

70. Whether the RBHSC, as the Regional Centre of Excellence, might have instituted more formal arrangements for the dissemination of learning is a matter that will be further considered during the Oral Hearings.

Nursing Education

71. "*There was not a similar education structure within nursing as existed within medical staffing and there was not one individual in charge of nursing education."*[214] The Ward Managers, Department Managers and Directorate Managers identified *"the Nursing Staff within their areas who were required to attend the courses"* offered by the North & West In-Service Education Consortium or the *"biannual mandatory training sessions for nursing staff"* organised by the AHSST.[215]

72. Each Directorate was required to undertake training needs analysis in respect of its nursing staff and submit this to the Director of Nursing on an annual basis.[216] This was forwarded to the DHSSPSNI who would advise as to whether or not training places could be made available to accommodate such requests.

73. The DLS informs the Inquiry that *"Nurses have been educated on the management of the IV Fluids in children since 2001"* and that the *"training given in respect of children on IV fluids has been in progress since 2002."*[217] It is noteworthy that Ward Sister Elizabeth Millar, who was responsible for the Paediatric Ward in 2001, had received no prior training in

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210 Ref: 319-025-004
211 Ref: 093-035-110o; Minutes of the meeting of SCLG on 26th June 2011
212 Ref: WS-038/3 p.3
213 Ref: WS-038/3 p.3
214 Ref: 321-026-001
215 Ref: 321-026-001-2
216 Ref: 321-026-002
217 Ref: 316-004-002

respect of fluid management in children, the use of hypotonic fluids[218], the management of post-operative vomiting and nausea[219] or the risk of hyponatraemia, or in observations and record-keeping.[220] Sister Millar further states that *"At that time (2001) I was not aware of the factors that can cause electrolyte imbalance in a paediatric patient following surgery... I recognise that vomiting can be one of those factors."*[221] It was, however, the Ward Sister who was *"expected, through the staff appraisal system, to identify the needs of staff in the ward"* and would *"meet with the staff of EDUCARE (Inservice Education Consortium)"* to determine training and educational requirements.[222] Miss Duddy, the Nursing Director attended quarterly meetings of the Senior Nursing Advisory Group together with other Trust Nursing Directors, *"other senior nurses from Practice and education"* and the Chief Nurse of the WHSSB to consider *"professional Nursing, Midwifery and Education issues"*[223] and was a member of the Nurses Leader's Network.[224]

74. As a part of ongoing education and training, medical textbooks were made available on hospital wards. These works of reference helped ensure that care and treatment was provided in accordance with established practice. The DLS has informed the Inquiry that *"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 for Infants and Children'- Whaley and Wong, 1995."*[225] Notwithstanding the provision of out-of-date textbooks in 2001, Forfar and Arneil's 'Textbook of Paediatrics' did advise that in respect of the management of vomiting in paediatric patients: *"Electrolyte losses should be corrected..."*[226]

Consultant Appraisal

75. To aid the identification of the training needs of senior clinicians the DHSSPSNI introduced the Circular *"Compulsory appraisal for all consultants from 1st April 2001."*[227] Agreement was reached with the British Medical Association ("BMA") on a national appraisal scheme, and Trusts were required to implement systems for appraisal within the scope of this national agreement.[228] The Circular acknowledges that *"appraisal must follow a standardised format if it is to be applied consistently*

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218 Ref: WS-056/2 p.3
219 Ref: WS-056/2 p.3
220 Ref: WS-056/2 p.4
221 Ref: WS-056/2 p.8
222 Ref: WS-323/1 p.7
223 Ref: WS-323/1 p.4
224 Ref: WS-323/1 p.5
225 Ref: 321-004g-004
226 Ref: *"Textbook of Paediatrics"* (Forfar and Arneil, Fourth Edition, Churchill Livingstone) 1992
227 Ref: 317-030-001 et seq; Circular HSS(TC8) 3/01 'Consultants' Contract: Annual Appraisal for Consultants' (12th March 2001)
228 Ref: 317-030-001

and satisfy the GMC's requirements for revalidation."[229] Following the issue of this Circular, Chief Executives were *"accountable for ensuring that employing authorities comply with action set out in the circular, through the usual performance management mechanisms."*[230]

76. Appraisal was defined by the national scheme as a *"professional process of constructive dialogue, in which the doctor being appraised has a formal structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved."*[231] The stated objectives of the scheme were to enable consultants to *"optimise the use of skills and resources in seeking to achieve the delivery of service priorities"* and to consider their *"contribution to the quality and improvement of services."*[232] The Chief Executive was accountable to the Board for the appraisal process, the content of which was based on the principal responsibilities as set out by the GMC in 'Good Medical Practice.'[233] Focus was to be given to a consultant's clinical performance, teaching and research activities (as to junior medical staff and other postgraduate teaching activity) and personal and organisational effectiveness.[234] In its Annual Report for 2001-2002 the AHHSST includes as one of its *"Key Achievements"* that *"Staff Appraisal and revalidation procedures for career grade medical staff [was] introduced in accordance with DHSSPS requirements."*[235] Dr. Fulton informed the Inquiry that while *"annual appraisal for consultants was gradually introduced in Altnagelvin from about 2000"*[236] *"not all doctors at Altnagelvin were appraised by 2001 as the process was at an early stage and not yet mandatory."*[237] Dr. Fulton described how, in 2001, there was no formal mechanism to enforce implementation of external guidelines *"however, annual appraisal increasingly asked for evidence of knowledge of, and implementation of, national guidelines."*[238]

77. Despite this the DLS has confirmed that *"There were no written Policy, Protocols or Guidelines"* in place in Altnagelvin pertaining to the assessment or appraisal of clinical performance *"as this was the professional responsibility of each individual clinician."*[239] To understand the importance of appraisal, junior staff were referred to the 'Junior Doctor's Handbook.' The job description for Clinical Directors set out their specific responsibility to *"ensure that staff appraisal is carried out for all staff, training needs are identified and a Directorate Training Plan is*

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229 Ref: 317-030-002
230 Ref: 317-030-003
231 Ref: 317-030-004
232 Ref: 317-030-004
233 Ref: 317-030-011
234 Ref: 317-030-006-7
235 Ref: 321-004gk-044
236 Ref: WS-043/3 p.7
237 Ref: WS-043/3 p.5-6
238 Ref: WS-043/3 p.9
239 Ref: 321-004f-005

developed."[240] The DLS further informed the Inquiry that the AHHSST *"complied with the Department of Health Guidance 'Confidence in the Future.'"*[241]

V. Consent

78. Obtaining valid consent from a patient before treatment is more than a matter of courtesy, it is a legal requirement and a right accorded by the 1992 Northern Ireland HPSS 'Charter for Patients and Clients.'[242] This right, which in Raychel's case transferred to her parents because of her age, was the right to give or withhold consent prior to treatment. This is a basic principle of healthcare.

79. The 'Risk Management in the NHS' Manual 1993 stressed *"obtaining consent to treatment is an area almost entirely under the control of professional healthcare staff, and not one in which managers are generally involved. But, managers have a responsibility to ensure that professionals are fully aware of their obligations and understand the legal framework in which they are operating."*[243]

80. It is acknowledged that *"The Chief Executive would have held overall responsibility for the implementation and monitoring"* of consent.[244] The 'Junior Doctor's Handbook' notes *"an obligation upon the doctor obtaining consent for a procedure to ensure that the patient has been adequately informed about the nature of the proposed procedure and any significant complications that may arise... In the event of a child under the age of 16, the parent/guardian will sign the form on their behalf..."*[245]

81. The AHHSST Consent Form, which conformed to HSS (GSH) 2/95, required that *"Patients should be given sufficient information, in a way that they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to treatment at any time. The patient's consent or treatment should be recorded on this form."*[246] The AHHSST 'Policy on Consent to Examination or Treatment' 1996[247] states that *"written consent should be recorded in the patient's notes with relevant details of the health professional's explanations"* and *"the most important element of a consent procedure is the duty to ensure that the patient understands the nature and purpose of the proposed treatment. Where a*

240 Ref: 321-004ge-002
241 Ref: 321-004f-005
242 Ref: 306-085-001 *et seq*
243 Ref: 211-003-008
244 Ref: 321-004f-005
245 Ref: 316-004g-015
246 Ref: 020-008-015a
247 Ref: WS-046/2 p.112

patient has not been given appropriate information then full consent may not always have been obtained despite the signature on the form."[248]

82. It is acknowledged by Dr. Nesbitt that the procedures governing consent, and whether they were complied with *"was not the subject of discussion at the review meeting"*[249] a view with which Dr. Fulton agrees.[250] Both Dr. Makar and Raychel's parents have given evidence during the clinical hearings in relation to consent. Whether consent was validly taken by Senior House Officer Dr. Makar in accordance with these standards, and whether there was a failure to adequately explain the option of postponing Raychel's surgery for further observation and investigation, are matters that will be considered from a governance perspective during the Oral Hearings.

VI. Nursing

83. Whilst the role of the nursing staff in Raychel's care and treatment has already received consideration at Hearing, it remains relevant to the governance Inquiry to understand the structures within which nursing care was delivered.

84. All registered nurses were, in 2001, subject to the UKCC 'Code of Professional Conduct'[251] and 'Guidelines for Professional Practice.'[252]

85. The Guidelines for Professional Practice stipulated that nurses:

(i) Were professionally accountable to the Nursing and Midwifery Council ("NMC") as well as having a contractual accountability to their employer and to the law for their actions[253]

(ii) Had a legal and professional duty to care for patients, meaning that a registered practitioner could be found negligent at law, or professionally guilty of misconduct and removed from the register, if a patient suffers harm because he/she failed to care for the patient properly[254]

(iii) Had a duty to practise patient advocacy and recognise patient autonomy[255]

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248 Ref: WS-046/2 p.115
249 Ref: WS-035/2 p.14
250 Ref: WS_043/3 p.13
251 Ref: 202-002-058 *et seq*; June 1992
252 Ref: 314-003-001 *et seq*; 1996
253 Ref: 314-003-009
254 Ref: 314-003-011
255 Ref: 314-003-014

(iv) Had a duty to practise good communication (which includes an obligation to ensure that medical records are *"clear, legible and accessible"* insofar as *"written communication is as important as verbal communication"*)[256]

(v) Had a professional duty of truthfulness[257]

(vi) Had a duty to make concerns known with respect to the provision of care and treatment[258]

(vii) Had a duty to work together with other health care staff to provide multi-professional and effective care.[259]

86. Whilst overall responsibility for nursing matters rested with Miss Duddy, the Director of Nursing, daily responsibility for nursing on Ward 6 was borne by Ward Sister Elizabeth Millar who described her obligation *"to carry continuing overall responsibility for the children's unit"* to *"provide professional and clinical leadership to a multi-professional team"* to *"act as advocate for children and their parents"* and to maintain *"overall management of the Unit, deployment and management/supervision of staff, the teaching of basic and post basic learner and the development of trained staff."*[260] The Clinical Services Manager for the Paediatrics department was Mrs. Margaret Doherty.[261] Mrs. Anne Witherow served as the Clinical Effectiveness Co-ordinator and the F-Grade Sisters[262] were Mary McKenna and Kathryn Little.[263]

87. A copy of the AHHSST *"Nursing Philosophy"* was permanently displayed in Ward 6 enjoining nurses to *"provide the child and family with skilled, researched, individualised nursing care"*, to *"liaise with the multi-disciplinary team to ensure safe return of the child into the community"* and to *"ensure the safety of children and their families."*[264] Furthermore, the AHHSST *"totally embraced the concept of family-centred care within the Children's Ward and the ethos of family centred care was embedded within the Unit."*[265]

88. Systems for the maintenance and improvement of nursing standards had evolved so that relevant information was *"copied to wards and*

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256 Ref: 314-003-016
257 Ref: 314-003-016
258 Ref: 314-003-022
259 Ref: 314-003-024
260 Ref: WS-056/2 p.2
261 Ref: 321-004gk-022
262 Ref: 303-004-051; Registered nurses or first level nurses, who had completed a 3 year programme of education and are registered with the UKCC/NMC, 'Nomenclature & Grading of Nurses 1989 to 2012'
263 Ref: WS-049/4 p.2
264 Ref: 316-023-004
265 Ref: 316-023-002

departments" and *"important issues [were] raised at Sisters meetings (held every 4 to 6 weeks)."* In addition, the *"senior nurse for Quality held 'standards' meetings on a regular basis with a representative from each ward or department to address patient care improvements."*[266]

89. Additional nursing standards structures were in place in 2001, including:

    (i) The Northern Ireland Paediatric Benchmarking Group which was attended by nursing representatives from each Paediatric Unit in Northern Ireland with the objective to *"improve standards of care and to standardise them throughout Paediatric Units within the province"*[267]

    (ii) The Queens University Partnership Group which engaged to *"review practices for Paediatric Student Nurse Training"*[268]

    (iii) AHHSST Quality Improvement Meetings, and Paediatric Clinical Management Meetings to *"improve the quality and standard of care"*[269]

    (iv) The Quality Facilitator's Meetings within the AHHSST where *"quality initiatives were discussed."*[270]

90. The Chief Executive has observed that the *"nursing care in the Ward was well regarded by the various consultants who had patients there"* and *"did not have a pattern of complaints."*[271]

91. However, the following issues have arisen in respect of the nursing care:

    (i) Adequacy of arrangements in place for the prescription and management of fluid therapy

    (ii) Adequacy of arrangements for U&E assessment in post-operative period

    (iii) Systems in place to ensure adequate completion of patient records

    (iv) Efficacy and application of the Episodic Care Plan

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266 Ref: WS-327/1 p.7
267 Ref: WS-056/3 p.2
268 Ref: WS-056/3 p.3
269 Ref: WS-056/3 p.3
270 Ref: WS-336/1 p.4
271 Ref: WS-046/2 p.25

(v) Communication with clinicians, particularly with the surgeons who ostensibly had responsibility for the management of Raychel's clinical care

(vi) Communication with Mr. and Mrs. Ferguson

(vii) Staffing/workload levels.

For the most part, many of these issues will be dealt with as part of this Opening's broader discussion of governance matters. However, is worth drawing attention to the following matters at this stage.

Nursing Issues

92. Mr. George Foster, Expert to the Inquiry, concludes that "*the care of the surgical patients on Ward 6 was to all intents and purposes left to nursing staff on the ward... The doctors simply complied with requests from the nursing staff and as very junior trainees could not have been expected to make clinical decisions on postoperative children.*"[272] Dr. Simon Haynes observes that the post-operative care given Raychel was "*deficient*" insofar as "*fluid prescription in the paediatric ward appears to have been dictated by the nursing staff- they could recite to junior medical staff what was routinely prescribed to postoperative patients... according to longstanding custom and practice but the nurses were very unlikely to have a proper understanding of fluid and electrolyte balance or understand how abnormalities could arise.*"[273] In this regard Miss Sally Ramsay, the Inquiry's Expert on nursing, has "*concluded that there was no clear system in place.*"[274]

93. Raychel was allocated a patient specific 'named nurse' upon admission to Altnagelvin. This was compliant with that 'right' accorded her by the Charter for Patients and Clients.[275] Staff Nurse Patterson, who had been named as Raychel's nurse, did not however provide continuous care for her. Sister Millar has described how "*on days, staff were allocated to designated areas on the Ward and on nights the staff worked as a team for all patients.*"[276] Margaret Doherty, Clinical Services Manager, advises "*that the Named Nurse allocation was not totally compliant due to the quick turnover of patients at that time. The admitting nurse was often identified as the Named Nurse but she could have been off duty the next day.*"[277] Indeed a finding of the AHHSST Clinical Audit Report 1999/2001 was that only "*83% of patients appeared to be allocated a named nurse on admission with 84% of those patients having <u>almost no contact</u> with their named nurse*

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272 Ref: 223-002-011
273 Ref: 220-002-003
274 Ref: 224-002-017
275 Ref: 306-085-010
276 Ref: WS-056/3 p.6
277 Ref: WS-336/1 p.11 6(a)

during their hospital stay."[278] Professor Swainson observes that "*the concept of a named nurse for a whole episode of care may have resulted in better communication with the parents; even on a single shift, a nurse with responsibility for a child could have resulted in earlier recognition of the child's deteriorating clinical state."*[279]

94. The DLS have described the "*computerised Nursing Care Planning system known as 'DM Nurse'"* as allowing "*Nurses to select care plans which had been approved through a nursing forum within the Trust and saved on the system. Nurses were responsible for individualising the care plan for the specific patient. Because it was a computerised system nurses would update the care plan/evaluation section once per shift...The system is no longer in use within the Trust."*[280] Ms. Ramsay notes that "*after a long span of time it is possible to forget care that has been given and consequently fail to record it."*[281] The extent to which retrospective and irregular recordings of information significantly devalued its usefulness is a matter for your consideration Mr. Chairman. Mr. Melaugh, Director of Clinical Support Services, has informed the Inquiry that the AHHSST declined to pursue the development of this system as a priority and eventually discontinued its use.[282]

95. Mr. Foster was "*concerned at the lack of written nursing notes for 8th June... Any critical reader of the file can only conclude that the true severity of the vomiting suffered by this child was seriously underestimated by the nursing staff on ward 6."*[283] Dr. Robert Scott-Jupp, the Inquiry's Expert on paediatrics, explained that "*Medical staff are dependent upon the nursing staff to inform them if any patient continues to have symptoms for which they have been treated, and which should have subsided by that time."*[284] Miss Duddy is of the view that, whilst monitoring of patients is a shared responsibility "*nurses are with the patients all of the time, so it could be perceived that they carry the greater responsibility."*[285]

96. Sister Millar has said in evidence that she had told the Critical Incident Review that *"I thought it was totally unfair that the nurses had such responsibility for the surgical children. I felt it was unfair. I felt that we had to be the lead all the time in looking after the surgical children. We are nurses, we are not doctors, and whilst we do our very best, I don't think we should be prompting doctors."*[286]

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278 Ref: 321-068-005
279 Ref: 226-002-005
280 Ref: 316-023-001-2
281 Ref: 224-002-014
282 Ref: WS-334/1 p.8
283 Ref: 223-002-019
284 Ref: 222-004-024
285 Ref: WS-323/1 p.24
286 Ref: Transcript of the Oral Hearings, 28th February 2013, p.58 line 7

97. Sister Millar also stated that, in terms of specific allocation of nursing care to Raychel, she was *"two nurses down that day."*[287] It may be of relevance that in June 2000, Senior Staff Nurse Mary McKenna wrote to Mrs. Margaret Doherty informing her of *"the difficulties [nurses] are experiencing at present in providing adequate cover on the [children's] ward."*[288] She informed Mrs. Doherty of an increase in workload and volume of patients in Ward 6 and called upon her *"to address the problem of staffing levels on the ward and reach a solution."*[289] Staff Nurse McKenna has indicated that *"The concerns raised were acknowledged by our CSM [Mrs. Doherty], and I believe she shared the concern with her seniors."*[290]

98. Staff Nurse McKenna and Sister Elizabeth Millar, wrote to Mrs. Doherty in February 2001, to express concern about a deterioration in morale *"as staff are mentally and physically exhausted, many from working extra hours and they are frustrated at little apparent improvement in the staffing situation."*[291] Nurse McKenna and Sister Millar further stated that this *"ridicules the ethos of holistic care, and we find that we are practising task oriented care"*[292] and *"we have brought our concerns forward by writing, but unfortunately we have not found solutions, and yet we are faced with repeated situation time and time again"* - *"we are now at the situation where we feel things may be unsafe."*[293] The letter concludes with a request that their concerns be brought to the attention of Miss Duddy and Mrs. Burnside.[294] The week before Raychel's admission to hospital Staff Nurse McKenna wrote again to Mrs. Margaret Doherty to inform her of continuing difficulties and assert that nursing staff were *"in need of help on an immediate basis."*[295]

99. Sister Millar has indicated that *"at that time within Paediatrics we were also auditing and gathering information on workforce related matters to provide evidence on what were the gaps in our service."*[296] A document was compiled within Ward 6 on the *"Dependency Levels and Review of Staffing Establishment within the Children's Ward"* for the months December 2000, January 2001 and February 2001.[297] It indicated that 4 working time equivalents were *"required over and above the present*

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287 Ref: Transcript of the Oral Hearings, 28th February 2013, p.64 line 13
288 Ref: 321-051-002
289 Ref: 321-051-003
290 Ref: WS-346/1 p.3
291 Ref: 321-051-005
292 Nurse McKenna defines these terms in the following manner: *"To me holistic care meant that a nurse could give total care to her patients...Task orientated care means that a group of staff are allocated jobs... and staff worked predominantly with their group of patients..."* Ref: WS-346/1 p.5
293 Ref: 321-051-005
294 Ref: 321-051-005
295 Ref: 321-051-006
296 Ref: WS-056/3 p.11
297 Ref: 321-051-007

staffing levels to maintain services"[298] and noted that Sister Millar had recently experienced a significant increase in management responsibility, impacting on delivery of clinical care to patients.[299] These findings were shared with the Senior Management Team[300] and sometime in 2002 *"a decision was made to recruit outside Northern Ireland for paediatrics."*[301] While this proved a *"slow gradual process"*[302] and *"was not an immediate transformation... over the following couple of years staff education, staff development, mentorship etc. improved."*[303]

100. It is noteworthy that, when asked whether she knew who the Nursing Director was at Altnagelvin through the 1990s to 2001, Staff Nurse Noble was unable to recall, and unable to differentiate the Director of Nursing and the Chief Executive of the AHHSST.[304] This raises the issue of the leadership given by the Director of Nursing within the AHHSST, and how, given her lack of visibility to the nursing staff on the wards, Miss Duddy was able to understand the nursing practices and standards of care on Ward 6.

101. It is for you, Sir, to determine whether nursing systems, leadership or staffing levels may have played any part in the standard of care and treatment given to Raychel.

VII. Communication between Nursing and Medical Staff

102. Effective clinical care relies upon effective communication as and between medical and nursing staff. Systems must ensure that important medical information passes freely between clinicians. Dr. Jenkins has emphasised the importance of communication between working clinicians: *"communication is at the heart of so many problems where a doctor makes a judgement as to the treatment for a child and passes that information on but perhaps doesn't write it down or someone mishears what they say and I think that communication and the record keeping which gives a written record of what a doctor prescribes or the treatment that a doctor wants a child to have- that to me is at the core of this; that is the thing that can best protect our children."*[305]

103. The AHHSST 'Junior Doctor's Handbook' gives limited guidance. Under the heading *"Relationships with Other Staff"* doctors are informed of their role as *"a vital link in a clearly defined chain of responsibility"* and

298 Ref: 321-051-013
299 Ref: 321-051-014
300 Ref: WS-346/1 p.8
301 Ref: WS-346/1 p.6
302 Ref: WS-346/1 p.8
303 Ref: WS-346/1 p.9
304 Ref: Transcript of the Oral Hearings 26th February 2013, p.189-90
305 Ref: 068a-013-072

staff are encouraged to liaise closely with their supervising or responsible consultant.[306] In her Report to the Inquiry Sally Ramsay observed that *"no communication protocols were available at the time"*[307] a viewpoint that is shared by Mr. Foster in that he found *"evidence of poor vertical communication between members of the surgical teams."*[308] Sister Millar highlights a situation whereby attempts were made by the nurses to contact *"the surgical SHO initially and then the SHO to come and give Racheal [sic] some i.v. anti-emetic for her vomiting"* however *"they did not answer their bleeps immediately."*[309] She states that *"there was difficulty in contacting the surgical doctors as they were in theatre and did not answer their bleeps."*[310] Mr. Foster describes this as a *"very unsatisfactory situation."*[311]

104. The fact that the *"doctor responsible for Raychel's care was not known to nurses"* had the *"result that she was seen by several junior doctors during the day."*[312] That *"Mr. Gilliland clearly did not know details of his patients admitted on 7th"* is also a matter of concern for Mr. Foster, and suggestive of *"serious vertical communication problems at the Altnagelvin Hospital."*[313] Mrs. Anne Witherow, the Clinical Effectiveness Co-ordinator indicated that nursing staff were *"responsible to provide information about the patients in their care to doctors..."*[314] Nurse Noble has accepted that *"nurses were guided to contact junior doctors initially, explain concerns, seek advice, follow instruction and record in the nursing evaluation"* and to *"inform senior doctors and consultants if they had continued concerns regarding patients and their care."*[315]

105. Dr. Makar described confusion as to the identity of the on-call consultant surgeon, reporting *"talk that a swap happened and maybe that's why there's some confusion."*[316] The on-call surgical rota is now no longer available.[317]

106. Mr. Foster gives his view that *"there was obviously confused communication between the nurses and [doctors]... and a mindset that did not seem to accept that a serious problem was occurring"* and further that *"these were very junior doctors and they did not inform their senior colleagues. As I have mentioned on more than one occasion in my report the paediatric SHOs must have been present on the ward virtually constantly and I cannot*

306 Ref: 316-004g-004
307 Ref: 224-004-029
308 Ref: 223-002-037
309 Ref: 021-068-159
310 Ref: WS-056-1 p.3
311 Ref: 223-002-015
312 Ref: 224-004-030
313 Ref: 223-002-007
314 Ref: WS-329/1 p.10
315 Ref: WS-049/4 p.5
316 Ref: Transcript of the Oral Hearings 13th March 2013, p.181 line 25
317 Ref: 316-004-001

understand why the nursing staff did not speak to them."[318] Professor Swainson agrees that *"there was insufficient communication between the nurses and surgical staff"*[319] and that *"systems for the clear lines of communication when plans do not go as expected are notable by their absence, and are below the standards expected in 2001."*[320]

107. The medical notes, records and plans generated in the care of Raychel were channels of communication.

108. It is for you, Mr. Chairman, to determine whether, in this most fundamental aspect of clinical effectiveness, there were functioning systems, and if there were shortcomings, how they arose and how they might best have been avoided.

VIII. Medical Records & Record-Keeping

109. The provision of high quality, evidenced based, healthcare depends on the maintenance of high quality healthcare records. Information has most value when it is accurate, comprehensive, up to date, accessible and targeted at clinical need. It is the foundation upon which audit, review and research are based.

110. The UKCC 'Standards for Records and Record Keeping' (1993)[321] described the importance of records as a means of:

(i) Communicating with others and describing what has been observed or done

(ii) Organising communication and the dissemination of information among the members of the team providing care for a patient

(iii) Demonstrating the chronology of events, the factors observed and the response to care and treatment

(iv) Demonstrating the properly considered clinical decisions relating to patient care.[322]

111. In making the medical record, importance is attached to the proper recording of observations and advices given the *"substantial evidence to indicate that inadequate and inappropriate recordkeeping concerning the care of patients neglects their interests through:*

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318 Ref: 223-002-042
319 Ref: 226-002-012
320 Ref: 226-002-014-5
321 Ref: 202-002-052 *et seq*
322 Ref: 202-002-053

(i) *Impairing continuity of care*

(ii) *Introducing discontinuity of communication between staff*

(iii) *Failing to focus attention on early signs of deviation from the norm*

(iv) *Failing to place on record significant observations and conclusions."*[323]

112. Guidelines for record keeping were available in 2001 from a number of sources including the Department of Health ("DoH"), the Royal Colleges and professional regulatory bodies such as the GMC, UKCC and, latterly, the NMC. The GMC directed doctors to: "*keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatment prescribed.*"[324] The DoH 'Risk Management in the NHS' Manual[325] (1993) addressed the importance of medical records and records generally, including their role in risk management through: "*tracking, trending, monitoring and projection.*"[326]

113. The AHHSST 'Junior Doctor's Handbook' advised doctors to write legibly, and sign every entry[327] and further:

(i) "*The admitting doctor should give his impression at the end of writing up the case in the form of a differential diagnosis*

(ii) *A 'Problem List' should be formulated*

(iii) *Regular notes after admission should be made including the progress of the patient and how the results of the investigations have confirmed or altered the differential diagnosis...*

(iv) *A record should be made of the content of discussions with the patient and relatives..."*[328]

114. The AHHSST produced its own 'Patient Casenote Standards' (1996)[329] and a casenote documentation audit was performed in Altnagelvin in 1999-2000. The Clinical Audit Report 1999/2001 records that only "*57% of patients had a daily entry in their medical records.*"[330] This indicated "*large gaps in some patient's notes*" which "*may be reflective in the clinical activity of the area*"[331] and prompted a query as to whether it was

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323 Ref: 202-002-053
324 Ref: 314-001-004
325 Ref: 314-013-001
326 Ref: 314-013-001
327 Ref: 316-004g-017
328 Ref: 316-004g-017
329 Ref: 321-014c-001
330 Ref: 321-068-009
331 Ref: 321-068-009

"acceptable for patients occupying acute admissions beds not to be seen daily by the medical officer."[332] These results were discussed at the Clinical Audit Committee Meeting on 23rd November 2000 and Dr. Parker, the Clinical Audit Co-ordinator indicated *"that each individual Directorate [had] received a copy of their own results and were informed that a re-audit would take place in one year's time. Mrs. Witherow said that she had attended the Ward Sister's meetings to discuss the action required in relation to nursing. She added that the Clinical Directors would be required to action the medical aspect of this."*[333] It is unclear which Clinical Director would have driven the response to this audit within Ward 6 for the benefit of Paediatric patients. The extent to which the AHHSST properly implemented guidance on record keeping and the extent to which medical record making was monitored will be a matter for further inquiry at Oral Hearing.

115. A number of issues have arisen in respect of the medical records relating to Raychel's case:

(i) The Fluid Balance Chart does not record all the vomiting that took place on 8th June.[334] Mr. Foster notes that "*There was no attempt to record accurate volumes and there is a complete inconsistency in their recording from ++ through to the use of words such as 'small' and 'large'. These are of course totally subjective."*[335] In his Report for the Coroner, Dr. Edward Sumner, describes the Fluid Balance Chart as *"confusing as the IV input is in the wrong column"* and *"there is no note of any urine output or oral fluid intake."*[336] Perhaps, most unusual was the use of a chart headed *"Neo-Natal"*

(ii) Written observation sheets were inadequately maintained for the 8th June. The general chart contains only one reference to vomiting. [337] Mr. Foster is unequivocal in observing: *"Notes made at 13:00 and 18:00 do not mention vomiting at all! Any critical reader of the file can only conclude that the true severity of the vomiting suffered by this child was seriously underestimated by the nursing staff on Ward 6"*[338] He further states that *"I cannot understand why a different observation sheet was apparently kept for the 8th June when it is admitted that Raychel suffered multiple episodes of vomiting throughout this day. Larger, more commonly used observation sheets, would have allowed the contemporaneous recording of specific events (such as vomiting) and requests for medical visits with times and*

332 Ref: 321-068-009
333 Ref: WS-332/1 p.120
334 Ref: 020-018-037
335 Ref: 223-002-014
336 Ref: 012-001-003
337 Ref: 020-015-029
338 Ref: 223-002-019

outcomes from these. More detailed records throughout the 8th would have assisted the nursing staff to detect an ongoing deterioration throughout the afternoon and evening of the 8th. In reality there was so little written down that it would only have been by verbal communication that the nurses would have realised the reality of the clinical situation and it is my belief that this communication was lacking."[339] Ms. Ramsay further notes that the *"observation chart did not conform to the usual graph style, making it difficult to assess trends and changes"*[340]

(iii) There is only one reference to vomiting in the Episodic Care Plan. Mr. Foster concludes that the records *"confirm the lack of awareness by the nursing staff on Ward 6 of the seriousness of Raychel's condition throughout the 8th June... only a single entry mentions vomiting and completely underestimates the amount."*[341] He found this *"difficult to explain and much to be regretted"*[342]

(iv) Changes in Raychel's condition were not properly recorded so as to prompt assessment by a doctor[343]

(v) The Episodic Care Plan does not record the Zofran administered by Dr. Devlin. Sally Ramsay observes that *"the efficacy of medicines aimed at relieving symptoms would normally be entered in the evaluation section of the care plan. This was an omission in record keeping"*[344]

(vi) Mr. Foster notes that he is *"puzzled by the lack of any nursing note or record that relates to the request to bleep Dr. Zafar and to the visits of Drs. Butler, Devlin and Curran together with the timings of these visits"*[345]

(vii) The clinical notes for 8th June contain only one record, an untimed 3 line entry made by Mr. Zafar in relation to his ward round first thing in the morning. Mr. Foster notes that whilst it directs *"continue observations"*[346] it does not state what those 'continued observations' should be.[347] It became clear during the evidence at the Hearing of Mr. Makar and Sister Millar that they had different views on what was expected. The lack of clinical notes is despite the fact that Mr. Makar, Dr. Butler, Dr. Devlin

339 Ref: 223-003-002
340 Ref: 224-002-025
341 Ref: 223-002-021
342 Ref: 223-002-021
343 Ref: 224-002-016
344 Ref: 224-002-024
345 Ref: 223-002-043
346 Ref: 020-007-013
347 Ref: 223-002-010

and Dr. Curran all attended on 8th June. A significance of that is that Dr. Curran did not appreciate when he attended at about 22:00 and prescribed the anti-emetic valoid (cyclizine)[348] that Dr. Devlin had already attended at about 18:00 and prescribed the anti-emetic Zofran,[349] which had been unable to prevent further vomiting.

116. It will be a matter for you, Mr. Chairman, to consider and determine the extent to which Altnagelvin allowed the doctors and nurses to regulate the standard of their own record keeping and whether there was a system of scrutiny of the practices that developed.

IX. Clinical Protocols

117. The September 1998 AHHSST 'Proposed Strategy for Implementing Clinical Governance'[350] cites risk management as an aid to *"formulating new policies, procedures, guidelines or protocols designed to define more clearly the way that care should be managed or delivered."*[351] The Strategy recognised that *"accessing and appraising objective evidence of good clinical practice is becoming increasingly important and could rapidly become a core clinical competency."*[352]

118. The first AHHSST 'Clinical and Social Governance Report' (2002 to 2003) explains *"Guidelines and Standards have been described as "systematically developed statements to assist the healthcare worker in making patient decisions about the appropriate healthcare for specific patient groups."*[353] *"External guidelines, policies and protocols provide excellent standards to audit against."*[354]

119. Specific responsibility for incorporating clinical guidelines into the work of Altnagelvin was included in the written terms of clinicians' employment. The *"Job Description"* of the late Mr. Bateson FRCS (Clinical Director of Surgery & Critical Care in 1998) included a responsibility to manage *"the total quality dimension of service delivery including the development of quality standards specific to the specialty services."*[355]

120. Standards expressed as clinical policies or clinical protocols would have been routinely available to Altnagelvin from a wide range of

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348 Ref: 020-017-034
349 Ref: 020-017-035
350 Ref: 321-004fg-001 *et seq*
351 Ref: 321-004fg-004
352 Ref: 321-004fg-004
353 Ref: 316-004d-017
354 Ref: WS-324/1 p.8 (11h)
355 Ref: 321-004gd-001

sources in 2001. Recommendations deriving from the NCEPOD or from regional guideline groups such as the Clinical Resources Efficiency Support Team ("CREST") were in circulation. The late 1990s witnessed the emergence of the internet and intranet as potent vehicles of evidenced based medical knowledge.[356] Clinicians often worked together to produce *"pathways and guidelines."* Dr. Taylor recalls how *"on an ad hoc basis the Sick Child Liaison Group developed two sets of clinical guidelines on meningococcal disease and bronchiolitis for paediatricians and anaesthetists in Northern Ireland."*[357]

121. The Royal Colleges and the UKCC kept members informed of appropriate professional standards. Individual clinicians might observe these standards but in order to provide universal guidance within the hospital, the information would have to be adopted by the AHHSST as Protocol. However, Royal Colleges guidance, which could have informed multidisciplinary clinical practice, was not the subject of systematic collation or distribution within Altnagelvin.

122. Clinical policy might have also derived from internal procedures, audit or the 'lessons learned' from Critical Incident Reviews, complaints or claims. DHSSPSNI guidance, GMC advice and teaching developments could all have been channelled into AHHSST clinical policies. The Medical and Clinical Directors had a central role to play in the adoption of clinical policy and, through the Clinical Governance Committee, for the implementation, monitoring and enforcement of policy. Dr. Fulton is, however, unable to recall *"a specific monitoring structure"* for clinical policies.[358]

123. Dr. Nesbitt has described how, in respect of recommendations from Royal Colleges *"implementation at departmental level would be overseen by the relevant Clinical Director or Postgraduate tutor within that department."*[359] *"Recommendations from the external sources [having been] disseminated to consultants by a variety of ways... [would] then be disseminated to other staff including junior medical staff through Directorate meetings... audit meetings and Teaching sessions."*[360]

124. Examination of the clinical issues arising from Raychel's case has drawn attention to the absence, in 2001, of written clinical guidelines or protocols in respect of:

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356 Evidence based medical reviews – *"A recently launched database combining and linking the Cochrane Database of systematic reviews and best evidence to MEDLINE Website: http://www.ovid.com/"* Lugon & Secker Walker 'Clinical Governance: Making it happen' (Royal Society of Medicine Press 1999)

357 Ref: WS-330/1 p.8

358 Ref: WS-043/3 p.8

359 Ref: WS-035/2 p.9

360 Ref: WS-324/1 p.9 (15)

(i) Relaying information to on-call Consultants in respect of patients admitted under their care

(ii) Clarifying medical responsibility for surgical cases on paediatric wards[361]

(iii) The decision to operate on children at night[362]

(iv) The performance of out-of hours surgery by junior doctors acting without Consultant knowledge

(v) Supervision and management of post-operative children[363]

(vi) Prescription of intravenous fluids in post-operative children and the accurate weighing of children

(vii) Management of intravenous fluids in post-operative children[364]

(viii) The post-operative measurement of serum electrolytes

(ix) Effective patient handovers and post-take ward rounds[365]

(x) Contact by junior surgical/anaesthetic doctors of their on-call Consultant

(xi) Management of Post-Operative Nausea and Vomiting ("PONV")

(xii) The discharge of children from hospital or the transfer of patients between hospitals[366]

(xiii) The making of records and/or record keeping for staff above JHO level.[367]

125. Healthcare Risk Resources International noted in its Risk Management Report to the DHSSPSNI in 1997 that *"treatment protocols and agreed standards cannot be overemphasised in relation to risk reduction. Often, a major cause of risk is that members of staff are individually uncertain of what is expected of them, particularly in emergency situations. This can be compounded when other members of the same team have different understandings about what actions should be taken in such situations."*[368]

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361 Ref: 316-004-003
362 Ref: 316-023-001
363 Ref: 316-023-002
364 Ref: 220-002-003
365 Ref: 321-004f-005
366 Ref: 321-004f-005
367 Ref: 321-004f-004
368 Ref: 317-035-002

126. Commenting on the absence of clinical guidelines in the wards of the Royal Belfast Hospital for Sick Children ("RBHSC") in 1996 Dr. Roderick McFaul, the Inquiry's Expert on governance in relation to the Claire and Lucy cases, commented that in *"this respect the RBHSC was out of step and timing with the introduction of guidelines in the NHS in England and it is particularly remarkable in that the hospital is a teaching centre for paediatrics, nurses and other specialists in training"*[369] and that the absence of such guidelines in 1996 constituted *"a major shortcoming in standards of clinical governance."*[370] Such observations have even greater force when applied to Altnagelvin in 2001. That the AHHSST failed to address its responsibility to develop clinical policies in such a context and in the light of the additional encouragement of the Report of 'The Working Group on Paediatric Surgical Services in Northern Ireland'[371] is an issue to be further explored during the Oral Hearings.

127. Immediately following Raychel's Inquest the Altnagelvin Communications Department produced a document entitled *"Potential Media Questions (and some suggested answers) arising from the Raychel Ferguson Inquest and our Statement"* which included the following potential question *"How can the public be sure that there are no other 'procedures and practices' in Altnagelvin that might lead to this kind of tragedy happening again? Suggested answer - the public should be reassured that Altnagelvin practises in accordance with the highest professional standards as required by the various Royal Colleges in the United Kingdom. We constantly audit our work against these standards and ensure we keep up to date with the new developments and new treatment options."*[372] Such a commendable system can only have been developed after Raychel's death because Dr. Parker, the Clinical Audit Coordinator, when invited to address the Altnagelvin Hospital Management Team on 10th April 2001 referred to *"the Royal College practice of issuing guidelines to relevant consultant staff only and not to any other staff. This means that there is no central library where all guidelines can be stored and accessed. He suggested there is a need to identify an individual to whom all consultants will send a copy of the guidelines they receive. This proposal was felt to be worthwhile and it was agreed that this would be discussed further at the forthcoming Clinical Governance Workshop."*[373]

128. It is to be recognised that even if Altnagelvin had had a fully functioning system of clinical governance producing clinical standards in 2001, it is highly improbable that it would have developed hyponatraemia guidelines before any other Teaching Hospital in the UK. However, the absence of any obvious system for the

369 Ref: 238-002-070
370 Ref: 238-002-071
371 Ref: 224-004-090 (DHSS 1999)
372 Ref: 023-018-030
373 Ref: 316-006e-002

implementation and monitoring of clinical standards raises concerns that the AHHSST Board might not have been in a position to feel confident that the DHSSPSNI's Hyponatraemia Guidelines were being observed from March 2002.

Recommendations of the National Confidential Enquiry into Post-Operative Deaths ("NCEPOD")

129. Neither the consultant anaesthetists, nor the consultant surgeon who were on-call were informed of Raychel's admission or were involved in the decision to operate. No guidelines were available to Drs. Makar or Gund to clarify the circumstances in which they should contact their consultants. The 1999 NCEPOD Report 'Extremes of Age' recommends that *"anaesthetic and surgical trainees need to know the circumstances in which they should inform their consultants before undertaking an operation on a child."*[374]

130. The 1999 NCEPOD advice was important not least because the NCEPOD 1989 Report observed that children operated on at night are more likely to have complications. Mr. Orr described the 1989 NCEPOD recommendations as a *"wake up call to the surgical and anaesthetic professions in regard to the management of children... [they] received significant publicity and circulation within the professions."*[375] That these recommendations were not applied in Altnagelvin in 2001 both surprised and worried Mr. Orr because there had been *"eleven years to implement a Report which made a major impact on the professions."*[376]

131. Notwithstanding, Mr. Foster's comment that *"the role played by NCEPOD recommendations in the 1990s in advancing surgical standards cannot be over emphasised and is well understood by all surgical specialists,"*[377] Drs. Makar, Zawislak, Gund and Jamieson gave evidence that they were unaware of the 1989 Recommendation that *"no trainee should undertake any anaesthetic or surgical operation on a child of any age without consultation with their consultant."*[378] Dr. Jamieson accepted that *"Altnagelvin had no guidelines on the point... I feel the NCEPOD Report... certainly would have influenced me at that time if I had known and I would have contacted the third on* [call] *consultant."*[379] Mr. Gilliland has acknowledged that the NCEPOD recommendations were not applied in Raychel's case, were not adopted as policy at Altnagelvin and that he was unaware of the NCEPOD 'Who Operates When' Report.[380] Mrs. Brown considers that *"the professional leads would have had*

374 Ref: 220-002-023
375 Ref: Transcript of the Oral Hearings 21st March 2013 p.46, line 23
376 Ref: Transcript of the Oral Hearings 21st March 2013 p.53, line 14
377 Ref: 223-002-008
378 Ref: 223-002-054
379 Ref: Transcript of the Oral Hearings 7th February 2013, p.64 line 8
380 Ref: WS-044/2 p.6

responsibility for implementation of these recommendations."[381] Mrs. Burnside recalls that *"NCEPOD recommendations were used to improve practice and where possible would be implemented. Often NCEPOD recommendations would have significant resource implications and substantial business cases had to be produced to attempt to secure the additional resources."*[382]

132. Professor Swainson is of the view that *"The Trust should have had clear systems for ensuring compliance with relevant national UK professional guidance. Clinical audit was established firmly by 2001 and doctors would be expected to review their practice and service organisation against NCEPOD reports and guidance. The Trust medical director should have ensured that the report was considered and acted upon, and in many Trusts this would have been reported to the Board, or at least the Clinical Governance or Risk Committee, in 2001. Reasons for not implementing a NCEPOD report recommendation would need to be agreed by the medical director and signed off by the Board."*[383] Failure to adopt NCEPOD advice must be seen as a weakness in the Altnagelvin system, most especially given its occasional practice of paediatric surgery and its role as a Teaching Hospital.

133. The NCEPOD recommendations were not only then available to Altnagelvin staff but Dr. J. N. Hamilton (Consultant Anaesthetist) and Mr. P. G. Bateson (Consultant Surgeon) acted as contributors to the work of NCEPOD.[384] The *"Report of a Working Group... Paediatric Surgical Services in Northern Ireland"* made the recommendation that *"there should be adherence to the NCEPOD recommendations regarding supervision of junior, anaesthetic and surgical staff."*[385] It is to be noted that Mr. Panesar FRCS, Consultant Surgeon of Altnagelvin served as a member of this Working Group.[386]

X. Audit

134. The 1989 White Paper 'Working for Patients' was the first attempt to standardise audit as a part of healthcare. It defined medical audit as *"the systematic critical analysis of the quality of medical care including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient."*

135. The 1990s witnessed an emerging requirement for hospitals to pursue clinical audit as part of the drive for improvement in standards of

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381 Ref: WS-322/1 p.13 (12c)
382 Ref: WS-046/2 p.32 (c)
383 Ref: 226-002-015
384 Ref: 220-002-154
385 Ref: 306-079-033
386 Ref: 306-079-037

practice. The 'HPSS Management Plan 1995/96 – 1997/98' stipulated that hospitals *"should ensure that there is a clear policy on clinical audit as part of a programme to improve all aspects of service quality, not just clinical outcomes."*[387]

136. The 'Service Agreement for the Provision of Hospital Services' between Altnagelvin and the WHSSB of June 1999 provided that *"each specialty will be required to participate in clinical audit on a multidisciplinary basis as appropriate. Individual professions will also be required to initiate audit projects in relevant circumstances. Audit projects should be designed to develop suitable guidelines and treatment protocols from which outcomes can be measured."*[388] Altnagelvin was in fact charged to *"share details of its quality framework with the purchasers [WHSSB]. This document should set out the various professional guidelines and policies being adhered to, together with details and internal arrangements which are in place in respect of key activities such as... medical, nursing and clinical audit."*[389]

137. The GMC requirement of doctors, in 2001, was to *"work with colleagues to monitor and maintain the quality of the care you provide... in particular, you must take part in regular and systematic medical and clinical audit recording data honestly."*[390] This was also expressed as one of the *"duties"* outlined in the AHSST 1996 'Junior Doctor's Handbook'- *"All doctors are required to attend medical audit within the hospital."*[391] The Royal Colleges, including the Surgeons and Anaesthetists[392] also laid down similar requirements for their members.[393]

138. Notwithstanding a requirement for clear policy on audit, the DLS have advised that the AHSST *"had no written protocols, guidelines, guidance or practice documents in relation to clinical audit."*[394] If true, this is a notable shortcoming in the standard of clinical governance because the consequences must include a risk of substandard clinical audit and a loss of focus on clinical guidelines, risk reduction and risk control.

139. Nonetheless, the 1998/99 AHHSST Annual Report was able to highlight as a *"key achievement"* the

    (i) *"Reorganisation of a multidisciplinary clinical audit committee which will provide the focus for all audit activity in the Trust. This Committee works closely with Ward and Departmental staff in reviewing clinical practices against best practice standards and*

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387 Ref: WS-066/1, p.28
388 Ref: 321-028-010
389 Ref: 321-028-009
390 Ref: 314-014-008
391 Ref: 316-004g-003
392 Ref: 210-003-014
393 Ref: 220-002-083
394 Ref: 321-004f-004

implementing change to improve the quality of care given to the patient

(ii) *Annual Audit Report and Conference*

(iii) *Appointment of a Clinical Effectiveness Coordinator who will work with the Chairperson of the Clinical and Medical Audit Committee, and with staff undertaking uni-professional audit to improve their practice*

(iv) *Development of clinical care pathways to ensure best practice."*[395]

140. Dr. Parker is named as the Clinical Audit Coordinator for the hospital[396] and the Clinical Support Services Directorate is advertised as providing the medical audit service.[397] Dr. Parker *"was the medical lead for audit and Chair of the Trust Audit Committee. The Clinical Effectiveness Co-ordinator was responsible for managing the audit team, for leading on standards and guidelines... The RMCO was responsible for developing a Trust-wide risk management culture... It was anticipated that all three officers would work closely together by meeting regularly and attending committees to ensure that trends emerging from incidents, claims, complaints and audits could be identified and further proposed action taken."*[398]

141. The Clinical Director of Surgery & Critical Care bore some responsibility for audit development according to the terms of his job description.[399] Dr. Makar has described *"meetings in the Surgical Directorate with Mr. Gilliland and Mr. Neilly about the audit projects."*[400] It is to be assumed that the surgical department presented completed audits *"at the monthly morbidity/mortality/audit meetings"* in much the same way as the anaesthetic department was said to do by Dr. Nesbitt.[401]

142. The Annual Report for 1999-2000 draws attention to the work of the multidisciplinary clinical audit committee in evaluating *"Outcomes of Care."* Its aims were said to *"encompass two major activities... audit of current practice against evidence based standards; audit in response to serious clinical incident reports."*[402] Dr. Parker has advised that he *"can find no record of any audits initiated following the identification of clinical risks in Raychel's case. I did not receive any correspondence following the Critical Incident Review requesting an audit be undertaken by the Audit department. I*

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395 Ref: 321-004gi-044
396 Ref: 321-004gi-010
397 Ref: 321-004gi-032
398 Ref: WS-322/1 p.5
399 Ref: 321-004gd-001
400 Ref: Transcript of the Oral Hearings 6th February 2013, p.41 line 8
401 Ref: WS-035/2 p.8
402 Ref: 321-004gj-042

did not sit on the Critical Incident Review panel."[403] He further states: *"an individual Critical Incident Review does not usually trigger an audit. However, if there was a suggestion that several cases were similar, the audit would have a role to help establish the facts."*[404]

143. Audit of a serious clinical incident was a key clinical recommendation of the 1999 NCEPOD Report so that *"the events surrounding the peri-operative death of any child should be reviewed in the context of multidisciplinary clinical audit."*[405] Mechanisms for analysing the outcome of care from critical incidents, that they might better inform current practice, were in place in AHHSST in 2001. The RMCO served on the Clinical Audit Committee.[406] In addition to the Clinical Audit Committee, the 1997 'Altnagelvin Policy for the Management of Clinical Risk' created the Trust Scrutiny Committee chaired by the Medical Director who, with the RMCO and solicitor, were charged with maintaining *"a close relationship with the medical/clinical Audit Committee."*[407] The fruits of this close relationship are not apparent.

144. Apart from the Critical Incident Review meeting there is no indication that Raychel's case was examined in the context of multidisciplinary audit, whether in 2001, or at all. Nor is there any indication that any individual aspect of her care or treatment was subject to audit. Only a limited number of Clinical Audit Committee minutes have been provided the Inquiry, despite request. Altnagelvin did perform an audit of fluid balance charts in February 2003.[408] This audit did not however extend to Ward 6 because it was said to use different intake/output charts to other Wards, which in any event, they were *"reviewing at present."*[409]

145. On 25th March 2002, Dr. Henrietta Campbell, the Chief Medical Officer ("CMO") wrote to the AHHSST to announce the DHSSPSNI's Guidelines on the Prevention of Hyponatraemia in Children. She stated *"it will be important to audit compliance with the guidance and locally developed protocols and to learn from clinical experience."*[410] The extent to which compliance was audited is unclear.

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403 Ref: WS-324/1 p.5 (5)
404 Ref: WS-324/1 p.6 (7e)
405 Ref: 220-002-023
406 Ref: WS-035/2 p.7
407 Ref: 321-004fd-001
408 Ref: 021-045-093
409 Ref: 021-045-098
410 Ref: 012-064c-329

XI. Medical Responsibility for Patients

146. *"On admission each patient was allocated a 'Named Consultant' as per on call rota. The name of the patient's consultant was on a card at the head of the patient's bed."*[411] Raychel Ferguson was admitted under the care of Mr. Gilliland as an emergency admission.[412] It was his *"responsibility to oversee Raychel's care"* and be *"available for consultation and delivery of care as required."*[413] He was expected, as on-call Consultant, to *"oversee the totality of the patient's care."*[414] As Mr. Gilliland explained *"the Consultant surgeon therefore takes responsibility for the management of his clinical service. The delivery of care will frequently be delegated to other members of the surgical team who are deemed by the consultants to be competent to deliver the care. Patient care is therefore consultant led rather than consultant delivered."*[415] The process by which Mr. Gilliland deemed his surgical team competent is unclear. In Mr. Gilliland's opinion the consultant *"overall was responsible for ensuring that there was a system that would deliver care to that patient."*[416] The process by which Mr. Gilliland deemed the system to be adequate is unclear.

147. The GMC 'Good Medical Practice' Guidance sets out Mr. Gilliland's duty as leader of the speciality surgical team charged with Raychel's care to *"ensure that her care was properly coordinated and managed"* and that arrangements were put *"in place to provide cover at all times."*[417] The Altnagelvin 'Junior Doctor's Handbook' emphasised that *"even when off duty you have a continuing responsibility for the patient under your care."*[418] Implicit to these statements of responsibility is the assumption that Mr. Gilliland was aware of the patients under his care and aware of the competency of those to whom care was delegated. Mr. Makar recalls that a consultant would normally check each morning for new patients admitted under his name.[419] Mr. Gilliland did not see Raychel at any time and there is no clear evidence that he even knew that Raychel was his patient until after her death. According to Mr. Gilliland *"there was no formal protocol for ensuring that the on-call consultant was informed of all patients under his care at that time."*[420] Mr. Foster regards this as a matter *"of concern"*[421] which suggests *"serious vertical communication problems"* at Altnagelvin.[422]

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411 Ref: WS-056/3 p.10 (6n)
412 Ref: 020-001-001
413 Ref: WS-044/2 p.5
414 Ref: WS-044/2 p.5
415 Ref: WS-044/2 p.5
416 Ref: Transcript of the Oral Hearings 14th March 2013 p.120, line 9
417 Ref: 314-014-016
418 Ref: 316-004g-003
419 Ref: WS-022/2 p.19
420 Ref: WS-044/2 p.5
421 Ref: 223-002-007
422 Ref: 223-002-007

148. Responsibility for paediatric surgical patients cared for on Ward 6 lay with the surgical team. Dr. Johnston observed *"although the surgical patients were on the paediatric ward, that was the only common denominator, they were solely managed by the surgical team and the surgical JHO, SHO, Registrar, Consultant; and we [paediatricians] had no involvement with them whatsoever."*[423] Mr. Gilliland described an informal practice on Ward 6 whereby paediatricians would respond to the needs of surgical patients if surgical staff were unavailable.[424] There was concern about the attendance of surgeons upon their patients in Ward 6. This had been, in the words of Dr. McCord, an issue that had been *"mentioned from time to time and it seemed to flare and then quieten, improve for a while and then it would come to the surface again. But it did seem to be an issue for the nursing staff... but I do remember Sister Millar at one of our Sister's meetings, you know, where senior nursing staff would meet with senior consultant staff and I think the encouragement was given by the paediatricians that Sister Millar should speak to the senior consultant surgeon to make her concerns known."*[425] These issues had not been resolved at the time of Raychel's death.

149. Dr. Scott-Jupp gave his view that *"the most accessible doctors to the nurses will always be the paediatric team... Surgical doctors can sometimes be difficult to get hold of for very good reasons because they may be in theatre, but even if they are not in theatre, they will be tied up with adults in a different part of the hospital, which may be a long way away... and the children's ward if quite a long way down their list of priorities. Part of the reason the children's ward is a long way down the list of priorities is perhaps, to some extent [because] they rely on their paediatric colleagues to do these minor tasks... for them without them having to spend a lot of time going there just to simply write up a simple prescription or carry out some fairly minor task. That is how children's wards tick over. I think they always have done and they continue to do to this day. This leads to different questions of responsibility and accountability... If one were to institute a universal rule that no prescription, procedure or anything could ever be done on a surgical patient except by a surgical doctor, that would be highly disruptive to the running of every children's ward in the hospital and I think that an important point. So although, in theory, accountability should be hierarchical in that each patient is under a consultant and that consultant's team, in practice it doesn't work like that."*[426] The importance of communication and clarity as to responsibilities as and between clinicians is therefore obvious. There was no protocol to provide guidance.

150. Mr. Foster gave the Inquiry a different model of the *"protocol in the hospital I worked in... in Nottingham. The paediatricians took over-arching*

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423 Ref: Transcript of the Oral Hearings 7th March 2013, p.168 line 24
424 Ref: Transcript of the Oral Hearings 14th March 2013 p.92, line 17
425 Ref: Transcript of the Oral Hearings 13th March 2013, p.22 line 15 *et seq*
426 Ref: Transcript of the Oral Hearings 20th March 2013, p.45 line 9

control of all children, surgical and medical, and would visit and see each patient every day, and this made sure [that] it was clear who was in charge. The surgeons were also there for surgical matters, but that immediately eliminated any equivocation about who was in charge and controlling the case. I think that was a protocol followed by a significant number of hospitals."[427]

151. Staff Nurse Noble gave evidence that *"the Consultants were not there often on the wards"* and that it was *"mostly Registrars"* who participated in the ward rounds.[428] A consultant responsible for *"the totality of a patient's care"*[429] must be satisfied that the junior doctors to whom care is delegated are competent. This was important in Raychel's case because she was seen by five junior doctors. None saw her more than once and none communicated with any other. No doctor had ongoing knowledge of her condition and no doctor was able to observe changes over time. Nursing staff did not report concerns about change of condition. Raychel was not seen by anyone more senior than a Senior House Officer from admission to seizure. Nor was any senior clinician involved in any post-operative investigation. Dr. Haynes condemns the lack of senior involvement in Raychel's care as *"completely unsatisfactory"*[430] and believes Mr. Gilliland should *"at the very least"* have seen her at some point during 8th June.[431] In consequence of this lack of continuity of care Sally Ramsay believes that *"the nurses were unsure of which doctor to call and who had responsibility for Raychel's care."*[432] As Dr. Haynes observed, the Critical Incident Review performed in the aftermath of Raychel's death, would have provided *"an opportunity for the medical director to insist that all his consultant colleagues took a hands-on role in the supervision of IV fluid therapy, consultants ensuring that the trainees knew they were expected to do the blood tests, get the results and act on them if necessary."*[433]

152. The surgical JHOs were also on-call for acute adults elsewhere in the hospital. Dr. Devlin recounted that *"on-call you had five or six wards to cover and you may have been called to different areas as well. You sometimes had what they call surgical outliers in general medical wards as well... you had the orthopaedic wards, all the general surgery wards, you had the paediatric ward and you had these outliers to cover at night; so you were busy."*[434] They were not therefore always available to attend upon surgical patients in the paediatric ward.

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427 Ref: Transcript of the Oral Hearings 21st March 2013, p.131 line 12
428 Ref: Transcript of the Oral Hearings 26th February 2013, p.189 line 2
429 Ref: WS-044/2 p.5
430 Ref: 220-002-003
431 Ref: 220-002-003
432 Ref: 224-004-028
433 Ref: 220-002-007
434 Ref: Transcript of the Oral Hearings 6th March 2013, p.20 line 1

153. The PRHOs, who were the first on-call clinicians for post-operative children, had yet to complete their basic medical education. Mr. Foster believes that *"to place PRJHO (who had never done a paediatric job) in a position of being first on-call for post-operative children was unsatisfactory and I am surprised that this situation escaped the scrutiny of the Post Graduate Deanery responsible for the continued education of these pre-registration doctors."*[435]

154. The supervision of the JHOs and the *"oversight [of them] would fall to the consultant... they would need to be assured that if someone was going to see a patient on the paediatric ward, that they would be able to make an assessment of that patient appropriately and, if not, or if they had any concerns, feedback to either the Registrar, or if that was not appropriate to the Consultant."*[436] Yet Mr. Gilliland did not *"really think that... [I] would have expected of a JHO to pick up the phone and phone a consultant. I would have expected that to come from someone in a slightly more senior position."*[437] The reliance placed upon inexperienced PRHOs was complicated by the fact that *"they sometimes require consultant guidance"*[438] and often required guidance from nursing staff. Notwithstanding, Mr. Gilliland nonetheless placed reliance on the proposition that *"if people knew that problems were developing and they required my input... I would expect to be told."*[439] In this case *"I think the problem was that no one at that stage realised what was exactly happening to Raychel and how rapidly she was deteriorating."*[440] Mr. Foster concludes *"in the situation they were put in to, by Junior House men being first on call, the nurses were the safety net."*[441] Staff Nurse Noble has confirmed that *"Junior House Officers, since Raychel's passing, have not been allowed to come on Ward 6. The only surgical people who have contact with the children are SHOs."*[442] Mr. Gilliland was not only responsible for his surgical team but was also expected *"to provide education for the... medical postgraduate trainees attached to [his] ward."*[443] The Postgraduate Clinical Tutor Dr. Gardiner recalls that *"the provision of up-to-date postgraduate education in the surgical department had been enhanced by the arrival of new consultants such as Mr. Robert Gilliland."*[444]

155. Dr. Zafar who was responsible for the post-take ward round had only four months experience at Altnagelvin[445] and accepted that he had not

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435 Ref: 223-002-011
436 Ref: Transcript of the Oral Hearings 14th March 2013 p.92, line 17
437 Ref: Transcript of the Oral Hearings 14th March 2013 p.195, line 1
438 Ref: Transcript of the Oral Hearings 14th March 2013 p.156, line 14
439 Ref: Transcript of the Oral Hearings 14th March 2013 p.138, line 1
440 Ref: Transcript of the Oral Hearings 14th March 2013 p.141, line 3
441 Ref: Transcript of the Oral Hearings 21st March 2013 p.171, line 7
442 Ref: Transcript of the Oral Hearings 27th February 2013, p.125 line 5
443 Ref: WS-328/1 p.5
444 Ref: WS-328/1 p.5 (4)
445 Ref: WS-025/2 p.1

"had very many paediatric patients before Raychel."[446] Mr. Foster views this as *"entirely unsatisfactory and unsafe and evidence of disorganisation of the surgical services at the Altnagelvin Trust."*[447] Mr. Foster comments that *"Mr. Gilliland does not tell us why he did not attend the ward round on the morning of the 8th and admits this was done by Mr. Zafar 'FRCS' who he describes as an experienced member of staff (WS-044/2 page 12)... Dr. Zafar had never looked after children and there was no evidence in his own witness statement that he had the FRCS qualification (WS-025/2)."*[448]

156. The critical importance of consultants supervising patients' care does not seem to have been specifically addressed by the Action Plan produced by the Critical Incident Review Meeting. Rather, and almost two years later, a Memorandum dated 2nd May 2003 between Dr. Nesbitt and Mr. Bateson, Clinical Director for Surgery, makes it clear that timetabling of duties would be altered to give the on-call consultant surgeon time to review in detail the patients admitted under his care.[449] The Memorandum emerged *"As a result of some uncertainty regarding the management of surgical paediatric patients"* with the expectation that it *"should ensure that all paediatric surgical patients received the highest standards of care possible."*[450] Dr. Haynes believed that this would *"ensure that consultant surgeons have a chance to fulfil their obligations to patients admitted under their care."*[451] Indeed, it appears designed to address many of the issues arising in Raychel's case. It resolved that: *"all surgeons to do a ward round Monday to Friday of all their patients... the previous days on-call surgeon will visit the paediatric ward first thing every morning to check the condition of surgical patients admitted during the night. Surgeons will direct the surgical management of the paediatric patient. The paediatric nursing staff will bleep the surgeon to inform him of results when available. If named consultant is not available then the on-call surgeon should be bleeped. Surgeons are responsible for the management of the children admitted under their care. If they require advice regarding the medical condition of the child the paediatricians will be happy to provide assistance."*[452] As Mr. Gilliland observed: *"if there weren't flaws in the system, we wouldn't have put a protocol in place."*[453] Professor Swainson notes that *"The Trust should have been aware of these gaps in clinical care, but these were not addressed until after the tragic death of Raychel."*[454]

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446 Ref: Transcript of the Oral Hearings 1st March 2013, p.144 line 2
447 Ref: 223-003-011
448 Ref: 223-003-016
449 Ref: 095-010-046bk
450 Ref: 095-010-046bk
451 Ref: 220-002-007
452 Ref: 021-044-091
453 Ref: Transcript of the Oral Hearings 14th March 2013 p.164, line 11
454 Ref: 226-002-013

Clinical Responsibility for Intravenous Therapy

157. Just as there would appear to have been a failure of one clinician to assume responsibility for Raychel's care, so too was there a failure to clearly understand individual responsibility for the prescription of IV fluids.[455] There was no protocol available to guide doctors in the post-operative prescription of IV fluids.[456]

158. Dr. Gund, the junior Anaesthetist *"initially made an appropriate prescription for IV fluid administration for Raychel on return to the ward (020-021-040)... he did not have the confidence in his own knowledge to ensure that his prescription was followed by the ward staff."*[457] Dr. Gund was unable to say with certainty whether prescription was the responsibility of the surgeons or the paediatricians.[458] He decided to allow Raychel's fluids to follow the ward *"protocols"* suggested by the nursing staff on the basis that they would ask the paediatricians to prescribe Raychel's fluids.[459] This was, in the view of Dr. Haynes, *"completely inappropriate."*[460]

159. The surgical SHOs thought that the intravenous prescription was the responsibility of the paediatricians. Dr. McCord, the Consultant Paediatrician, confirmed to the Coroner that *"neither I nor my staff were consulted regarding the prescription of IV fluids for Raychel – we would not have expected to be. It was a matter for the surgical team."*[461] Additionally, and in any event, both surgeons and paediatricians responded to nursing requests in respect of intravenous fluid prescription.

160. Mr. Gilliland has given his view that the *"ongoing prescription of fluids in surgical patients would be the responsibility of the surgical team"*[462] yet neither he nor his surgical team were aware of the Ward 6 practice of continuing pre-operative fluid prescriptions, post-operatively. He conceded *"I would have to say that I should have known that."*[463] *"There were clinical director meetings where we might have discussed that issue"*[464] yet *"the frailties of that system were only exposed by Raychel's tragic death."*[465] Professor Swainson is of the view however that *"the consultant surgeons should have been clear with the nurses and the junior*

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455 For full summary of clinicians' understanding of the responsibility for post-operative fluid management, see Clinical Opening Statement Senior Counsel to the Inquiry, 1st February 2013, p.35, on the Inquiry into Hyponatraemia-related Deaths website under 'Oral Hearings.'

456 Ref: 321-004f-002

457 Ref: 220-002-014

458 Ref: 095-013-066

459 Ref: 095-013-066

460 Ref: 220-002-017

461 Ref: 098-033-102

462 Ref: Transcript of the Oral Hearings 14th March 2013 p.79, line 1

463 Ref: Transcript of the Oral Hearings 14th March 2013 p.182, line 14

464 Ref: Transcript of the Oral Hearings 14th March 2013 p.179, line 12

465 Ref: Transcript of the Oral Hearings 14th March 2013 p.173, line 21

doctors on who was responsible for prescribing fluids to post-operative children, and what fluids to prescribe."[466]

161. In consequence of the failure of a senior clinician to become involved it would appear that nobody took 'ownership' for the supervision of fluid therapy. Neither surgeon, nor anaesthetist, nor paediatrician. *"The problem was that there was no clear structure, no acceptance of responsibility between the senior staff in the three specialities (Surgery, Anaesthesia and Medical Paediatrics) regarding this important aspect of patient management. It appears always to have been someone else's job. The consultant staff in each of the three Departments, by failing to meet to agree lines of responsibility, generated a system at Altnagelvin Hospital where IV fluid prescriptions for post operative surgical patients were being dictated to junior medical staff by the nursing staff on the basis of custom and practice rather than by patient observation and informed by individual patient need."*[467]

162. The GMC 'Good Medical Practice' Guidelines requires doctors working in teams to *"make sure that your... colleagues understand your professional status and speciality, your role and responsibilities in the team and who is responsible for each aspect of patient's care."*[468]A failure of clearly understood processes and clearly demarcated responsibilities was permitted. It is for you, Mr. Chairman, to determine if this amounted to a failure in clinical leadership and/or clinical governance.

XII. Transfer of Raychel to the RBHSC

163. Mrs. Ferguson has told the Inquiry that: *"We believe the cover-up began on the morning Raychel was being transferred to the Royal. We now know the situation was hopeless… Altnagelvin just sent her to Belfast so that it would be recorded that Raychel died there: there was no hope for her."*[469]

164. Dr. Nesbitt rejects such a proposition on the basis that *"the diagnosis was not clear and Neurosurgeons in Belfast had accepted that we transfer Raychel to their care. The ICU in Altnagelvin does not provide services for children and such cases are always transferred to the Regional Paediatrics Unit… It is never too late especially in children and I can confirm that I have personally seen recovery from positions I thought to be irretrievable."*[470]

165. When Dr. McCord attended upon Raychel at about 05:00 on 9th June 2001 he found her pupils fixed and dilated[471] and noted *"a marked*

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466 Ref: 226-002-016
467 Ref: 220-002-017
468 Ref: 314-014-015
469 Ref: Transcript of the Oral Hearings 26th March 2013 p.176, line 9
470 Ref: WS-035/3 p.3
471 Ref: 012-036-171

electrolyte disturbance with profound hyponatraemia."[472] He described to the Coroner how *"an urgent CT scan was arranged. Initial impression of CT scan was one of sub-arachnoid haemorrhage and raised intracranial pressure. Subsequently Raychel was to be transferred to intensive care for stabilisation."*[473] The first CT scan was performed at 06:06 by Dr. Morrison in the presence of Dr. Nesbitt. It reported evidence of sub-arachnoid haemorrhage.[474] Raychel was returned to the ICU.[475] A priest performed the last rites.[476] Mrs. Ferguson recalled Dr. McCord telling her that *"her brain was clear but Belfast [were] saying they needed another scan"*[477] and *"a doctor in ICU with a beard said that she was very seriously ill and that there was a lot of pressure inside her head and that they would operate to reduce the pressure."*[478] Mrs. Kay Doherty, Raychel's maternal aunt, recalls this *"conversation taking place as we felt this was the first bit of information that we were given as to Raychel's condition and as to what was going to happen to her..."*[479]

166. Dr. Morrison states *"the second scan was an enhanced scan, it was performed at 08:30am"*[480] Dr. Morrison discussed the scan with Dr. McKinstry of the Royal Victoria Hospital who felt that the appearances were *"more in keeping with cerebral oedema"* and that *"a sub-arachnoid haemorrhage is therefore unlikely."*[481] Nevertheless, Dr. McCord told Mrs. Ferguson on 3rd September 2001 *"there were no new findings on the second scan – arrangements were made to transfer Raychel to Belfast."*[482] The precise sequencing of events is unclear as Dr. Morrison is clear that he did not contact Dr. McKinstry to request his opinion on the sub-arachnoid haematoma until the following day 10th June.[483] Dr. McKinstry thinks the discussion took place shortly after the scan but he is unsure and concedes the possibility that it happened the following day, i.e on the 10th June.[484]

167. Dr. Nesbitt, who accompanied Raychel to the CT suite for the second CT scan, has described how *"We were extremely concerned as to the cause of Raychel's brain swelling. One diagnosis suggested by the Neurosurgeons had been that possibly a sub-dural empyema (an area of infection) had developed and we hoped that surgical intervention might be possible. Transfer*

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472 Ref: 012-036-171
473 Ref: 012-036-171
474 Ref: 020-015-026
475 Ref: 012-035-168
476 Ref: 012-035-168
477 Ref: WS-020-1 p.19
478 Ref: 012-028-146
479 Ref: WS-326/1 p.7
480 Ref: WS-036/1 p.2
481 Ref: 068a-036-161
482 Ref: 022-084-219; See to Ref: Transcript of the Oral Hearings, 13th March 2013 page 76
483 Ref: 021-065-155 & Ref: WS-036/1, p.3
484 Ref: WS-037/1, p.2

to the Children's Hospital was organised following this."[485] However, Dr. Morrison's Radiological report excludes the possibility of sub-dural empyema.[486]

168. Accordingly, the precise significance of the second CT scan to the decision to transfer Raychel to RBHSC is unclear. Whilst Dr. Nesbitt maintains the view that it was associated with the possibility of surgical intervention there, the results of that scan suggested that to be unlikely. Indeed Mr. Bhalla, the surgical registrar who attended in response to Raychel's collapse, confirms *"I was there... we got the report that the second scan confirmed that it was cerebral oedema and there was no haematoma there."*[487] His explanation for the transfer is rather different *"from the examination as well as the investigation results, it was quite clear she has got a very bad prognosis with dilated fixed pupils... [which] ... means that she will not survive"*[488] and *"all of them said she needs intensive care, conservative management."*[489]

169. Raychel was returned to the ICU following the second CT scan. A serum sodium value of 119 mmol/l[490] confirmed her ongoing acute hyponatraemia and a decision was taken to transfer her to PICU in Belfast. Dr. Nesbitt has explained the basis of the decision to transfer Raychel to Belfast as *"First: Altnagelvin does not have a Paediatric Intensive Care Unit. The only ICU for children is in Belfast. Secondly: the neurosurgeons had asked that we transfer her to their care."*[491] Furthermore, he noted that brain stem death tests could only be performed at PICU. This decision was recorded as having been taken at 09:10.[492] A further two hours elapsed before she left Altnagelvin for Belfast at 11:10.[493]

170. The Transfer Referral sheet records the referring Consultant as Dr. Nesbitt, the principal relevant diagnosis as *"?Meningitis ?Encephalitis"* and the results of relevant investigations as *"?sub-achnoid hae."*[494] It is unclear why the known diagnosis of hyponatraemia was not stated.

171. Upon arrival at the RBHSC at 12:30 Raychel's medical diagnosis was noted as *"?hyponatraemia"* and the reason for her admission recorded as *"neurological assessment and further care."*[495] Dr. Dara O'Donoghue noted his view that she appeared *"to have coned with probably irreversible brain*

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485 Ref: WS-035/1 p.2
486 Ref: 068a-036-161
487 Ref: Transcript of the Oral Hearings 14th March 2013, p.45 line 20
488 Ref: Transcript of the Oral Hearings 14th March 2013, p.46 line 19
489 Ref: Transcript of the Oral Hearings 14th March 2013, p.48 line 13
490 Ref: 020-022-042
491 Ref: WS-035/2 p.21
492 Ref: 020-024-052
493 Ref: WS-020-024-053
494 Ref: 012-002-073
495 Ref: 063-015-035

stem compromise."[496] Subsequent brain stem tests confirmed this opinion.[497]

172. The DLS has confirmed that there was no written guidance relating to transfer of patients to PICU from other hospitals in 2000-2001.[498] Guidance as to the *"Transport of Critically Ill Children"*[499] was however produced by the Paediatric Benchmark Nurses Project and disseminated through the Advanced Paediatric Life Society. These guidelines were reportedly used by the nursing staff of Ward 6 at Altnagelvin.[500]

173. The Ferguson family questioned whether they were given false hope by the mention of surgery and the transfer to Belfast. As the minute of 3rd September 2001 Meeting with Mrs. Ferguson records *"Dr. Nesbitt said he did not give false hope but he wanted Raychel to have every possible chance. You were right… the event in the Ward was the terminal event but you have to give it all you have. I tried my best."*[501]

174. However, Mr. and Mrs. Ferguson remember that on their arrival at RBHSC Dr. Nesbitt told them that Raychel had *"a good journey up and there was plenty of movement, that's a good sign."*[502] Dr. Nesbitt maintains that he "*said her condition remained unchanged, her observations were stable and that the movements, which were evident prior to transfer, remained. I do not believe that I placed undue emphasis on these movements and there was no inference that there had been any recovery. It is very much regretted that Mr. and Mrs. Ferguson took this meaning."*[503]

175. Dr. Nesbitt has remarked how the circumstances of that day underlined for him "*the importance of effective communication with distraught family members."*[504]

176. On the basis of the evidence received so far, it is difficult to appreciate exactly what informed the decision to transfer Raychel to PICU, in particular the relative significance of the second CT scan and the opinions of the consultant Radiologists, Anaesthetists and Surgeons in Altnagelvin and Belfast, informed. This is a matter that will be further examined at the Oral Hearing, in the context of the adequacy of communications between the clinicians at the 2 hospitals and the appropriateness of the information given to Raychel's family prior to

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496 Ref: 063-009-023
497 Ref: 063-010-024
498 Ref: 319-012-001 & 321-015b-002
499 Ref: WS-008/1 p.15
500 Ref: 321-051-002
501 Ref: 022-084-219
502 Ref: Transcript of the Oral Hearings 26th March 2013 p.148 line 13
503 Ref: WS-035/3 p.2
504 Ref: WS-035/3 p.3

her transfer. Ultimately, it is a matter for you, Mr. Chairman, to determine why Raychel was transferred to Belfast, and whether imperfect communication, an eagerness to believe, or cover-up gave rise to her family's *"false hope."*

XIII. Communication with Parents

177. The UKCC Guidance for Professional Practice (1996) stresses at Paragraph 22 that *"Communication is an essential part of good practice"* and *"listening is a vital part of communication."*[505] The GMC's 'Good Medical Practice' reminds doctors that *"Good communication... is essential to effective care and relationships of trust"*[506] and that *"In providing care you must keep accurate and contemporaneous patient records which report… information given to parents."*[507] The NIHPSS 'Charter for Patients and Clients' (March 1992) accords a *"Right to... be kept informed about your progress. Your relatives and friends are also entitled to be informed."*[508] Accordingly, and if it is accepted that the patient has a right to information about his condition, it follows that the professional practitioners involved in his case have a duty to provide such information.[509] At a more practical level the AHHSST 'Junior Doctor's Handbook' advises that *"The best defence against complaints is good communication with patients and relatives"*[510] and *"A record should be made of the content of discussions with the patient and relatives."*[511] Indeed the *"Clinical record should be supplemented and updated regularly to include details and reports of all... verbal advice given to the patient and his or her relatives."*[512]

178. Notwithstanding that the nurses' Episodic Care Plan incorporates a requirement to *"keep her parents informed"*[513] and Ms. Ramsay comments that *"it would have been usual to note in the Care Plan the information given to parents such as reassurance on the child's progress... It is important for nurses to listen to parents, note their concern and give appropriate information as necessary to allay any anxieties... The entries in the Care Plan (020.027.059) at 17:00 hours on 8th June indicate that Raychel's parents were happy with her care. However, none of Mrs. Ferguson's observations were recorded in the Care Plan."*[514] Mr. and Mrs. Ferguson

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505 Ref: 314-003-001
506 Ref: 314-014-011
507 Ref: 314-001-004
508 Ref: 306-085-004
509 Ref: 314-002-001 *et seq*: UKCC 'Exercising Accountability' March 1989
510 Ref: 316-004g-008
511 Ref: 316-004g-017
512 Ref: 210-003-1049: 'Guidelines for Clinicians on Medical Records and Notes'; The Royal College of Surgeons of England
513 Ref: 020-027-060
514 Ref: 224-004-029

have expressed upset that when they voiced concerns about Raychel's condition and vomiting this was neither accepted nor acted upon.[515] Indeed, it was not even recorded.

179. Dr. Sumner has observed that *"In my opinion it is always very unwise to dismiss the opinions of the parents, after all, it is they who know their child best. And in this case there does seem to have been a failure of communication."*[516] *"Children's nursing is based on the principle that parents have greater knowledge of their child than the nurse caring for them (Family Centred Care), listening to the parents is vital. Where information from parents is inadequately recorded, the records will not portray a true picture of the clinical condition and as a result important problems may be missed."*[517]

180. Whilst Mr. Makar spoke briefly to Mr. Ferguson first thing on the morning of 8th June, Mrs. Ferguson recalls that *"Between 9:00am on 8th and 12:40am on the 9th no member of the medical staff (doctor) approached me."*[518] This failure of the medical staff, and the surgical team in particular, to communicate with Raychel's family during the day of her deterioration is compounded by a failure to communicate adequately with them after Raychel's collapse. Mr. George Foster notes that *"I am disappointed at the communication that took place between the surgical team and Raychel's parents. When Raychel suffered a fit and it was obvious that she was very seriously ill the consultant on call should have attended and seen Mr. and Mrs. Ferguson, urgently. The surgical team should also have been present at the meeting with the family in September 2001."*[519] However, Mr. Gilliland did not *"think the surgeon necessarily would have any clinical input at that time"*[520] and countered *"what he's effectively saying is that whenever a medical problem happens to any patient that causes their death, that he would expect the surgical consultant to come in and speak to the person's relatives. That just doesn't happen within the NHS."*[521] Neither the consultant on-call, nor the consultant with charge of Raychel's care attended to speak with Mr. and Mrs. Ferguson.

181. The Episodic Care Plan records that at 06:00 on 9th June 2001 Mr. and Mrs. Ferguson were *"spoken to [about Raychel's] condition and prepared for what to expect by Dr. McCord."*[522] He made no entry in Raychel's clinical notes of what he told them but he did record that the CT scan was 'normal'. Mr. Chairman you have heard evidence from Raychel's parents, Dr. McCord and Dr. Nesbitt on the 'false hope' issue. Dr. McCord acknowledged in his evidence that it would have been more

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515 Ref: Transcript of the Oral Hearings 26th March 2013, p.90 line 12
516 Ref: 068b-001-013
517 Ref: 224-004-029-30
518 Ref: 095-003-013
519 Ref: 223-002-043
520 Ref: Transcript of the Oral Hearings 14th March 2013 p.196, line 24
521 Ref: Transcript of the Oral Hearings 14th March 2013 p.201, line 1
522 Ref: 063-032-075

appropriate from him to await the report from the radiologist before making any entry into the notes and before discussing the CT scan with the parents.[523] Whilst Dr. Nesbitt believes Mr. and Mrs. Ferguson misunderstood his comments about the extent of Raychel's movement during her transfer to RBHSC and misinterpreted its significance.[524]

182. The issue of who should have spoken to Raychel's family, when and in what terms will be considered from a governance perspective at the Oral Hearing.

183. The PICU medical chart clearly records the information given to Mr. and Mrs. Ferguson at the RBHSC that *"Raychel is critically ill and that the outcome is very poor."*[525] The briefing with Drs. Crean and Hanrahan was noted and the Relative Counselling Record entry confirms the conversation.[526] Raychel's parents regard that bleak outlook as being in stark contrast with what they understood to be the position when they left Altnagelvin. They have no criticism of the way they were treated by the clinicians at the RBHSC and appreciated their candour.[527] In Mr. Foster's view, Mr. and Mrs. Ferguson were treated with *"All possible care and sensitivity"* at the RBHSC.[528]

184. Dr. Elma Ashenhurst, the Ferguson family GP, has confirmed that there is *"no record... of any communication from Altnagelvin Area Hospital re: Raychel's transfer to Belfast. Usually we would have received a form informing us of the transfer."*[529] Nor did *"any member of Altnagelvin staff [speak] to myself or a GP colleague about the fact or cause of Raychel's death... we did not receive a copy of the Autopsy Report."*[530] Neither was she *"briefed as to the outcome of the Critical Incident Review."*[531] No review or audit of communication with Mr. and Mrs. Ferguson was made in the aftermath of Raychel's death.

185. Apart from the suggestions in the 'Junior Doctor's Handbook', no protocols were in place, nor training given, to guide clinicians in the task of giving, receiving and recording information to parents.

186. Professor Swainson observes that *"The differing accounts of Raychel's condition during the 8th June suggest that communication was not strong and that the parents' concerns about [Raychel's] progress during the afternoon and*

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523 Ref: Transcript of the Oral Hearings, 13th March 2013, p.85
524 Mrs. Ferguson's evidence, Ref: WS-020/1, p.19 and Transcript, 26th March 2013, p.148. Dr. Nesbitt's evidence, Ref: WS-035/3, p.2
525 Ref: 063-009-021
526 Ref: 063-022-049
527 Ref: Transcript of the Oral Hearings, 26th March 2013, p.160 *et seq*
528 Ref: 223-002-027
529 Ref: WS-333/1 p.2(2)
530 Ref: WS-333/1 p.2
531 Ref: WS-333/1 p.3

evening of 8th June were not listened to or were dismissed... This is a central feature in this case."[532]

XIV. Critical Incident Review

187. Notwithstanding all that Drs. Nesbitt and McCord may have known about Raychel's collapse, low sodium levels and cerebral oedema early on the morning of 9th June, there is no evidence that a formal report of an adverse critical incident was made at Altnagelvin. There is however evidence of an investigation. Staff Nurse Gilchrist maintains that she made her written statement on 10th June 2001.[533] Clinical Services Manager Doherty, assisted by Sister Little, interviewed nurses, analysed the patient notes, and produced a preliminary *"Report re: Rachael Ferguson Ward 6."*[534]

188. Mr. Gilliland FRCS believes that "*there had been discussion between our own medical staff and the doctors in the RBHSC about the probable cause of Raychel's death. I believe I was made aware of that discussion sometime on 11th June..."*[535] and *"some of that discussion had been critical."*[536] A *"rumour"* alleging Altnagelvin's mismanagement of Raychel's fluid therapy emerged from RBHSC on Sunday 10th June 2001.[537]

189. The sad news of her death reached Dr. Fulton on the morning of Monday 11th June when the Chief Executive asked him *"to investigate this very serious event in [his] role as Medical Director."*[538]

190. Mrs. Therese Brown, the RMCO, assisted him and a meeting was convened quickly for 12th June 2001. A Review was initiated pursuant to the Altnagelvin Critical Incident Protocol of 2000.[539] As Dr. Fulton explains *"this protocol was based on the recommendations of the standard textbook 'Clinical Governance' by Myriam Lugon 1999 (Pages 94-96). We had invited the author to Altnagelvin to give a power-point presentation to the Trust on 25th October 2000. As a result of her advice on investigation of critical incidents we introduced the adverse Critical Incident Protocol in late 2000. This protocol was followed in investigating Raychel Ferguson's death."*[540] It was *"developed"* by Mrs. Brown.[541]

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532 Ref: 226-002-022
533 Ref: Transcript of the Oral Hearings 11th March 2013, p.65 line 7
534 Ref: 316-085-009
535 Ref: WS-044/4 p.11
536 Ref: WS-044/4 p.11 (q)
537 Ref: 021-020-041
538 Ref: WS-043/1 p.3
539 Ref: 026-012-016
540 Ref: WS-043/1 p.3
541 Ref: WS-322/1 p.6 (5b)

191. In setting up the Review Dr. Fulton said that he was concerned *"to form an accurate account of the events leading to Raychel's death while it was still clear in everyone's memory. I was also keen to ascertain whether lessons could be learned so that a recurrence of this tragic event could be avoided."*[542] The instigation of timely review was a proper response to Raychel's death. It will be a matter for you Mr. Chairman to consider how Altagelvin's response compares with the absence of any investigation or review by the RBHSC in relation to the deaths there of Adam, Claire and Lucy.

192. Furthermore, Mr. Chairman, you might consider the extent to which the actions of the AHHSST in reporting both the death from hyponatraemia and the implications of Solution 18 to other clinicians, other Trusts, the WHSSB and the DHSSPSNI, demonstrate how an open sharing of knowledge can lead to better healthcare and potentially save lives. There is an obvious comparison to be made with RBHSC in relation to Adam's death and the changes in its use of solution no.18. The CMO's Working Group and its Guidelines issued to hospitals across Northern Ireland resulted from the response of Altnagelvin. Dr. Edward Sumner (Expert Consultant Paediatric Anaesthetist) paid tribute to this work at Raychel's Inquest by describing how impressed he was by the Working Group and its findings and how moved he was that this had been done, doubting indeed that this could have been achieved in England or Wales in the same way.[543]

193. The Critical Incident Protocol adopted by the AHHSST and the conduct of the Review into Raychel's case was not a faithful interpretation of that suggested by Myriam Lugon, nor was the Review process itself a faithful response to the AHHSST's own Protocol. Myriam Lugon was straightforward in advice: *"staff must be interviewed and statements taken; in the case of potential litigation this is best done by the Claims Manager. It is important that they are made aware of the potential for litigation even though the Trust may not have received a letter before action and may not receive one for many months... Statements must therefore consist of factual information only. The actions of the organisation must be transparent and if negligence is identified during the investigation, this should not be hidden as it will serve no purpose..."*[544] The author's injunction to interview and take statements was rendered into the Altnagelvin Protocol as a reminder that *"staff may be asked to complete a statement, containing factual information of their involvement, to assist in the investigation. These statements may be discoverable in the event of future litigation."*[545]

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542 Ref: WS-043/1 p.4
543 Ref: 160-010-009
544 Ref: 317-034-002-4
545 Ref: 026-012-016

194. The AHSST Critical Incident Protocol directs that the *"Risk Manager will arrange a Critical Incident Review meeting ASAP comprising the Medical Director (Chairman) /Nursing Director/Clinical Effectiveness Coordinator/Clinical Director/CSM [Clinical Services Manager] / Consultant and other relevant staff. (On occasions the Trust's solicitors may be present.)"* Thereafter *"The Critical Incident Meeting will endeavour to clarify the circumstances surrounding the incident and identify further investigations and action required to prevent recurrence"* and *"the Risk Management Coordinator will provide the Chief Executive with a written report, with conclusions and recommendations within an agreed timescale."*[546]

195. It is not possible to assess the extent to which the Altnagelvin Protocol was adhered to from the scant documentation available. It might be supposed that so serious a case involving death, a large number of clinical witnesses, multiple issues of fact and a regional dimension would generate notes, statements, communications, commentaries, opinions, and a written report – but this was not seemingly the case.

196. Miss Duddy, Director of Nursing and Director for Risk Management, did not attend the Meeting and did not learn of Raychel's death until Mrs. Brown *"spoke to me sometime after the Critical Incident Meeting."*[547]

197. Dr. Fulton chaired the Critical Incident Review, and initially assured this Inquiry that Mrs. Brown contacted the relevant staff, all agreed to attend,[548] and that he recorded the attendees and what they said.[549] Despite that, initial, clear account he now recognises that not all relevant witnesses were contacted, that he made no record of those who did attend, that he did not record what was said and that, in terms, he has no reliable recollection of his review.[550] He confirms that *"only the staff present at the Critical Incident Meeting were interviewed by [himself] and not separately."*[551] Otherwise, Dr. Nesbitt was *"unaware of members of staff being interviewed."*[552]

198. The failure to gather evidence in any systematic fashion or to make a record of the Review meant that evidence was lost. The surgical rota is now no longer available.[553] Statements were not taken and memories have now faded. In the year after Raychel's death many of the medical personnel involved relocated to hospitals across Britain and beyond. It took Mrs. Brown 10 months to extract an inconsequential two line statement from Mr. Zafar then resident in Devon. The 'Risk

546 Ref: 026-012-016
547 Ref: WS-323/1 p.23
548 Ref: WS-043/1 p.4
549 Ref: WS-043/1 p.6
550 Ref: WS-043/2 p.1-3
551 ` Ref: WS-043/3 p.11
552 Ref: WS-035/2 p.12
553 Ref: 316-004-001

Management in the NHS' Manual advises that *"in addition to individual witness statements, it is useful to record the names of all staff on duty at the time of the incident, perhaps in the form of the staff rota... It can sometimes be several years before a claim is made and it is often difficult to track which staff were involved."*[554] An ordered approach to evidence gathering is central to any investigation. It was seemingly lacking from this investigation.

199. The Critical Incident Protocol[555] described itself as supplemental to the AHHSST Clinical Incident Policy of February 2000[556] which in turn declared itself an integral part of the clinical governance system with quality improvement as its object. The Policy emphasised that *"it is extremely important that any clinical incident should be reported on the appropriate documentation... [which] will be sent to the RMCO who will... contact all relevant staff and obtain detailed reports."*[557] It is not thought that the *"appropriate documentation"* was used in Raychel's case. It is not clear why, in this most serious of cases, it was decided to depart from Trust policy and dispense with the requirement to *"obtain detailed reports."*[558]

200. Two significant omissions from the clinicians contacted are Drs. Devlin and Curran who saw Raychel in the evening of 8th June 2001 when, arguably, something could have been done to avoid her terminal decline. Mr. Foster, on reviewing the evidence, concludes: *"I cannot understand why Drs. Devlin and Curran were not at this important meeting."*[559] Indeed Dr. Curran had *"expected either the Consultant or the Clinical Director or... someone from the hierarchy in the hospital to chat to all the staff involved."*[560] Mrs. Brown recalls that Dr. Fulton *"advised me that he had asked the consultant staff to identify the relevant clinicians and invite them to attend... I recall... getting a telephone call from one of the junior surgical doctors asking what the purpose of the meeting was and advising that both he and his colleague would not be able to attend the meeting because they were working that evening. It is my understanding that he had been advised by Mr. Gilliland that the meeting had been arranged. I cannot be certain of the identity of the doctor but it believe it may have been Dr. Devlin."*[561] Raychel's 'designated' paediatric *"named nurse"*- Staff Nurse Patterson was not present and no attempt was made to obtain a statement from her.[562] Dr. Bhalla has said *"I think I should have been invited because I was*

554 Ref: 314-013-004
555 Ref: 022-109-338
556 Ref: 316-004f-037
557 Ref: 316-004f-037
558 Ref: 316-004f-037
559 Ref: 223-002-031
560 Ref: Transcript of the Oral Hearings 7th March 2013, p.132 line 24
561 Ref: WS-322/1 p.16
562 Ref: Transcript of the Oral Hearings 4th March 2013, p.112 *et seq*

the person from the Surgical department who was present during the patient's critical time."[563]

201. Dr. Fulton has recalled that he *"stressed that the purpose of the meeting was to establish facts and not to blame individual staff members. This was the approach recommended for critical incident investigation to allow staff to give potential information in a non-judgmental atmosphere. To reassure all staff I said I would not take detailed minutes of the meeting..."*[564] *"No minutes were taken. I had explained at the start of the meeting that Mrs. Brown would take minutes. This caused anxiety and started a discussion about the need for legal advice before proceeding. I was concerned that this would delay the investigation"... "I believe some of the staff at the Review were aware of [the] potential"* for litigation.[565] Mrs. Brown, who managed claims for the AHHSST has said *"litigation was not a concern for me at that time."*[566] Given that it had been rumoured from RBHSC that Raychel had been given the *"wrong"* fluids, it is perhaps surprising that the Trust's solicitor was not present and there was no input from the RBHSC. Altnagelvin did not make any request for Raychel's RBHSC records. Discussions went completely un-minuted. The decision not to minute the meeting may have been prompted by a desire for openness but is equally consistent with a desire to avoid self-incrimination. Statements were seemingly not taken at the meeting. Four statements were submitted after the meeting and did not therefore inform the Review.

202. However, it is to be acknowledged that, in the words of Dr. Haynes *"the Critical Incident Inquiry at Altnagelvin was convened at the first possible opportunity and although complete minutes are not available, it is clear from the agreed action points (012-039-184) that the incident was treated with the utmost gravity; implicit is the realisation that up until that point, there was no robust system at Altnagelvin for supervising one of the commonest interventions in hospital admission– the administration of intravenous fluids."*[567]

203. Consequent upon the Review Meeting, Dr. Fulton drew up his Action Sheet dated 12th June 2001.[568] In Dr. Nesbitt's words *"The Action Plan describes the deficiencies identified by members of the Review team."*[569] Staff Nurse Noble gave evidence that the Review considered and concluded that there had been excess intravenous fluids administered and a failure to monitor electrolytes.[570] Indeed Dr. Fulton recalls how *"Dr. Nesbitt reviewed the infusion rate of Solution 18 and felt it was too high for*

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563 Ref: Transcript of the Oral Hearings 14th March 2013, p.51 line 21
564 Ref: WS-043/1 p.5
565 Ref: WS-043/3 p.11
566 Ref: WS-322/1 p.16 (17n)
567 Ref: 220-002-006
568 Ref: 026-011-014
569 Ref: WS-035/2 p.17
570 Ref: Transcript of the Oral Hearings 27th February 2013 p.191 line 18

Raychel's weight."[571] That these findings were made is likely given the content of paragraphs 2, 3 and 5 of the Action Sheet namely that U&E values were to be assessed daily and that this be brought to the attention of junior surgical staff. Furthermore, a chart setting out the correct intravenous infusion rates was to be prepared. Dr. Haynes commented of these second and third points that *"daily electrolyte assay is required for all children receiving intravenous fluids post-operatively [this] is merely reinstating something which had clearly fallen by the wayside over the years at Altnagelvin, I suggest that this occurred because of lack of consultant ownership of the issues."*[572]

204. Mrs. Brown remembers that Dr. Fulton *"agreed at the start of the meeting that the hospital notes would be reviewed chronologically by all present to endeavour to ascertain the sequence of events and key facts of the case."*[573] Close attention must have been paid to these and to the precise quantity of intravenous fluid received by Raychel given the deliberate care taken by Drs. Nesbitt and Jamison in retrospectively annotating the record of fluid received. Anaesthetist Dr. Gund was not at the Meeting and only became aware that the anaesthetic record had been subsequently amended when he was asked to supply a statement for the Coroner many months later.[574] Dr. Jamieson *"did not get invited to, or attend, any meeting."*[575]

205. The Review, it seems, must have identified a clear failing in fluid balance management, both in terms of assessment and recording. Paragraphs 4 and 6 of the *"Action Sheet"* consequently direct all urinary output (and possibly vomit) to be monitored and the fluid balance documentation be reviewed.[576] It is noteworthy that, in November 2000 a Benchmarking Exercise of standards of care was conducted to examine Altnagelvin's performance against other acute hospitals in Northern Ireland. The resultant Report identified *"areas that need[ed] addressed... some patients who were on intake/output charts had information missing (7 were incomplete out of 14)... To address these issues it will be necessary to involve staff and get their suggestions."*[577] Dr. Haynes finds it "*obvious from reading the documents furnished to me in this report that documentation of fluid balance in the hospital was not of a high standard prior to Raychel's death."*[578] "Whilst these Action points were no more than restatement of good clinical practice they are nonetheless an indication of those failings in Raychel's care identified at Review.

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571 Ref: WS-043/1p.7
572 Ref: 220-002-006
573 Ref: WS-322/1 p.15 (17d)
574 Ref: Transcript of the Oral Hearings 5th February 2013, p.153
575 Ref: Transcript of the Oral Hearings 7th February 2013, p.95 line 17
576 Ref: 026-011-014
577 Ref: WS-323/1 p.45
578 Ref: 220-002-006

206. Dr. Fulton recalls that there was considerable discussion as to *"the responsibility for IV fluid prescription/administration"* and that *"I should have recorded it as a separate Action Point but it was definitely understood at the meeting that Drs. Nesbitt and McCord would take this forward."*[579] Dr. Haynes further expressed the view that *"There was a significant omission from these action points. The consultant body at Altnagelvin had either never been involved, or had ceased to be actively involved in the fluid management of routine patients. There was an opportunity at that meeting for the Medical Director to insist that all his consultant colleagues took a hands-on role in the supervision of intravenous fluid therapy, consultants ensuring that the trainees knew they're expected to do the necessary blood tests, get the results, and act on them if necessary. It also seems unclear at that time who was responsible for fluid management in post operative children. The children were admitted under the care of a consultant surgeon, not the consultant paediatrician."*[580]

207. Ward Sister Millar recalled telling the Review Meeting that *"I had for some time been unhappy with the... system within the hospital for caring for surgical children."*[581] – *"There was always a difficulty in getting doctors"*[582] – *"there weren't enough of them"*[583] – *"I said that I thought that it was totally unfair that the nurses had such responsibility for the surgical children"*[584] – *"I had spoken about this before. I know I had spoken about it at the... Sister's meetings."*[585] Staff Nurse Noble said furthermore that there should have been *"more senior doctors... responsible for overseeing fluid management of surgical children."*[586] Ward Sister Millar acknowledged that *"it was recognised at the Meeting that... [there was] failure in the documentation"*[587] and *"that electrolytes should have been done."*[588] She said the *"main issue that was discussed that day was the fluid."*[589] Staff Nurse Noble conceded that she *"recognised that because Raychel had been vomiting all day, that that vomiting was severe and prolonged."*[590]

208. According to Dr. Fulton, Mr. Gilliland FRCS stated at the Meeting *"that he was not informed of Raychel's admission under his name. He said he did not need to be involved in Raychel's surgery as he had confidence in the junior surgical staff to perform this grade of operation... He said he did not expect to be contacted in a case of appendicitis."*[591]

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579 Ref: WS-043/3 p.14
580 Ref: 220-002-007
581 Ref: Transcript of the Oral Hearings 1st March 2013, p.57 line 6
582 Ref: Transcript of the Oral Hearings 1st March 2013, p.57 line 11
583 Ref: Transcript of the Oral Hearings 1st March 2013, p.59 line 22
584 Ref: Transcript of the Oral Hearings 1st March 2013, p.58 line 7
585 Ref: Transcript of the Oral Hearings 1st March 2013, p.60 line 19
586 Ref: Transcript of the Oral Hearings 27th February 2013, p.169 line 7
587 Ref: Transcript of the Oral Hearings 1st March 2013, p.63 line 23
588 Ref: Transcript of the Oral Hearings 1st March 2013, p.65 line 22
589 Ref: Transcript of the Oral Hearings 1st March 2013, p.64 line 18
590 Ref: Transcript of the Oral Hearings 27th February 2013, p.172 line 6
591 Ref: WS-043/3 p.14

209. Dr. McCord recalled that at the Meeting *"inappropriate ADH was considered a significant factor."*[592] Mr. Makar gave evidence that *"most of the discussion was about the type of fluid"*[593] and *"we looked in evidence before the meeting and we got papers about... hyponatraemia with hyponatraemic solutions."*[594] Dr. Nesbitt confirms that "*over the weekend and prior to the Review meeting I had already started [to research the literature] and had learned that there was evidence relating to problems with low sodium containing solutions in children."*[595]

210. Dr. Fulton recounts that at the Meeting on 12th June *"Dr. Nesbitt felt a low sodium solution such as Solution 18 could be unsuitable for post-operative children as they were predisposed to hyponatraemia. However, he was aware that the use of Solution 18 was common practice in such situations in other hospitals in Northern Ireland. Dr. Nesbitt offered to ring other hospitals in Northern Ireland to establish the current use of Solution 18. I also asked him to review the medical literature."*[596]

211. Dr. Nesbitt's grasp of the role of Solution 18 in Raychel's hyponatraemia was important and led to Dr. Fulton's *"Action Sheet 12/6/01"* note – *"1. Evidence ✓ change to Hartmann's."*[597] This conveys the sense that the evidence before the Review confirmed a planned change to Hartmann's. A Notice was then displayed immediately after the Review to inform that: *"From now onwards 12/6/01: all surgical patients are to have IV Hartmann's Solution... medical patients to continue on Solution 18."*[598]

212. The following day the Action Sheet was amended and partially rewritten to become the document headed *"Agreed Action following Critical Incident Meeting 12/6/01"*[599] and the first item on the plan changed to become *"Review evidence for use of routine post-operative low electrolyte intravenous infusion and suggest change if evidence indicates. No change in current use of Solution 18 until Review."*[600] The reason for this apparent change of response is unclear.

213. Dr. Nesbitt conducted a telephone survey, probably on 13th June 2001, of other hospitals in Northern Ireland to enquire as to post-operative fluid management practice. He wrote to Dr. Fulton and Mrs. Brown on 14th June 2001 to report *"the children's hospital anaesthetists have recently changed their practice and have moved away from No.18 Solution (fifth*

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592 Ref: Transcript of the Oral Hearings 13th March 2013, p.132 line 25
593 Ref: Transcript of the Oral Hearings 13th March 2013, p.190 line 1
594 Ref: Transcript of the Oral Hearings 13th March 2013, p.187 line 4
595 Ref: WS-035/2 p.13
596 Ref: WS-043/1 p.7
597 Ref: 026-011-014
598 Ref: 021-056-136
599 Ref: 022-108-336
600 Ref: 022-108-336

normal NACL in 4 percent dextrose) to Hartmann's Solution. This change occurred six months ago and followed several deaths involving No.18 Solution" and *"as from today we will no longer be routinely using this fluid in the management of surgical cases."*[601] Dr. Nesbitt named Dr. Chisakuta in Belfast as his telephone informant, but he cannot recall any such conversation. Dr. Nesbitt gives no further detail about the circumstances of the *"several deaths involving the No.18 Solution"* but has stated that he does not mean this *"to infer that the deaths occurred there."*[602]

214. None of the clinicians from RBHSC who gave evidence in relation to Lucy's death there the previous year were able to recall or shed any real light on the cessation of the use of solution No.18, however the RVH Pharmacy Department has produced supply data for Solution 18 to RBHSC in-patients which appears to confirms a decline in the use of Solution 18 in the months preceding Raychel's death.[603] Furthermore, Dr. Nesbitt discovered that *"The fact that the RBHSC had stopped using No.18 Solution was the reason behind Dr. Anand discontinuing its use in Tyrone County Hospital. This is what she told me when I contacted that hospital on or around 13th June 2001."*[604] Unfortunately, Dr. Anand has no recollection of this conversation.[605]

215. Dr. Nesbitt summarised Altnagelvin's position as having followed *"a widespread and accepted policy of using No.18 Solution for post-operative fluids. There is evidence to show that this policy is potentially unsafe in certain children who have undergone a surgical procedure."*[606] He has concluded that, had Altnagelvin known of the RBHSC change of practice from the use of Solution no. 18- *"this would have been a strong message and one we would have acted on."*[607]

216. Mr. Foster further comments: *"essentially this meeting established that the cause of death of Raychel was haemodilution and hyponatraemia and proposed actions including an urgent review of the use of Solution 18 (one fifth normal saline) if the protocol above [i.e. 6 point plan] had been in place... four days earlier it is likely that the sad events of that day would have been forestalled."*[608]

217. In focussing on the use of Solution no.18, the Review would appear to have omitted to consider the extent to which the failure to replace electrolyte losses caused by vomiting played a critical part in Raychel's

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601 Ref: 022-102-317
602 Ref: WS-035/2 p.26
603 Ref: 319-087c-003
604 Ref: WS-035/2 p.34
605 Ref: WS-347/1 p.3
606 Ref: 022-102-317
607 Ref: WS-035/2 p.34
608 Ref: 223-002-031

deterioration.[609] The connection between vomiting and sodium depletion was known. Nine incidents of vomiting were referenced in the case notes alone and two separate prescriptions of anti-emetic were recorded. The Critical Incident Review did not reconvene to reconsider the facts of the case in the light of the Autopsy Report, the Experts' opinions or the Coroner's findings. No audit was undertaken of the case or of its individual parts notwithstanding that it should have promised rich learning for a Teaching hospital.

218. Dr. Fulton has recounted how the nurses *"agreed that the vomiting was prolonged but not unusual after this type of surgery. They did not believe that the vomiting was excessive though they may not have witnessed all the vomit."*[610] That does not sit easily with Staff Nurse Noble's subsequent acknowledgement in her evidence that *"it was recognised that because Raychel had been vomiting all day, that that vomiting was severe and prolonged"*.[611] Even so, *"the nurses said that the Ferguson family told them during 8th June that they, the family, believed that Raychel's vomiting was repeated and severe. I was unable to reconcile the different views of the nurses and the family over the severity of the vomiting."*[612] However, no consideration was given to *"interview, receiving input from, or involving the Ferguson family in the Review"*[613]; engaging external experts[614]; appraising or assessing *"the record of communication with Raychel's parents"*[615] or interviewing the two junior doctors who had prescribed anti-emetic medication.

219. Documentation and record keeping could have been scrutinised, the several nursing issues explored, staffing and workload levels assessed and, given the potential for litigation, thought given to what Mr. and Mrs. Ferguson ought to be told in respect of the reasons for their daughter's death. That some in Altnagelvin may have considered the Critical Incident Review to be incomplete is suggested by the minute of the Drugs and Therapeutic Committee meeting of 20th November 2001 which records how *"discussion followed on the need for a clinical incident investigation on a multi-professional basis to bring out all of the events leading to the outcome in this case."*[616] Consideration of Raychel's case by this Committee may not have been accidental given the recommendation of the 1999 NCEPOD Report that *"Fluid management should be accorded the same status as drug prescription."*[617]

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609 Ref: WS-043/3 p.15
610 Ref: WS-043/3 p.14
611 Ref: Transcript of the Oral Hearings, 27th February 2013, p.172, line 6
612 Ref: WS-043/3 p.15
613 Ref: WS-043/3 p.12-13
614 Ref: WS-043/3 p.13
615 Ref: WS-043/3 p.13
616 Ref: 316-007e-001-2
617 Ref: 220-002-104

220. Dr. McCord thought *"there was a general acceptance... that things could have been done better"*[618] and conceded that he did not think consideration was given to communicating this to the Ferguson family.[619] The clinical failings identified at Review, in both fluid management and electrolyte testing were subsequently downplayed to the extent that they were not mentioned to the Ferguson family and any suggestion that deficiencies in the treatment of Raychel amounted to clinical negligence was firmly denied. That conclusions in respect of deficiencies and failures identified by the Review were not reduced to writing in a formal report is noteworthy. It is hard to understand the failure to produce a report given the dictate of the hospital protocol, unless natural defensiveness precluded it.

221. In the week following the Critical Incident Review Staff Nurse Noble and Sister Millar both submitted written statements to Mrs. Brown.[620] Neither referred to issues identified at the Review Meeting or made any reference to the administration of excess fluid nor the failure to measure electrolytes as identified at Review. That they should have omitted these important factual matters and that this should have gone unnoted by Mrs. Brown is an issue for this Inquiry to examine.

222. The Chief Executive did not request a written report but received verbal briefings. *"When the findings of the Review were reported to me there were no indications of persistent patterns of poor care to cause the alarm bells or to trigger an external review... Had there been an indication of a pattern of poor performance on the ward then I would have had no hesitation in seeking further scrutiny."*[621] She engaged in *"the normal rigorous questioning of the Medical Director, Clinical Director and Risk Manager and Mrs. Witherow. I assured myself that they were giving priority to the issues and follow up. I read some articles provided to me for reference. I would have given the utmost attention to my responsibility and I would have discussed my understanding with expert colleagues to inform my thinking and decision making."*[622] *"It was my clear understanding that the Critical Incident Review established that Raychel's care and treatment were consistent with custom and practice for a post-operative child of that age and did not obviously vary from the clinical care which had supported the recovery of many, many children in the preceding years in Altnagelvin."*[623]... *"The Critical Incident Review had identified an overriding causative factor which required rapid action. The areas for improvement of practice were undertaken simultaneously. An*

618 Ref: Transcript of the Oral Hearings 13th March 2013, p.144 line 4
619 Ref: Transcript of the Oral Hearings 13th March 2013, p.144 line 22
620 Ref: 021-069-160-4 & 021-068-159
621 Ref: WS-046/2 p.25
622 Ref: WS-046/2 p.27
623 Ref: WS-046/2 p.14

unusual or idiosyncratic response had precipitated the leading to the tragic death."[624]

223. The AHHSST 'Clinical Incident Policy' stressed that *"reviewing incidents will enable the Trust to pay particular attention to any deficiencies in procedures or practices which may have contributed to the incidents and to formulate directions and recommendations designed to alleviate or minimise the incidents of similar occurrences."*[625] Dr. Sumner was to conclude that *"Raychel's death was caused by a systems failure rather than by individuals at fault."*[626] A more thorough Critical Incident Review could have considered deficiencies in the hospital systems in a written, detailed and more fully considered way.

224. It will be a matter for you Mr. Chairman, to assess the scope and thoroughness of the Critical Incident Review.

Post-Review Action

225. The Action Plan developed by the Critical Incident Meeting was agreed for immediate action.[627] Individuals were tasked with specific responsibility. Mrs. Brown gave an *"Update"* to the Chief Executive on 9th July 2001 as to the progress made in implementing the Plan. She reported that the chart detailing correct IV rates was on display and that Sister Millar had actioned a daily check of U&Es on post-operative children with IV infusion.[628]

226. It would appear that the nursing staff, together with the Clinical Services Manager, Mrs. Margaret Doherty and Clinical Effectiveness Co-ordinator Ms. Anne Witherow, convened a meeting *"to discuss in detail the fluid balance management."*[629] It was agreed that fluid balance sheets be properly completed. Consideration was given to other systems issues. It was noted *"There is a concern by nursing staff that surgeons are unable to give a commitment to children on Ward 6 unless they are acutely ill and are bleeped. Could paediatricians maintain overall responsibility for surgical children in Ward 6?"*[630] They agreed *"(d) Vomit to be recorded as, small, medium or large as opposed to ++. (e) Nursing staff to be proactive in advising medical staff regarding discontinuation of fluids. (f) Nursing staff to be proactive in the management of fluids required after 4.00pm (refill bag not just automatically put up)."*[631] These are issues which could have emerged at the Critical Incident Review. There is no

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624 Ref: WS-046/2 p.26
625 Ref: 316-004f-037
626 Ref: 098-093-346
627 Ref: 022-108-336
628 Ref: 022-097-307
629 Ref: 022-097-307
630 Ref: 022-097-307
631 Ref: 022-097-307

indication that the Director of Nursing was involved in the nursing discussions or made contribution to the response. This is an area of clinical governance inquiry which may be more fully explored at Oral Hearing.

227. Professor Swainson comments: *"A critical review would typically meet again after a few weeks to check that the agreed actions had been completed and to begin the task of determining what went wrong. Incidents do not have single, proximate causes but rather a number of causal factors that came into play at the same time to cause the incident. The examination of these is important (root cause analysis). In this case this would include communication between consultant and trainee on the emergency admission and proposed operation; the switching of fluids from the theatre/recovery suite to different fluids on the ward; the responsibilities of nurses to change fluids; the calculation of fluids required; the post-take ward round and review by a consultant; the recognition of vomiting; communication with parents and other aspects. Root cause analysis was a common methodology in Trusts in 2001, and does not appear to have been carried out. Reports would be compiled by the risk management coordinator and shared with the medical and nursing directors (who would chair such a review) and the chief executive. A report would be discussed with a Board committee together with plans to prevent recurrence. I have seen no evidence of this process."*[632] Nor did Professor Swainson find *"evidence of morbidity and mortality meetings in the Surgical Directorate, and in particular after the death of Raychel Ferguson."*[633] It may also be noted that the Clinical Services Manager recalls no reference to Raychel's case at any nurse meeting, audit, learning session, hospital committee meeting or in any other healthcare context.[634]

228. On 9th April 2002, some ten months after the Critical Incident Review, Dr. Fulton assessed progress of the Agreed Action prior to the first listing of the Inquest. His review was carried out after the DHSSPSNI had issued its Guidelines on the Prevention of Hyponatraemia. His Memorandum of this meeting is dated 11th April 2002.[635] He took no minutes of the meeting and cannot now recall with certainty who attended. His Memorandum sets out each of the six numbered points of the Agreed Action and describes the extent to which each had been addressed.[636]

229. Notwithstanding an apparently positive description of compliance with each of the six agreed objectives – a closer reading of the progress as detailed is less encouraging:

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632 Ref: 226-002-024
633 Ref: 226-002-007
634 Ref: WS-336/1 p.17 & 21
635 Ref: 022-092-299
636 Ref: 022-092-299

(i) In respect of the use of Solution 18 it is noted that *"An immediate Review was undertaken"* but is silent as to when all surgical patients would be receiving IV Hartmann's

(ii) Daily U&E testing response was recorded as being: *"immediately actioned by Sister Millar."*[637] But it also notes: *"It is not clear who is responsible for ordering the blood. Mrs Witherow and Mrs Brown to prepare ward guidelines"*[638]

(iii) Prompt assessment by junior doctors of results was noted as being *"Immediately actioned by Mr. Gilliland"* but observes that it had not been included in the 'Junior Doctor's Handbook' and emphasises that as *"agreed that all bloods are to be reported to the surgeons routinely"*[639]

(iv) Compliance with the agreed action that *"All urinary output should be measured and recorded whilst IV fusion is in progress"*[640] was unclear, it being noted *"The fluid balance sheet has been revised to allow recording of urinary output and vomit."*[641]

(v) The IV infusion rate *"Chart was prepared and displayed by Dr. McCord by July 2001"*[642]

(vi) The final Action Point, No.6, to *"Review fluid balance documentation on Ward 6"*[643] noted *"that there is a regional group currently reviewing this form. We will await receipt of the revised form."*[644]

230. On 29th May 2002 Mrs. Brown asked Sister Millar in relation to daily U&E testing of post-operative children receiving IV fluids: *"Can you advise how you currently ensure that the above is carried out on all these patients? In particular can you advise that this is carried out when you are not on the ward?"*[645] Sister Millar replied that Notices in draft were displayed pending finalisation.[646] However, no information was given as to the systems for monitoring and enforcing such guidelines.

231. It is noteworthy that the Review Meeting of 9th April 2002 considered systemic issues which should have been within the scope of the original Critical Incident Review, namely: whether a Ward Guideline

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637 Ref: 022-092-299
638 Ref: 022-092-299
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643 Ref: 022-092-300
644 Ref: 022-092-300
645 Ref: 021-047-103
646 Ref: 021-046-100

in respect of daily U&E testing was indicated, whether the computer presentation of blood serum results was efficient given that it omitted reference to the normal range, and where responsibility lay for taking blood samples. Most importantly Dr. Fulton noted the *"need to agree responsibility for the prescribing and management of fluids post operatively. Agreed that Dr. Nesbitt will discuss with anaesthetists and agree a maximum time that post-operative fluids will be prescribed by anaesthetists."*[647]

Steps to Clarify Responsibility for Post-operative Fluid Management

232. Dr. Nesbitt had attempted to agree responsibility for post-operative paediatric fluid management with Dr. McCord in the immediate aftermath of Raychel's death. He reported on 14th June 2001 that Dr. McCord had *"agreed that, pending discussion with his colleagues, fluid management in post-operative children should be under the supervision of paediatricians..."*[648]

233. Dr. Nesbitt wrote to Mr. Bateson FRCS, Clinical Director of the Surgical Directorate, on 3rd July 2001 to seek consensus on responsibility for the fluid management of surgical children on a paediatric ward. *"With agreement it may also be possible for the paediatricians to undertake fluid management of surgical children. Obviously this impacts on surgical care and needs your support."*[649]

234. It would seem that this suggestion did not meet with the agreement of surgeons. Progress by Dr. Nesbitt in achieving consensus on prescription and management of post-operative fluids was slow. He wrote to all medical staff on 1st May 2002, to observe *"From a practical point of view, in surgical cases the responsibility for fluid therapy and electrolyte balance rests with the surgical team but it would be entirely appropriate that the anaesthetists should prescribe the fluids for the first 12 hours post operatively."*[650]

235. The need to agree responsibility focused attention on the possibility of a formal clinical protocol for guidance. Dr. Nesbitt wrote to Dr. McCord on 28th May 2002 to note: *"You suggest that the management of fluid prescription and the responsibility for requesting laboratory investigation rests with the individual clinicians. It might be helpful (if) we had such a protocol because then nursing staff could use it as a gentle reminder to clinicians to order and, more importantly, look at the laboratory results."*[651]

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647 Ref: 022-092-300
648 Ref: 022-102-317
649 Ref: 021-057-137
650 Ref: 021-049-106
651 Ref: 077-003-004

236. The Consensus Statement on *"IV Fluid Therapy for Paediatric Patients"*[652] effective May 2002, suggests that the uncertainty as to speciality responsibility for post-operative fluid management remained unresolved. *"IV fluid solution and rate of administration are the responsibility of the relevant paediatric medical or surgical staff. In surgical patients though, anaesthetic staff may prescribe fluid for the first 12 hours post operatively"*[653] and *"The responsibility for requesting and interpreting laboratory investigations remains with the patients' clinicians, but paediatric medical staff will provide advice on fluid measurement on an ad hoc basis."*[654]

237. A protocol was agreed. However, Dr. Nesbitt was forced to write to Mr. Bateson FRCS on 18th February 2003 *"it would appear that the checking of electrolytes during the post-operative management of children who are receiving fluids is not following the agreed protocol. I know that there is a manpower crisis in surgery but it is clearly not the responsibility of the nursing staff to check electrolytes or contact the medical staff to say what the results are. The requirement would be that a doctor from the surgical team responsible for the post-operative care visits the ward and checks the results... I feel that it is imperative that we do not have a repeat of the recent tragedy where the problem was clearly one of electrolyte balance."*[655]

238. Dr. Nesbitt sent a reminder to the medical staff on 23rd September 2004 *"Re: Hyponatraemia and Fluid Administration in Children"*[656] noting *"in surgical cases the responsibility for fluid therapy and electrolyte balance rests with the surgical team but it is entirely appropriate that the anaesthetist should prescribe the fluids for the first 12 hours post-operatively."*[657]

Developments in Relation to the Use of Solution 18

239. It was agreed following the Critical Incident Meeting that Dr. Nesbitt would review evidence relating to the use of Solution no. 18 and suggest changes if appropriate.

240. Sister Millar has described Solution no.18 as the fluid of choice in children requiring IV fluids at Altnagelvin- *"the practice was in place when I came to Altnagelvin in 1976 from the RBHSC where the same practice was in place."*[658]

241. On 13th June 2001, Dr. Nesbitt was able to report that *"In view of recent events, and papers on the subject, and the fact that the Children's Hospital no longer uses No.18 Solution, I have decided to recommend that we do the same.*

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652 Ref: 021-052-113
653 Ref: 021-052-113
654 Ref: 021-052-114
655 Ref: WS-035/2 p.91
656 Ref: 021-039-082
657 Ref: 021-039-082
658 Ref: WS-056/3 p.21 (i)

I have spoken to Sister Millar in the Paediatric Ward and also with Dr. McCord who both are in agreement. As from today we will no longer be routinely using this fluid in the management of surgical cases."[659] *"In Altnagelvin the use of No.18 Solution in paediatric surgical patients stopped in June 2001."*[660] Whilst the Anaesthetic and Paediatric teams were seemingly content with such an approach, the surgeons were less so. Dr. Nesbitt wrote to the Clinical Director of Surgery on 3rd July 2001, stating that "*Some clinicians evidently feel that No.18 is the fluid they wish to prescribe and have disagreed with the regime suggested. Obviously clinical judgment is important, and I am sure that there is a place for No.18 Solution, but I am concerned that any attempt to put in place a safe policy has met with resistance so quickly, perhaps you could discuss this urgently within the surgical directorate so that a regime can be agreed."*[661]

242. Mrs. Brown updated the Chief Executive on 9th July 2001 and advised him that: *"One of the surgeons is not supporting this change."*[662] This was for no *"specific reason other than he saw no reason to change and was happy to use No.18 Solution."*[663] Accordingly, it was noted that a more extensive review of the research would be undertaken by Mrs. Brown. Subsequently, and with some reservation, Hartmann's became the post-operative fluid used in the management of surgical cases.

243. Dr. Fulton's April 2002 review of progress on the Action Plan, taken in the light of the DHSSPSNI's Guidelines on Hyponatraemia and in the face of the impending Inquest, may have prompted activity to focus on fluid guidance. Dr. Nesbitt was to write to all medical staff on 1st May 2002 that *"this might be a good time to change the default post-operative fluid from Hartmann's to 0.45% saline in 2.5% dextrose. This solution is now available in the hospital and is being increasingly used in paediatric practice."*[664] The DHSSPSNI's Guidelines did not recommend the sodium content of maintenance fluids. The debate was no longer about whether Solution no. 18 should be used for post-operative children but whether the fluids used should be *"at least 0.45% NaCl- or perhaps (only use) 0.9% NaCl or Hartmann's?"*[665] A draft Consensus Statement was produced in May 2002 to direct that the *"principal routine IV solution for use in paediatric patients is to be 0.45% sodium chloride/ 2.5% dextrose."*[666] The statement allowed discretion in the non-surgical paediatric patient to use *"other IV fluid solutions [as] may be appropriate."*[667] No discretion was allowed in the post-operative paediatric context. A Notice was

659 Ref: 022-102-317
660 Ref: WS-035/2 p.33 (44)
661 Ref: 021-057-137
662 Ref: 022-097-307
663 Ref: WS-035/2 p.30 39(e)
664 Ref: 021-049-106
665 Ref: 021-054-131
666 Ref: 021-052-113
667 Ref: 021-051a-111

posted: *"From now onwards 9/5/02- all surgical children (including orthopaedics) are to have n/saline 0.45% with dextrose 2.5%."*[668] Dr. Nesbitt asked Dr. McCord *"if this Consensus Statement will be incorporated into a ward protocol, which should be identified as belonging to Altnagelvin hospital and which would be dated and signed."*[669] It was subsequently signed[670] and adopted. It is unclear if any steps were taken to audit compliance with this protocol.

244. The CMO wrote to the Chief Executive on 4th March 2004 in respect of the DHSSPSNI's Guidance on the Prevention of Hyponatraemia to seek assurance that the *"Guidelines have been incorporated into clinical practice in your Trust and that their implementation has been monitored. I would welcome this assurance and ask you to respond in writing before 16th April."*[671] Dr. Nesbitt replied on 22nd March 2004, to confirm that the Guidance *"was fully endorsed by Altnagelvin Trust"* that *"a detailed protocol was developed"* and that implementation would be *"monitored through the Trust's incident reporting mechanism."*[672]

245. Dr. Nesbitt continued to strive for a complete discontinuance of the use of Solution no. 18. He wrote on 23rd September 2004 to *"remind all medical staff treating children that No.18 Solution is not to be prescribed."* On 15th November 2004, almost three and a half years after Raychel's death, Dr. Nesbitt again wrote in relation to fluid management to Clinical Director Dr. Moles: *"The use of 'No.18 Solution' within the hospital was discussed at the recent Clinical Incident Meeting. I understand that you now agree that the Solution be removed from use within the hospital as you feel an alternative is appropriate for your needs. Please confirm that you agree that the Solution can be removed from use."*[673] Dr. Nesbitt confirms a *"removal of No.18 Solution from use in all clinical areas by January 2006."*[674] The National Patient Safety Agency ("NPSA") Alert 22 did not recommend discontinuance of its use in paediatric practice until 2007.[675]

246. In 2008, the Regulation and Quality Improvement Authority ("RQIA") surveyed the implementation of the DHSSPSNI's Guidelines on the Prevention of Hyponatraemia in the light of the recommendations of NPSA Alert no. 22. The RQIA provided a *"survey report following validation visits to Trusts and independent hospitals throughout Northern Ireland"*[676] in which it reported that *"sodium chloride 0.18% with glucose*

668 Ref: 021-046a-102
669 Ref: 077-003-004
670 Ref: 077-004-005
671 Ref: 021-043-089
672 Ref: 007-066-136
673 Ref: 021-036-079
674 Ref: WS-035/2 p.18 (21d)
675 Ref: WS-035/2 p.33
676 Ref: 303-058-771

4% (no.18 solution) has been removed completely from stock in... Altnagelvin hospital."[677]

XV. 3rd September 2001 Meeting

247. Mrs. Ferguson remembers that *"as time went on, I was getting more annoyed because at this stage Raychel had died and was buried and we still didn't know what had happened... we got the letter on the 15th* [June 2001]*, I remember phoning Altnagelvin, it was a while after that, and I wanted to have a meeting."*[678] The letter came from the Chief Executive, Mrs. Burnside who wrote to *"Express to you my sincere sympathy following the death of your daughter Rachel [sic]. We are all deeply saddened and appreciate the loss you must be feeling. The medical and nursing staff who cared for Rachel [sic] would like to offer you both their sincere condolences and they would also like to offer you the opportunity to meet with them if you feel this would be of any help. If you wish me to arrange this for you please contact my Department..."*[679]

248. The Chief Executive had met with Dr. Fulton her Medical Director and Mrs. Brown the RMCO to review *"The issues and actions identified from the analysis"*[680] and was alive to *"Our duty of care to the parents and family."*[681]

249. Contact was made with Mr. and Mrs. Ferguson and a meeting scheduled for Monday 3rd September 2001 at Altnagelvin. It is not known how the AHHSST prepared for this meeting but Mrs. Ferguson's sister Mrs. Kay Doherty approached Mr. Stanley Millar of WHSSC to seek advice.[682] From his *"Memo [of] phone call 23 August 2001"*[683] it may be inferred that the Ferguson family was aware that low sodium was implicated in Raychel's death and that the adequacy or otherwise of *"sodium level checks"* was a matter of relevance. Mr. Millar advised the family to go to a solicitor and seek access to the medical notes.[684]

250. The Meeting was minuted by the Patient Advocate, Mrs. Anne Doherty (no relation to Kay Doherty)[685] and her record is accepted as an accurate account of the substantive content of the meeting.[686] Recorded

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677 Ref: 303-058-783
678 Ref: Transcript of the Oral Hearings 26th March 2013 p.166 line 17
679 Ref: 022-085-225
680 Ref: 098-267-072
681 Ref: 098-267-722
682 Ref: 014-001-001
683 Ref: 014-001-001
684 Ref: 014-001-001
685 Ref: 022-084-215
686 Ref: Transcript of the Oral Hearings 4th March 2013 p.179 line 12

as being in attendance were Mrs. Ferguson, her sister Mrs. Kay Doherty, her brother, a family friend, the family GP and Ms. Helen Quigley of the WHSSC. The Chief Executive attended with Drs. Nesbitt and McCord, Sister Millar and Staff Nurse Noble. As Mrs. Burnside explained, it was *"staff who had been involved in Raychel's care and who wished to meet with the family [who] attended the meeting."*[687]

251. The 'Junior Doctor's Handbook' described the Patient Advocate as the individual employed *"to take the comments and complaints of the public and act on their behalf to clarify the situation."*[688] Her role was not only *"to support patients/relatives in voicing concerns"*[689] but also to assist the *"Chief Executive in response to complaints."*[690] She was not an independent advocate and on this occasion acted solely on behalf of the Chief Executive *"to take minutes."*[691] It is not thought that she introduced herself to the Ferguson family[692] or made any contribution to the meeting.

252. Notable for their absence from the meeting was Mr. Gilliland or any senior member of the surgical team. Dr. Haynes notes that *"Mr. Gilliland did not attend the meeting with the Ferguson family convened by the Chief Executive. In his own words 'he was responsible for the totality of her care'. If that was the case it is my opinion that he should have attended that meeting."*[693]

253. Mr. Gilliland has recognised that Raychel's care was his responsibility[694]; as such his duty was defined by Paragraph 23 of The GMC's 'Good Medical Practice': *"If a child under your care has died you must explain, to the best of your knowledge, the reasons for, and the circumstances of, the death to those with parental responsibility."*[695] Mr. Gilliland made no contact with the Ferguson family after Raychel's death. Mr. Gilliland was, however, invited to attend the Meeting with Mrs. Ferguson on 3rd September 2001 but declined on the basis that he had not met her before, nor had he met Raychel and he considered there was nothing he could do to assuage Mrs. Ferguson's grief. Furthermore, he *"felt that the problem was in and around fluid management"* and *"didn't think if there was a particular surgical issue. I understand now... that there were surgical issues and that there were questions that the family wished to have answered... I do not think I could have answered anything any better than the answers that they got. But if they*

687 Ref: WS-046/1 p.6
688 Ref: 316-004g-008
689 Ref: WS-325/1 p.2 (1d)
690 Ref: WS-325/1 p.2 (1c)
691 Ref: WS-325/1 p.4
692 Ref: WS-326/1 p.5
693 Ref: 220-003-006
694 Ref: Transcript of the Oral Hearings 14th March 2013 p.217 line 25
695 Ref: 314-014-012

feel that I have let them down at that particular moment in time then I am very sorry."[696] When asked did he *"not think it might be appropriate for either or both Mr. Makar or Mr. Zafar to be there?"* he replied: *"I didn't think I would have put Mr. Makar or Mr. Zafar into that position. I think if that was to be done, that would have been my responsibility."*[697] Mr. Gilliland has said that he *"was the only member of the surgical team who was advised of the Meeting."*[698]

254. Mr. Gilliland, as leader of his speciality surgical team, does not appear to have encouraged his junior doctors to assist the Critical Incident Review, meet with the Ferguson family or attend the subsequent Inquest into her death. This point was not lost on Mrs. Ferguson who expressed the view that *"Surely, in our belief, the head consultant, Mr. Gilliland, would have wanted to gather information on the tragic death of one of his patients."*[699] If he did, he chose not to share it with Mrs. Ferguson or her family. This may have been a failing of both professional duty and clinical governance.

255. Mr. Foster observes, of the Meeting, that *"Dr. Nesbitt did his best to explain clinical matters to the family. I cannot believe that he and Dr. McCord were left to do this and that no surgeon was present. Raychel had been admitted with an abdominal pain and was operated on. As a result of this surgery she suffered complications and died. Raychel was a surgical patient and was under the care of their team. The surgeons at senior level should have been at this meeting. As far as I am aware from perusing the clinical documents relating to this case no representative of the senior surgical staff have met with the Ferguson family since the death of their daughter. This is much to be regretted."*[700]

256. The Medical Director and the Director of Nursing were both absent from the Meeting. No external expert or independent figure of authority was in attendance. None of the doctors responsible for treating Raychel before her collapse was present. No report as to the findings of the Review was available to the Meeting. It is not thought that the meeting had recourse to Raychel's medical notes.

257. The Chief Executive remembers *"that in preparation for the meeting I agreed with the Risk Manager that the purpose of the meeting was to open discussion with the family in order to facilitate their understanding and to offer support"*[701] and *"within the hospital it was our practice to be open with patients and their families if and when there was an untoward event. In*

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696 Ref: Transcript of the Oral Hearings 14th March 2013 p.216-17
697 Ref: Transcript of the Oral Hearings 14th March 2013 p.218 line 24
698 Ref: WS-044/2 p.36
699 Ref: Transcript of the Oral Hearings 26th March 2013 p.182 line 2
700 Ref: 223-002-034
701 Ref: 098-267-724

support of this I had sought to develop a culture where we would approach families to offer explanation of relevant circumstances."[702]

258. However, a serious breakdown in communication and understanding appears to have occurred at the meeting because Mrs. Ferguson has said of it *"I left the meeting totally confused believing it to be pointless. I remember feeling a sense of Raychel being blamed for her own death or that we were in some way responsible."*[703] She has further stated that she was *"Completely and utterly dissatisfied. I look back on this meeting now with some disgust, anger and annoyance. To me it was just the beginning of a cover-up by Altnagelvin Hospital. They had three months to get their version of events in order and the meeting was deeply upsetting."*[704] *"Even to this day I really do find it very hard not to get agitated and angry looking back at the behaviour of Altnagelvin at that meeting. Their behaviour was appalling as they knew, or must have known, full well what happened to Raychel by that stage"*[705] and *"Everything with them involves aggression and a defensive mindset and in the context of my daughter, who would have lived but for the treatment she received at the hands of Altnagelvin, is simply shocking."*[706]

259. This impression of the meeting was not shared by Mrs. Burnside who recalled *"We offered explanations around the following issues, namely the process of Critical Incident Review, the research findings on post-operative reaction leading to hyponatraemia, our subsequent actions to prevent risk of recurrence, and the measures in place to monitor improvement."*[707]

260. The minute of the Meeting appears to record a different exchange of information to that remembered by the Chief Executive. No mention appears of any reference to the Critical Incident Review whether of process or findings, or of failings identified, actions taken or measures put in place.

261. The explanations offered as to *"the research findings on post-operative reaction leading to hyponatraemia"*[708] are recorded in the exchange: *"Mrs. Doherty said she had looked up low sodium. Raychel had all the symptoms, vomiting, headache etc. and if it drops rapidly it can cause brain damage and death. Dr. Nesbitt said they had also looked up the effects of low sodium and a rapid drop in sodium was evidenced in a fit. Raychel had followed a normal course of events following her operation."*[709]

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[702] Ref: 098-267-724
[703] Ref: WS-020/1 p.20
[704] Ref: WS-020/1 p.20
[705] Ref: WS-020/1 p.21
[706] Ref: WS-020/1 p.21
[707] Ref: WS-046/1 p.7
[708] Ref: WS-046/1 p.7
[709] Ref: 022-084-220

262. The details given to the Ferguson family of Altnagelvin's *"subsequent actions to prevent risk of recurrence"*[710] are minuted as:

> *"Mrs. Burnside said...The hospital would look at things and see if there were ways of improving care."*[711]
>
> Dr. Nesbitt said: *"The fluids used are the standard across the country. We may have to change these if children are getting too much sodium. There has to be a middle ground. Nothing we were doing was unusual."*[712]
>
> Mrs. Doherty asked if they should not have checked Raychel's sodium levels after the operation. Dr. Nesbitt said that *"they may have to review procedures. It may be necessary to check routine admissions pre-op and post-op. The reason why they are not done routinely is that it requires a needle into the vein to take the blood."*[713]
>
> Mrs. Doherty asked Dr. Nesbitt: *"if on looking back, he has learned anything from this. Dr. Nesbitt said I do think it was low sodium. I have been in contact with children's hospitals and we will look at ways of preventing this happening. This has made me change my practice."*[714]

263. The minute of the Meeting is silent as to any description of the means put *"in place to monitor improvements."*[715]

264. Mrs. Burnside further recalled of the Meeting that *"the family representatives had many questions and staff answered all questions to the best of their ability."*[716] Some instances of question and answer are minuted, namely:

> *"Raychel was bringing up blood when she vomited. Why was this? Dr. Nesbitt said that when you are vomiting the back of the throat can become irritated and can bleed."*[717]
>
> *"Why did the nurses not look about her when she was so sick and had a sore head? Dr. Nesbitt said that on the day following surgery, the first post-op day, people can be sick and have a sore head."*[718]
>
> *"Mrs. Doherty asked what were Raychel's sodium levels the first time they were done? What is routine? What checks do you do? Dr. McCord said bloods*

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710 Ref: Ws-046/1 p.7
711 Ref: 022-084-221
712 Ref: 022-084-223
713 Ref: 022-084-220
714 Ref: 022-084-221
715 Ref: Ws-046/1 p.7
716 Ref: WS-046/1 p.7
717 Ref: 022-084-217
718 Ref: 022-084-217

are checked routinely on admission. 36 hours prior to this Raychel's bloods were normal."[719]

265. Mrs. Burnside has recalled that the purpose of meeting the family was *"to facilitate their understanding and offer support."*[720] The Minute of the Meeting does not record any real attempt to ensure that Altnagelvin's understanding of the facts and circumstances of Raychel's treatment was adequately conveyed to Mrs. Ferguson. For whilst it is noted that *"Dr. McCord said the same fluids were used for children up and down the country. He felt that there had to be an innate sensitivity in Raychel's case. These fluids had the correct amount of sodium and glucose in the same amount of water"*[721] and *"Dr. Nesbitt said... Raychel had the common symptoms found in a child after operation. This is a common experience."*[722] There seems to be no attempt to reconcile that with the views expressed during the meeting of 12th June 2001 that the infusion rate of Solution 18 was too high for Raychel's weight,[723] post-operative children were predisposed to hyponatraemia[724] or that inappropriate ADH was a significant factor.[725] Such understanding as Mrs. Ferguson had as to what happened to her daughter may not have been assisted by the explanations given to her. Indeed her sister, Kay Doherty, concluded *"we had no more knowledge leaving than what we had when we went in."*[726]

266. Mrs. Burnside is not alone in recalling a very different explanation of matters than that noted by the Minute. Dr. Nesbitt points out that the minute does not record that *"Mrs. Burnside offered an apology to the family for the loss of their daughter whilst in our care and said it shouldn't have happened... I have a clear memory of discussing the reason why I thought Raychel had died... this is not recorded."*[727] He recalls: *"on several occasions during the meeting we stressed that had we known then what we now knew following our investigation into the circumstances of Raychel's death, then perhaps the tragedy could have been prevented. I went on to explain all the steps, which we had taken so that such an occurrence would not happen again. I gave details of the discussions which I had with my colleagues in other hospitals treating children so that they would be aware of the risks of hyponatraemia, of how we'd managed the fluid prescription in our children's ward, and of how I was introducing teaching on fluid management and the dangers of hyponatraemia to both nurses and doctors within Altnagelvin*

719 Ref: 022-084-220
720 Ref: WS-046/1 p.6
721 Ref: 022-084-221
722 Ref: 022-084-220
723 Ref: WS-043/1p.7
724 Ref: WS-043/1 p.7
725 Ref: Transcript of the Oral Hearings 13th March 2013, p.132 line 25
726 Ref: WS-326/1 p.6
727 Ref: WS-035/2 p.24

hospital."[728] Ward Sister Millar can recall *"Dr. Nesbitt saying 'we have learned lessons' so to me he was acknowledging deficiencies"*[729] and *"he was very, very sympathetic and there was an apology, he apologised to the family."*[730] Staff Nurse Noble recalls *"Dr. Nesbitt saying that she had got a little bit too much fluid."*[731]

267. However, Raychel's GP, Dr. Ashenhurst has *"no recollection of deficiencies in the care of Raychel being mentioned at the meeting by the representatives."*[732]

268. The accuracy and completeness of the Patient Advocate's Minute would therefore be an issue for further consideration at Oral Hearing had not the AHHSST formally accepted its substantive accuracy.[733]

269. Nevertheless and despite the differing accounts of what was said at the meeting no one no one has described, and certainly the Minute does not record, Mrs. Ferguson being told in clear terms what Staff Nurse Noble acknowledged was recognised at the 12th June meeting, namely: *"Altnagelvin and its staff recognised their own failures in terms of how they treated Raychel"* including *"a failure to ensure that Raychel's electrolyte assessment was carried out in or about the evening of 8 June"*[734] and *"that if that apparently simple step had been taken in a timely manner there would have been time perhaps to address Raychel's ill health so that she wouldn't encounter the seizures and, ultimately, death"*. [735]

270. The Meeting apparently lasted one hour and fifteen minutes.[736] *"No official notes were kept of this meeting."*[737] The Patient Advocate whose role, according to the Chief Executive, was to *"act on behalf of the patients and their family"*[738] did not share her minutes with Mrs. Ferguson but sent them to the *"Chief Executive and consultant... for approval."*[739] The Ferguson family did not seek a further meeting with the Chief Executive or the doctors and nurses from Altnagelvin.

271. The Meeting was not a success. Mrs. Ferguson gave evidence that *"Dr. McCord has told us personally that the meeting was a disaster. My only recollection of that Meeting was the attitude of Nurse Noble sitting with her*

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728 Ref: WS-035/1 p.5
729 Ref: WS-056/3 p.18(d)
730 Ref: Transcript of the Oral Hearings 1st March 2013, p.79 line 25
731 Ref: WS-049/4 p.13 (19i)
732 Ref: WS-333/1 p.3
733 Ref: Transcript of the Oral Hearings 4th March 2013, p.179 line 12
734 Ref: Transcript of the Oral Hearings 27th February 2013, p.178 line 20
735 Ref: Transcript of the Oral Hearings 27th February 2013, p.179 line 4
736 Ref: 022-084-224
737 Ref: WS-035/1 p.5
738 Ref: WS-046/1 p.6
739 Ref: WS-325/1 p.4 (7e)

arms folded, repeating that she had no concerns about Raychel."[740] The Meeting cannot have been easy for any of the participants. Mrs. Ferguson, in particular, expressed her frustration with the Altnagelvin attitude, as she perceived it, when she said: *"We have heard how traumatised and devastated they were, but none of them have a clear recollection of Raychel during her time in their care but do have a very clear memory of their tea breaks and dinner breaks."*[741] Her irritation that the Altnagelvin staff should express their distress is something that may not have occurred to Dr. Nesbitt when he said at the meeting: *"I was totally devastated"* and that he *"felt sorry for everyone on the Ward. Looking back it was an awful experience for staff on the Ward... I was very upset."*[742] Training and preparation for such a difficult and sensitive communication task should be part of good practice. The Altnagelvin delegation to this Meeting was not prepared. Sister Millar has described how she *"attended the Meeting and found it extremely difficult. I had not attended a meeting similar to it before, the atmosphere was understandably tense and I felt I was not able to give the family the reassurance and explanations that I would have wished."*[743] *"I was not sure of the part I was expected to take."*[744] ... *"I just felt there were too many people in the room."*[745] Dr. Nesbitt recalls that there was *"no decision made prior to the Meeting about who would speak, who would address certain areas, or what we would or would not say. It was very much an opportunity for the family to ask questions... and an opportunity for us to express our sympathy."*[746] Mrs. Burnside advises that *"the staff were given no brief other than to be gentle and answer questions openly."*[747]

272. Mrs. Ferguson's distress and dissatisfaction were compounded by this Meeting. It cannot therefore be regarded as having fulfilled any useful purpose. It is a matter for you Mr. Chairman to determine whether this was inevitable in any event, or was due to lack of sensitivity and poor communication skills on the part of the Altnagelvin staff, or whether defensiveness gave rise to the perception of *"cover-up."*

Altnagelvin Dissemination

273. In the days following Raychel's death, concerted efforts were made to bring the matter to the attention of interested parties outside the Altnagelvin, and to gather additional information.

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740 Ref: Transcript of the Oral Hearings 26th March 2013, p.177 line 14
741 Ref: Transcript of the Oral Hearings 26th March 2013, p.177 line 24
742 Ref: 022-084-220-224
743 Ref: WS-056/1 p.7
744 Ref: WS-056/2 p.17
745 ` Ref: Transcript of the Oral Hearings 1st March 2013, p.79 line 25
746 Ref: WS-035/2 p.24 (31f)
747 Ref: WS-046/2 p.30

274. Dr. Fulton described to the Coroner how *"On 18th June 2001 at a meeting of Medical Directors with Dr. I. Carson, Medical Adviser to the CMO at Castle Buildings, I described the circumstances of this death. There were several anaesthetists present, some of whom said that they had heard of similar situations though it was not clear if there had been fatalities. I suggested that there should be regional guidelines"*[748] and *"told the Medical Directors present at the meeting that in my opinion there was evidence that Solution 18 was hazardous in post-operative children."*[749] Dr. Carson, who chaired the meeting, was the Medical Director of the RGHT at the time.

275. Four days later Dr. Fulton telephoned the CMO personally and *"informed her of circumstances of the death. I suggested she should publicise the dangers of hyponatraemia when using low saline solutions in surgical children. I said there was a need for regional guidelines. Dr. Campbell suggested that CREST (Regional Guidelines Group) might do this."*[750] Taking the issue directly to the CMO was a critical part of the campaign to alert the medical profession to the risks of hyponatraemia in conjunction with the use of Solution no. 18. It is a matter for you to determine Mr. Chairman whether in 1996 the RGHT might reasonably have been expected to do likewise given the knowledge it had gained during Adam's Inquest about the risks of Solution no.18 and Dr. Taylor's acknowledgement that the article of Arieff et al,[751] which was highlighted by Dr. Sumner[752] and the pathologist Dr. Alison Armour,[753] had a *"wider significance in terms of alerting the profession to the potential risks of dilutional hyponatraemia"*.[754]

276. However, no formalised written report of Raychel Ferguson's death as a critical incident was made to the DHSSPSNI at that, or at any time. There was no formal requirement to do so. Professor Swainson considers it *"regrettable that there was not a clear framework from the Department that would have ensured that serious clinical incidents were reported by Trusts and disseminated to the other Trusts. Wide sharing of serious incidents can stimulate quicker and national efforts to reduce harm."*[755]

277. Dr. Fulton telephoned Dr. McConnell, Director of Public Health at the WHSSB to inform him. He forwarded relevant extracts from the British Medical Journal on hyponatraemia. Dr. McConnell raised the matter at the next meeting of the Directors of Public Health on 2nd July 2001 in

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748 Ref: 012-039-179
749 Ref: 095-011-054
750 Ref: 012-039-180
751 Ref: Arieff AI, Ayus JC, Fraser CL; 'Hyponatraemia and Death or Permanent Brain Damage in Healthy Children'; BMJ 1992, 304:1218
752 Ref: 011-011-064
753 Ref: 011-011-074
754 Ref: Transcript of the Oral Hearings 20th April 2012, p.139 line 11
755 Ref: 226-002-010

the presence of the Chief and Deputy Chief Medical Officers to highlight *"a recent death in Altnagelvin Hospital of a child due to hyponatraemia caused by fluid imbalance. Current evidence shows that certain fluids are used incorrectly post operatively. It was agreed that guidelines should be issued to all units."*[756]

278. Dr. McConnell wrote to other Directors of Public Health, circulating Dr. Fulton's extract of medical literature and suggesting that the matter be brought to the attention of paediatricians. The issue was thus efficiently disseminated. Furthermore, Dr. McConnell suggested that if *"more specific information is required [he was] sure that Dr. Fulton would be happy to discuss this with anyone who contacted him."*[757]

279. In mid-June 2001 Dr. Fulton telephoned *"Mr. Martin Bradley, Chief Nursing Officer of the Western Area Health Board to give him details of this death."*[758] It was subsequently felt appropriate to send Mr. Bradley a *"summary of the investigation following the death of Rachael[sic] on 09/06/2001[sic]."*[759] The Inquiry has not yet seen a copy of the *"summary of the investigation"* unless it is the *"Agreed Action following Critical Incident Meeting 12/06/01"*[760] as suggested by Mrs. Brown.[761] On 26th June 2001, Dr. Taylor was able to advise the Sick Child Liaison Group that *"work* [is] *to take place on agreed guidelines from the Department of Health on this subject."*[762]

280. Dr. Fulton kept his Chief Executive informed of developments. Five weeks after he had spoken to the CMO she reinforced his work by communicating (this time in writing) with the CMO to emphasise that she was *"concerned to ensure that an overview of the research evidence is being undertaken. I believe that this is a regional, as opposed to a local hospital issue, and would emphasise the need for a critical review of evidence. I would be extremely grateful if you would ensure that the whole of the medical fraternity learned of the shared lesson. I await to hear further from you."*[763] Dr. Fulton remembers seeing the reply *"from the CMO saying that she would set up a regional group to review hyponatraemia and bring forward guidelines. Dr. Nesbitt would be a member of this group."*[764]

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756 Ref: 320-080-005
757 Ref: 022-094-303
758 Ref: 095-011-055
759 Ref: 021-025-062
760 Ref: 022-108-336
761 Ref: 321-008-001
762 Ref: WS-008/1 p.15
763 Ref: 022-093-301
764 Ref: 095-011-056

Chief Medical Officer's Working Group

281. The CMO sought advice on the subject. Dr. Ian Carson of RGHT sent her a background briefing on *"Dilutional Hyponatraemia in Children"* on 30th July 2001.[765] He copied Drs. Fulton and Taylor into this correspondence, and sent her a *"document on the above subject drawn up by Dr. Bob Taylor and his colleagues... The problem today of 'dilutional hyponatraemia' is well recognised (See reference to BMJ Editorial). The anaesthetists in RBHSC would have approximately one referral from within the hospital per month. There was also a previous death approx. six years ago in a child from the Mid Ulster. Bob Taylor thinks that there have been 5-6 deaths over a 10 year period of children with seizures... I hope this is helpful. I will copy this to Raymond Fulton for his information."*[766] Dr. Carson did not investigate this information.[767]

282. The CMO can only have been struck by the mortality figures cited. It is not known if she asked for further details of the 5-6 deaths referred to. She ordered further research with a view to drafting preventive guidelines and to that end directed Dr. Paul Darragh to assemble a *"Working Group to consider hyponatraemia in children. The Group will make recommendations on the fluid balance in children. These will be presented to SAC Surgery, SAC Paediatrics and SAC Anaesthetics."*[768]

283. The Working Group held its first meeting on 26th September 2001.[769] It drew on a range of highly respected specialists including, amongst others, Drs. Taylor, Nesbitt, Loughrey, Crean and Jenkins. These group members had knowledge not only of hyponatraemia and of Raychel's case but, collectively, also of the other cases being scrutinised by this Inquiry.[770] The minutes record Dr. Darragh, the Deputy CMO welcoming *"all to the meeting. He explained that concerns had arisen about hyponatraemia occurring in children after surgery... Dr. Taylor informed the meeting about the background, incidence of cases seen in RBHSC and patients who are particularly at risk of hyponatraemia. This is a problem that has been present for many years... A general discussion then followed on the management of children in hospital... There was agreement that guidelines should be simple and that all patients in whom 'surgical stress' and fluid replacement was anticipated should have a U&E undertaken... Action – small group to be formed- Dr. McCarthy... and Dr. B Taylor undertook to inform CSM of a recent death in Altnagelvin Hospital associated with hyponatraemia."*[771]

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765 Ref: 021-056-135
766 Ref: 021-056-135
767 Ref: WS-331/1 p.4
768 Ref: 320-081-001
769 Ref: 007-048-094
770 Ref: 328-003-001; Schedule of the 'Knowledge of the Clinicians on the CMO's Working Group'
771 Ref: 007-048-094 *et seq*

284. Dr. Taylor duly reported Raychel's case to the Medicines Control Agency requesting that it consider issuing a hazard notice to prevent further deaths related to Solution 18 fluid.[772] He informed them, amongst other things, that *"I am also conducting an audit of all infants and children admitted to the PICU with hyponatraemia. My initial results indicate at least two other deaths attributed to the use of 0.18NACL/4% glucose."*[773] The Medicine Controls Agency considered the matter and wrote to Dr. Taylor on 26th November 2001: *"The MCA has conducted a review of 4% dextrose/0.18% saline and hyponatraemia in children. This has now been considered by the Working Group on paediatric medicines, a sub group of CSM. The Working Group considered that although hyponatraemia is a risk in children during the use of 4% dextrose/0.18% saline, electrolyte imbalance is a risk with the use of all intravenous solutions. The Working Group noted that careful monitoring of children after surgery is crucial and in particular, care should be taken not to overload patients with intravenous fluids if they are oliguric as part of the normal response to surgery. The Working Group advised that there should be no amendments to product information."*[774]

285. The CMO's Working Group moved swiftly. By 5th November 2001 Dr. McCarthy was able to introduce to the meeting of the Directors of Public Health/DHSSPS *"The draft paper on guidance for the prevention of hyponatraemia in children receiving intravenous fluids. This guidance was considered helpful and a discussion followed on the best way to disseminate. It was suggested that it would be beneficial if this guidance was endorsed by CREST. The guidelines already had the support of SAC Anaesthetics and Paediatrics."*[775]

286. The draft failed to address Dr. Nesbitt's position that Solution no.18 was the significant hazard factor in children's post-operative hyponatraemia. Accordingly Dr. Fulton was prompted to write to the Chief Executive, Mrs Burnside, on 14th November 2001 that: *"You may have received a copy of the enclosed correspondence about intravenous fluids in children together with the draft Guidelines. I have told Dr. Nesbitt that I think the 'choice of fluid' section is totally inadequate considering the gravity of our local experience. As Geoff says it is a 'fudge' and fails to address the use of No.18 Solution. I firmly advised Geoff to challenge this section."*[776]

287. Dr. McCarthy subsequently sought the views and advice of Dr. Sumner on the level of detail in the draft guidelines and on recommendations for specific fluid choices.[777] Dr. Sumner replied on 17th December 2001 to advise that *"Post-operatively fluid should be restricted for the first 24-48*

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772 Ref: 093-035-110p
773 Ref: 012-071e-412
774 Ref: 064-010-038
775 Ref: 320-082-001
776 Ref: 021-055-134
777 Ref: 012-062-314

hours because of inappropriate ADH associated with surgical stress. At GOS we give 2ml per kg per hr of 4% (10% for newborns) dextrose/.18% saline for the first 24 hours BUT replace colloid losses with the appropriate colloid and intestinal losses with an equal volume of normal saline with 10mmol potassium in 500ml."[778] This may be interpreted as Dr. Sumner's view that he was content with Solution no.18 being used so long as it was used in the manner he described.

288. Dr. McCarthy received a contrary submission from Dr. Nesbitt by email on 24th January 2002 *"I am in receipt of your email dated 10 January (now that our email is working again), but was disappointed to learn that you plan to drop the reference to No.18 Solution. What evidence do you need exactly? We had a child who died and for that reason I feel strongly that No.18 Solution is an inappropriate fluid to use... You can be sure that it will remain highlighted as a risk in any protocol produced by Altnagelvin Hospital."*[779]

289. The DHSSPSNI published its Guidance on the Prevention of Hyponatraemia in Children in March 2002.[780] The CMO wrote a general letter on 25th March 2002 to accompany publication in which she advised that: *"The Guidance is designed to provide general advice and does not specify particular fluid choices. Fluid protocols should be developed locally to compliment the Guidance and provide more specific direction to junior staff... It will be important to audit compliance with the Guidance and locally developed protocols and to learn from clinical experiences."*[781]

Other Deaths

290. Dr. Nesbitt's letter of 14th June 2001 to Dr. Fulton recounts the RBHSC change of practice in relation to Solution no.18, following *"several deaths involving no. 18 Solution."*[782]

291. The Coroner wrote to Dr. Brian Herron, the Neuropathologist charged with Raychel's post-mortem on 30th November 2001, stating *"You may be aware that in 1996 I held an inquest into the death of a four year old child called Adam Strain – for your information I am enclosing two copies of the post mortem report... The reason I am sending these to you is to enable me to discover whether there are any parallels between the death of Adam Strain and Raychel Ferguson."*[783] He also enclosed two copies of Dr. Sumner's Report on Adam Strain to enable Dr. Herron to pass one to Dr. Clodagh Loughrey, the Chemical Pathologist. At that time, Dr. Loughrey was serving on the CMO's Working Group into the Prevention of Hyponatraemia. Accordingly, copies of the Adam Strain

778 Ref: 007-016-032
779 Ref: 007-003-005
780 Ref: 077-005-008
781 Ref: 021-064c-328
782 Ref: 022-102-317
783 Ref: 012-060e-308

post-mortem Report and Dr. Sumner's Report on that death could have been available for the purpose of the deliberations of that Group.

292. On 30th November 2001 Dr. Loughrey wrote to Dr. Miriam McCarthy to enquire whether she was *"aware of the death of a four year child in what sound like very similar circumstances in Northern Ireland in 1996? I was speaking to the Coroner about it today he is to send me a copy of his report in that case. Let me know if you'd be interested in seeing it. Perhaps you are already aware of it."*[784] Mrs. Brown subsequently made a note on 4th December 2001 of a telephone conversation with H.M. Coroner in which she was informed of the Inquest into the death from hyponatraemia of a child who can only have been Adam Strain.[785]

293. The Inquiry has received comparatively little information detailing the Working Group research. Dr. Taylor recalls that *"to assist in the work of the Northern Ireland Working Group on Hyponatraemia Working Group in Children"- "I did discuss the hyponatraemia deaths with other colleagues. I cannot recall what information was discussed. At this time in 2001 we were aware of Lucy and Raychel's deaths."*[786] Whilst it is clear that the individual cases which concern this Inquiry were known to individual group members, the extent to which information was shared within the Working Group is unknown. This matter will be pursued at Oral Hearing.

Power-point Presentations

294. On 14th January 2002, the CMO visited Altnagelvin. Dr. Nesbitt took the opportunity to deliver a power-point presentation on hyponatraemia and children.[787] The *"presentation was approximately one hour in length and* [had] *been presented to many groups in Altnagelvin Hospital. My target is principally nurses and doctors but the talk has been presented to the Hospital Management Team, Hospital Executive Members and I recall giving the presentation to the Trust Board of the Hospital."*[788]

295. Dr. Nesbitt's presentation was, in part, based on the power-point presentation prepared by Dr. Taylor for the Departmental Working Party and sent to the Deputy CMO Dr. Darragh on 18th September 2001. Dr. Taylor says that he did not actually use the presentation and he has conceded that the hyponatraemia statistics are incomplete.[789] Dr. Nesbitt used Dr. Taylor's data on the 'Incidence of Hyponatraemia

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784 Ref: 007-025-048
785 Ref: WS-322/1 p.18 (17v) & 022-070-170 & 022-100-312
786 Ref: WS-157/2 p.3
787 Ref: 021-054-117 *et seq*
788 Ref: 095-010-042
789 Ref: WS-157/2 p.2

RBHSC' despite it omitting reference to the deaths of Adam, Claire and Lucy.[790]

296. It is unfortunate that the presentation, which Dr. Nesbitt says was first prepared around September 2001,[791] was not shared with Mr. and Mrs. Ferguson at the 3rd September 2001 meeting (or at any time subsequently) because it contains a detailed case study of their daughter Raychel's treatment - 'Fatal Hyponatraemia Following Surgery'.[792] They would have learned from it that she received excessive maintenance fluids[793] that no U&E tests were requested[794] that she was a risk patient for SIADH[795] and that the notes were deficient.[796] In addition, they would have been introduced to the British Medical Journal *"Lesson of the Week"* for the first week of April 2001, namely *"Do not infuse a hypotonic solution if the plasma sodium concentration is less than 138mmol/l."*[797]

XVI. RBHSC Involvement

297. Raychel was admitted to PICU, RBHSC on 9th June 2001 after transfer from Altnagelvin. The initial brain stem death test was conducted by Drs. Hanrahan and Crean at 17:30.[798] Relative Counselling Records for 9th June 2001 note that they met with Raychel's parents and her aunt, and that Dr. O'Donoghue met with Raychel's parents, grandparents and aunt.[799] At 10:05 the following morning Dr. O'Donoghue noted that the Coroner's office had been contacted.[800] The nursing notes record the second negative brain stem test at 11:35 with confirmation of death at 12:09 and an indication that Raychel was to be the subject of a Coroner's post-mortem.[801] An untimed Relative Counselling Record for 10th June 2001 notes that Drs. Crean and Hanrahan met with Raychel's parents, uncle and aunt.[802]

298. Mr. Ferguson has said in evidence that *"I don't remember whether it was Dr. Crean or Mr. Hanrahan, they kept going over about the vomiting, what kind of vomiting, how many vomits, what time was there blood in the vomit, they just kept repeating these questions. I remember one of them walking*

790 Ref: 007-051-103 & 321-020a-034
791 Ref: WS-035/2, p.27
792 Ref: 095-010-046ag
793 Ref: 021-054-128
794 Ref: 021-054-124
795 Ref: 021-054-120
796 Ref: 021-054-124
797 Ref: BMJ.322/31301/ p.780
798 Ref: 063-010-024
799 Ref: 063-022-049
800 Ref: 063-012-026
801 Ref: 063-016-040
802 Ref: 063-023-050

around the room with his hand up to his mouth and just kept asking, going on about the vomit, what time was there blood in the vomit... I do mind them asking all these questions about the vomiting and the next words coming from his mouth were, before he went out, 'What's Altnagelvin trying to do here, pass the buck?'"[803] Mrs. Ferguson remembered *"one of them saying that this should never have happened."*[804]

299. Sister Millar has recalled how *"when Raychel was taken to the Royal, one of my nurses accompanied Raychel and a nurse in the intensive care in the Children's in Belfast said when Raychel arrived and there was handover, that she was on the wrong fluid."*[805] However, Staff Nurse Dooher, has advised the Inquiry *"I was the only nurse who accompanied Raychel to Belfast. I did not have any conversation with a nurse there about fluids, nor did I relay same to Sister Millar."*[806] Mrs. Burnside recalls that *"The following day Altnagelvin heard a 'rumour' from PICU that the 'wrong fluids' had been used. This 'rumour' emerged from a nurse in PICU responding to an inquiry from Altnagelvin Ward Nurse on the child's state on the Sunday.'"*[807] Dr. Nesbitt says he contacted the RBHSC anaesthetists on 13th June 2001 and was informed that *"The Children's Hospital Anaesthetists have recently changed their practice and have moved away from No.18 Solution... to Hartmann's Solution. The change occurred six months ago and following several deaths involving No.18 Solution."*[808]

300. The RGHT Pharmacy records indicate that the RBHSC anaesthetists had indeed *"moved away from No.18 Solution."*[809] Dr. Nesbitt reported a similar approach at the Tyrone County Hospital and furthermore that it was under consideration at Craigavon Hospital.[810] As Mr. Stanley Miller of WHSSC noted on 22nd January 2002: *"A question has to be asked... Did the Royal Victoria Hospital withdraw use of this Solution?... Were other hospitals including Altnagelvin Area Hospital notified?"*[811] That question remains.

301. There does not appear to have been formal communication by the RBHSC to Altnagelvin of the opinion that the *"wrong"* fluids had been used. You may wish, Mr. Chairman, to consider the possible parallels between this and the failure of the RBHSC to formally communicate to the Erne the concerns of its clinicians about Lucy's fluid management there.

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803 Ref: Transcript of the Oral Hearings 26th March 2013 p.161 line 19 *et seq*
804 Ref: Transcript of the Oral Hearings 26th March 2013 p.164 line 10
805 Ref: Transcript of the Oral Hearings 1st March 2013, p.64 line 22
806 Ref: WS-344/1 p.3
807 Ref: 021-020-041
808 Ref: 022-102-317
809 Ref: 022-102-317
810 Ref: 095-010-040
811 Ref: 014-007-017

302. Furthermore, there does not appear to have been formal communication of the RBHSC change in the use of Solution 18. Staff Nurse Noble told this Inquiry: *"I think we had heard that Solution 18 was no longer being used in the RBHSC because I had heard that a nurse had told the Ferguson family that Raychel had been receiving the wrong fluids in Altnagelvin. We were not aware of this at all... It had never been communicated down through the Trusts... and I felt it would be beneficial that, as a centre of excellence that Belfast, should have shared this information with everybody."*[812] Dr. Hicks, Clinical Director of Paediatrics at RBHSC, agreed with the proposition that it would be reasonable to criticise the RBHSC *"as the Regional Paediatric Centre... having made a significant change in its practice [for not] advising the other hospitals"*[813] but was herself unable to recall any change in the use of Solution no.18.[814]

303. Professor Swainson states that he has *"been provided with the full clinical notes from the RBHSC, but I have not seen a formal discharge summary from RBHSC to the Altnagelvin Hospital following Raychel's death. A discharge summary to the general practitioner and to the referring hospital would be expected practice and in this case, I would expect a full analysis of the cause(s) of the cerebral oedema and the role of acute hyponatraemia in that. The evidence that Altnagelvin Trust heard only through an informal conversation between nurses is surprising and disturbing."*[815]

304. Raychel's death did not prompt a Critical Incident report or review within RBHSC, nor did the RBHSC play any part in the Altnagelvin Review of Raychel's case. Dr. Crean has explained *"that if an adverse event occurred in RBHSC and it was considered to have led to an unexpected death, then it would be reported. However, I do not believe an event occurring in another hospital would have been reported."*[816]

305. Dr. Crean provided the same explanation in relation to Lucy's death the previous year.[817] Professor Scally observed, in relation to that case that *"if there was any significant suspicion amongst the staff of the RBHSC that Lucy's death was due to inadequate treatment then the matter should have been reported within the mechanisms available within the Royal Group of Hospitals. In addition, under these circumstances, the Sperrin Lakeland Trust should also have been informed in a formal manner. My view is that this expectation arises out of a general obligation in the case of a death that may have been caused by inadequate treatment and is reinforced by the RBHSC role as a Regional Centre of Excellence."*[818]

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812 Ref: Transcript of the Oral Hearings 27th February 2013 p.169 line 18
813 Ref: Transcript of the Oral Hearings 7th June 2013 p.43 line 12
814 Ref: WS-340/1 p.2
815 Ref: 226-002-010
816 Ref: WS-038/3 p.6
817 Transcript of the Oral Hearings 4th June 2013 p.147 line 5 *et seq*
818 Ref: 251-002-017

306. Raychel's death was also not reported to Dr. Hicks, the Clinical Director.[819] It is not known whether the necessary report of her death was made to NCEPOD.[820]

307. After Dr. Fulton had alerted the CMO to the tragedy of Raychel's death and the issue of Solution no.18, the RGHT became active in sharing information. Dr. Ian Carson, the Medical Director, sent Dr. Taylor's incidence figures, analysis and informed advices to the CMO.[821] Dr. Taylor shared the same information with Dr. Nesbitt[822] and copied the Coroner into his 23rd October 2001 letter to the Medicines Control Agency to inform him that *"Of all infants and children admitted to the PICU with hyponatraemia... at least two other deaths [are] attributable to the use of 0.18NaCl/4% glucose."*[823]

308. The Ferguson family, having failed to obtain satisfaction from meeting Altnagelvin staff on 3rd September 2001, sought further information from the RBHSC. Dr. Crean contacted the Coroner on 11th October 2001 who noted *"The parents wish to speak to him. It was agreed that he could say nothing more than the treatment Rachael[sic] received in the Intensive Care Unit"* and *"He said there was mismanagement of this case in the Altnagelvin Hospital... The fluid balance was the key to why her condition deteriorated– dilutional hyponatraemia."*[824] It was proper that Dr. Crean should bring this information to the Coroner's attention. There nonetheless remains the question as to whether he ought not to have brought it to the attention of Mr. and Mrs. Ferguson as well. He had been Raychel's admitting Consultant at the RBHSC and might have felt an obligation pursuant to paragraph 23 of the GMC's 'Good Medical Practice' to tell them.[825]

309. Dr. Crean, as Consultant responsible for Raychel, was the sole RBHSC witness at Raychel's Inquest. In preparation Mr. Walby of the RGHT Litigation Management Office, Mr. George Brangam, Trust Solicitor and Dr. Crean met. The Solicitor wrote to Mr. Walby on 16th January 2003: *"At first blush I cannot see how the Trust can be implicated in the tragic circumstances surrounding the treatment given to the child and the subsequent demise at RBHSC. Dr. Crean has indicated to me that the facts surrounding an earlier matter (Adam Strain deceased) were not on all fours with the present case, but, I believe, it would be prudent for you to speak directly with Dr. Ian Carson in relation to this matter, particularly, given it would appear that the Department has some knowledge of the circumstances*

819 Ref: WS-340/1 p.3
820 Ref: 321-004g-003 & 321-030-001
821 Ref: 021-056-135
822 Ref: 321-020b-001
823 Ref: 012-071e-412
824 Ref: 012-052c-275
825 Ref: 314-014-012

surrounding this particular incident."[826] Dr. Carson was then the Deputy Chief Medical Officer.[827]

310. That the RGHT was interested in differentiating Raychel's case from Adam's could suggest that it was concerned lest the Coroner might conclude that the cases were so similar that lessons should have been drawn from one which might have been applied to the other. Mr. Walby replied to the Solicitor that he had *"spoken to Dr. Crean and he will stick to his brief at the Inquest and he is aware you will want to consult with him finally just before the hearing."*[828] Dr. Crean's evidence to the Coroner dealt only with the facts of Raychel's case and made no reference to any other case.

311. Of the Inquest Mr. George Brangam was to report to Mr. Walby that *"I cross examined Dr. Sumner in relation to the Adam Strain case and I asked him to distinguish and differentiate between the two cases and in particular the following matters...*

(i) *In the Adam Strain case the incident occurred intra-operatively*

(ii) *The procedure involved was complex and difficult*

(iii) *Cerebral perfusion was also detailed as a contributory cause of death."*[829]

312. Mr. Walby was prompted to thank Mr. Brangam *"very much for minding our back at this inquest. Although my alarm bells proved to be ringing unnecessarily it was wise to be prepared just in case."*[830] Mr. Walby has advised that his *"alarm bells were the concerns raised by Mr. Brangam that he considered it possible that the care and treatment given [Raychel] by the Trust could have been explored at the Inquest."*[831] Whether it is correct to infer that the RBHSC felt vulnerable to potential criticism in Raychel's case because of the earlier findings in Adam Strain's case and a failure to learn and/or to disseminate the learning from it as the Coroner assumed would happen,[832] is a matter for you Mr. Chairman.

313. The Ferguson family Solicitor intimated litigation against the RGHT by letter of claim dated 1st May 2003.[833] An almost identical letter was sent to Altnagelvin.[834] The claim was not pursued as against the RGHT.

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826 Ref: 064-022-063
827 Ref: 306-088-002
828 Ref: 064-019-054
829 Ref: 064-016-050
830 Ref: 064-014-046
831 Ref: WS-341/1 p.5 (11c)
832 In particular his observation that: *"Children are not always treated in a paediatric unit and, in the event of surgery, the anaesthetist may not be a paediatric anaesthetist"* Ref: WS-091/1, p.3
833 Ref: 065-013-027
834 Ref: 024-001-001

314. It is to be emphasised that the RBHSC did refer the death to the Coroner and did report a suspicion of mismanagement. It took the fluid issues to the Medicines Control Agency[835] and did receive a post-mortem Report based on a chemical pathologist's opinion as to the cause of the hyponatraemia.[836] RGHT has provided a schedule which indicates that Raychel's death was discussed within the mortality section of a RBHSC Audit Meeting on 10th April 2003 chaired by Dr. Taylor.[837]

315. If such a meeting did take place, then it is not known if insights from any discussion that took place were shared with Altnagelvin. The extent to which clinicians in the two hospitals might have been obliged to communicate with each other for the purposes of review, information and learning remains a matter to be pursued by this Inquiry.

XVII. Inquest

316. In the immediate aftermath of Raychel's death, it was clear to Altnagelvin that issues of mismanagement were being raised and that the matter had been referred to the Coroner. It must have seemed very likely that an Inquest would be held. Notwithstanding the obvious contribution statements might have made to the Critical Incident Review, they were going to be even more obviously necessary for an Inquest. Yet no statements were taken from the doctors who treated Raychel before her collapse or from the Consultant into whose care she was admitted.

317. The task of collecting and collating statements for Inquest fell to Mrs. Brown who had likewise played a significant part in the Critical Incident Review.[838] She played a pivotal role in liaising with the relevant clinical team, the Trust Solicitors, the Coroner and the AHHSST Board.[839] She was charged with helping the AHHSST and its personnel through the coronial process as well as assisting the Coroner in obtaining evidence for Inquest.[840] She advises that *"in 2001 I had approx. 15 years experience in the management of claims and litigation."*[841] *"I didn't receive any formal training. I had attained an LLB qualification in 1999 and had an understanding of legal systems. It was part of my role to liaise with the Coroner. I took direction from the Coroner and, were necessary,*

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835 Ref: 093-035-110p
836 Ref: 014-006-014 *et seq*
837 Ref: 063-037-095
838 Ref: WS-322/1 p.24
839 Ref: WS-322/1 p.24
840 Ref: WS-322/1 p.24
841 Ref: WS-322/1 p.7 (6c)

sought advice from the Trust's solicitor."[842] Her responsibilities extended from the investigation of adverse clinical incidents to the defence of clinical negligence suits and communication with the police. A potential for conflict was inherent in her roles. The Altnagelvin 'Junior Doctor's Handbook' directed that doctors *"do not release any report to the police or coroner without showing it to the Trust RMCO. This is particularly important when the family of the deceased have employed a barrister to represent them in Court, or if you feel that an allegation of medical negligence will be made in Court."* [843]

318. Mrs. Brown proposed the identities of those who might give statements to the Coroner. Accordingly, she had an input into the selection of witnesses to be called at Inquest. She checked statements, suggested amendments and forwarded evidence to the AHHSST's Solicitors for approval. Accordingly, she had an input into the evidence to be given at Inquest. She was informed when doctors' professional indemnity insurers edited statements before she sent them to the Coroner and she liaised with others in the preparation of evidence for Inquest.[844]

319. At the time of Raychel's Inquest, doctors were bound by the explicit duty set forth at Paragraph 32 of the GMC's 'Good Medical Practice' that *"You must assist the Coroner... by offering all relevant information to an inquest."*[845] In addition, Section 7 of the Coroner's Act (Northern Ireland) 1959 imposed a legal obligation on medical practitioners to notify the Coroner of the *"facts and circumstances"* of a death where the doctor had *"reason to believe that the person died, either directly or indirectly as a result of...negligence... or in such circumstances as may require investigation."* As a non-clinician, Mrs. Brown was under no such legal obligation. Accordingly, there was potential scope for the duty of the doctor to offer all relevant information to conflict with Mrs. Brown's task as RMCO to defend medical negligence claims.

320. Dr. McCord, Sister Millar and Nurses Noble and Rice provided statements in June 2001.[846] No further statements were volunteered. The Coroner wrote to Mrs. Brown on 17th October 2001 to notify as to Inquest and to inform that he had *"been advised by the Pathologist and Consultant Anaesthetist from the Intensive Care Unit that questions must be asked regarding the management of this child whilst a patient at Altnagelvin Hospital... It would greatly assist me if you would arrange to let me have as soon as possible statements from all those concerned with the case and*

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842 Ref: WS-322/1 p.23 (32a)
843 Ref: 316-004a-026
844 Ref: WS-322/1 p.23
845 Ref: 314-014-014; May 2001
846 Ref: 022-104-319 & 022-100a-313 & 022-101-314 & 022-099-311

management including the consultant in charge, the surgeon and the nursing staff."[847]

321. On 7th November 2001, Mrs. Brown asked individuals for statements advising that "*Your report will be forwarded to our solicitor prior to release to the Coroner."*[848] She explained that she had *"initially requested statements from the surgeon, the consultant staff, the nursing and the medical staff who had been identified at the Incident Review meeting."*[849] She chose not to ask any of the doctors who had attended upon Raychel on 8th June 2001 for statements and forwarded such statements as she did receive to the AHHSST's CSA Solicitor for "*approval."*[850]

322. The Coroner sent a reminder to Mrs. Brown on 29th November 2001 to forward "*statements from all those concerned with the care and management of the above deceased."*[851] Mrs. Brown wrote, in turn, to remind those from whom she had sought statements.[852] The Coroner forwarded the post-mortem Report to Mrs. Brown on 5th December with the enjoinder that *"I require statements as a matter of some urgency."*[853] Mrs. Brown's job might have been easier had statements been taken as part of the Critical Incident Review. They had not – and such as were obtained had to be channelled through the CSA solicitors in Belfast. She assured the Coroner on 7th December 2001 that the Solicitor *"has advised that she will return the reports to me within the next few days and I will forward these to you... Thank you for providing a copy of the post-mortem Report. I will make it available to the relevant medical staff."*[854]

323. A further reminder was sent by the Coroner on 11th December 2001.[855] Dr. Johnston, Paediatric SHO, submitted his Report and Mrs. Brown noted *"Dr. Johnston makes reference to Dr. Curran, Mr. Zafar. I have not requested reports from these doctors, as they have not written in the notes."*[856] It is noteworthy that over six months from the date of Raychel's death and in the face of a potentially controversial Inquest that Mrs. Brown was ignorant of the roles played by these two clinicians. Both were identified in the hospital documentation of Raychel's case[857] and Mrs. Brown was *"the custodian of the notes."*[858] Dr. Zafar not only conducted the post-take ward round and made the only entry in Raychel's clinical

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847 Ref: 022-081-212
848 Ref: 022-079-207
849 Ref: WS-322/1 p.24 (32d)
850 Ref: 160-212-001
851 Ref: 022-072-187
852 Ref: 022-071-183 & 022-071-184 & 022-071-085 & 022-071-086
853 Ref: 022-070-170
854 Ref: 012-050r-258
855 Ref: 022-068-167
856 Ref: 160-207-001
857 Ref: 020-017-034 & 020-007-013
858 Ref: WS-322/1 p.25 (33b)

notes for 8th June[859] but he was the most senior member of the surgical team to have seen Raychel on 8th June.[860] He also saw her after her collapse on 9th June. Had a methodical review been undertaken then Mrs. Brown would have been aware of the identities of the relevant clinicians and would have already recorded statements from them.

324. Mrs. Brown wrote to Mr. Gilliland on 31st December 2001: *"I have not yet requested a statement from Mr. Zafar or Mr. El-Shaffie. Do you think I should seek statements from them now or should I wait to see if the Coroner feels it necessary?"*[861] At this time Mr. Gilliland, Consultant responsible for the care of Raychel, had not yet himself provided a statement. However, and in response to H.M. Coroner's investigation into the death of his patient wherein mismanagement was a live issue, he was being asked for advice as to the evidence to be offered the Coroner. It is a matter for you, Mr. Chairman, to determine whether this approach was sufficiently disinterested in all the circumstances.

325. Mr. Gilliland had *"sent his statement off to his defence organisation"*[862] which advised amendment.[863] Mr. *"El-Shaffie"* was a mistaken reference to Dr. Bhalla, the most senior member of the surgical team involved in Raychel's care who, likewise, had not yet been asked for a statement.

326. Mrs. Brown wrote to Dr. Jamieson on 25th January 2002 to *"note that you do not make reference to the post entry note, which you made on 13th June 2001. I think it is important that you do refer to it. Do you wish to amend your statement? I am returning a copy for your attention."*[864] On 25th January 2002, Mrs. Brown purported to send nine witness statements to the Coroner and advised that *"Mr. Zafar, Surgical SHO, who is no longer employed by the Trust, saw Rachel[sic] on the ward in the morning following her operation. I will now ask him for a statement."*[865] Unfortunately, the letter enclosing the statements went *"astray."*[866] Mrs. Brown produced a list of those involved with Raychel's care, with the names of Mr. Gilliland and Drs. Jamieson, Makar and Date asterisked to denote that Mrs. Brown had received their statements but had returned them *"for minor amendments."*[867] Her list of 13 Altnagelvin witnesses is remarkable in that it omits all of the surgical witnesses to Raychel's post-operative care.

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859 Ref: 020-007-013
860 Ref: 020-007-013
861 Ref: 022-060-159
862 Ref: 022-057-155
863 Ref: 022-053-050
864 Ref: 022-056.154)
865 Ref: 022-054-151
866 Ref: 022-038-099
867 Ref: 022-055-153

327. Mrs. Brown wrote to Dr. Zafar on 30th January 2002 stating *"Your name appears in the records and therefore I feel that a statement will be required from yourself."*[868] The next day she was able to send the Coroner Mr. Gilliland's statement and advise that Dr. Zafar was currently employed as an SHO in Plymouth: *"I have written to him requesting a report."*[869] H.M. Coroner's office received this letter on 5th February 2002.

328. Simultaneously the Coroner wrote to her on 31st January 2002. This letter was received by Altnagelvin on 1st February 2002. He had not received the statements, and sought advice as to progress.[870] This prompted the production of Mr. Makar's statement on 6th February.[871] The Inquest was listed for 10th April 2002. The DLS requested that H.M. Coroner *"let [it] have a copy of all statements you have obtained, together with a copy of any independent reports"*[872] on 25th February 2002.

329. Dr. Sumner's Report had been shared with Altnagelvin. Dr. Sumner had seen the Altnagelvin statements. The Coroner had not. Mrs. Brown asked the Coroner to *"advise the names of the staff who would be required to attend at the Inquest."*[873] It was not until 6th March 2002 that the 'complete' set of Altnagelvin statements was forwarded to the Coroner who asked Dr. Sumner *"If you feel that I have overlooked calling a witness whom you would regard as important please let me know."*[874] The Coroner had to remind Mrs. Brown to forward the statement of Mr. Zafar *"as a matter of urgency."*[875]

330. On 21st March 2002, the Coroner wrote to Mrs. Brown to ask for *"Mr. Zafar's address in order that I may serve a witness summons on him."*[876] On 25th March 2002 the Risk Management Office received Dr. Zafar's remarkable statement.[877] Some nine months after Critical Incident Review and five months after H.M. Coroner's request for a statement, he provided his Report to the Coroner that *"I saw Rachael Ferguson on 8th June 2001, who had appendectomy operation on 7th June 2001. On my ward round she was free of pain and apyrexial, plane[sic] was to[sic] continuous observation."*[878] Mrs. Brown informed the Coroner on 26th March 2002 that *"Mr. Zafar has just faxed me through a very brief statement. I will send it to you once our solicitor has viewed it."*[879]

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868 Ref: 022-052-149
869 Ref: 012-050n-253
870 Ref: 022-050-145
871 Ref: 012-050l-251
872 Ref: 012-070p-405
873 Ref: 012-050h-247
874 Ref: 012-067k-354
875 Ref: 022-032-077
876 Ref: 022-028-072
877 Ref: 160-239-001
878 Ref: 160-239-001
879 Ref: 022-027-071

331. The Inquest hearing was adjourned.[880] Mrs. Brown wrote to Dr. Zafar stating *"I enclose draft statement. Please amend. I enclose a statement from Dr Johnston."*[881] Dr. Zafar obliged and included an additional paragraph[882] derived from Dr. Johnston's statement.[883] This was sent to the Coroner on 25th April 2002 with the proviso *"that this is an unsigned copy of the statement."*[884]

332. Mrs. Brown sent the Chief Executive an *"update with the current position"* on 12th March 2002. She advised in respect of *"the report from Dr. Sumner. Some of the clinical staff have come back and advised me that there are factual inaccuracies in the Report."*[885]

333. The Altnagelvin witnesses had arranged to consult with Counsel on 27th March 2002.[886] The Assistant Director of Legal Services Mrs. Donna Scott, acting on behalf of the AHHSST, wrote to H.M. Coroner on 29th March 2002[887] *"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 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."*[888]

334. This formal acknowledgment as to cause of death reflects Dr. Herron's post-mortem Report commentary that *"her death was thought to be caused by three main factors.*

    (i) *Infusion of hypotonic fluids*

    (ii) *Profuse vomiting*

    (iii) *Anti-diuretic hormone (ADH secretion)."*[889]

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880 Ref: 012-072b-416
881 Ref: 021-001a-002
882 Ref: 021-059-143
883 Ref: 012-013-114
884 Ref: 022-023-064
885 Ref: 022-036-097
886 Ref: WS-322/1 p.23
887 Ref: 160-163-001
888 Ref: 160-163-001
889 Ref: 022-070-176

335. Having provided a full description of how *"the Trust has taken this tragic incident very seriously and has fully and promptly investigated this matter"*[890] and the new practices and procedures put in place to ensure that such a tragic incident could not recur, the letter proceeded to question the appropriateness of certain opinions expressed by Dr. Sumner in the context of an inquest, namely that Raychel *"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."*[891] Further, *"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 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."*[892]

336. It is not clear whether and if so to what extent, AHHSST distinguished between Dr. Herron's reference to 'profuse vomiting' and Dr. Sumner's reference to 'severe and prolonged vomiting'.

337. Mrs. Scott's letter proposes an approach which identifies the causes of Raychel's hyponatraemia but ignores the hospital's interaction with those causes. It is defensive of the Altnagelvin position rather than supportive of broader analysis. Dr. Sumner's Report refers to the administration of excess quantities of Solution no.18 fluid, the failure to check Raychel's electrolytes on 8th June and the apparent failure to measure fluid losses.[893] These were failings known to Altnagelvin, having been identified at their Critical Incident Review. Altnagelvin could not deny these failings therefore, it seems, it suggested that they be ignored.

338. The Altnagelvin approach was thereafter may be characterised as maximising the importance of Altnagelvin's responses to the incident, its role as a catalyst for the DHSSPSNI's Guidelines, the dangers of Solution 18, whilst suggesting that others had failed in not alerting it to concerns about the use of Solution no.18. However, Dr. Sumner's belief

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890 Ref: 160-163-002
891 Ref: 160-163-003
892 Ref: 160-163-003
893 Ref: 012-001-005

that *"the state of hyponatraemia was caused by a combination of inadequate electrolyte replacement in the face of severe post-operative vomiting and the water retention always seen post-operatively from inappropriate secretion of ADH"*[894] posed a real difficulty. The only part of this conclusion that could be denied was the severity of the vomiting. Accordingly, and notwithstanding what was recorded in the hospital notes and what Staff Nurse Noble says was acknowledged during the meeting on 12th June,[895] the Coroner's Inquest was approached on this basis.

339. The Coroner's response to Altnagelvin's Solicitor's letter was terse: *"So far as the point you made regarding vomiting I have no objection to receiving evidence from any nurses who are in a position to give relevant evidence."*[896] This letter was copied to Mrs Brown.[897]

340. The Coroner met with the Ferguson family on 3rd April 2002[898] and adjourned the hearing of the Inquest to permit them the opportunity to retain full legal representation.[899]

341. Dr. Fulton returned to convene a pre-Inquest meeting on 9th April 2002 with the key participants from Altnagelvin namely, Drs. Nesbitt, McCord and Makar and Mr. Gilliland.[900] The same impending Inquest date may also have prompted Dr. Fulton's review of the Critical Incident Review Action Points which he arranged for the same day.[901]

342. On 1st May 2002, Dr. Nesbitt wrote to the CMO: *"I am interested to know if any... guidance was issued by the Department of Health following the death of a child in the RBHSC which occurred some five years ago and whose death the Belfast Coroner investigated. I was unaware of the case and am somewhat at a loss to explain why. I would be grateful if you could furnish me with any details of that particular case for I believe that questions will be asked as to why we did not learn from what appears to have been a similar event."*[902] The timing of this enquiry to the CMO appears belated and could have been motivated by the need to defend Altnagelvin's position at Inquest. Dr. Nesbitt had had many months to ask this and other questions of the CMO. It is to be recalled that Dr. Nesbitt himself served on the CMO's Working Group to develop her Guidelines.[903]

343. The CMO responded by assuring Dr. Nesbitt that *"This Department was not made aware of the case at the time either by the RVH or the Coroner. We*

894 Ref: 012-001-005
895 Ref: Transcript of the Oral Hearings 27th February 2013 p.172 line 6
896 Ref: 022-026-069
897 Ref: 022-026-070
898 Ref: 012-059-301
899 Ref: 012-059-301
900 Ref: 022-029-073
901 Ref: 022-092-299
902 Ref: 022-091-298
903 Ref: 007-048-094

only became aware of that particular case when we began the work of developing guidelines following the death at Altnagelvin."[904] The letter carries an annotation in Mrs. Brown's handwriting noting that it should be copied to the AHHSST's solicitor Mrs. Scott.[905]

344. Preparatory work for the Inquest included the deployment of a statement from Dr. Fulton detailing his work investigating *"the circumstances of her death within the hospital and... suggestions for any action to prevent recurrence."*[906] Even though Dr. Fulton was not included in the Coroner's list of witnesses his statement was forwarded to the Coroner who was asked to confirm that he would be called to give evidence.[907] The Coroner replied that *"so far as Dr. Fulton is concerned whilst it is not strictly necessary for him to give evidence, I can understand why the Trust might wish to put in evidence the response to the death of Rachel[sic]."*[908] Dr. Fulton's statement was then re-formatted and accepted by the Coroner on the basis that *"it would be helpful if he gave evidence."*[909]

345. The Inquest was re-listed for 26th November 2002.[910] The AHHSST's solicitor Mrs. Scott retained Counsel to represent the Trust.[911] Counsel gave advices on 7th October 2002 that *"in order to ensure that all possible steps are taken to protect the Trust's interests in this case, I would advise that a report should be obtained from an independent Consultant Paediatric Anaesthetist who should comment management of this case, the contents of Dr. Sumner's report and the steps taken by the Trust following this incident to ensure that such an incident could not occur again... Once this report has been obtained, please furnish me with a copy to enable me to comment on the same prior to the submission of the report to the Coroner. If it is deemed appropriate to furnish the report to the Coroner, a copy should be provided by the Coroner and the Coroner should be invited to allow the expert to give evidence at the hearing of the Inquest."*[912]

346. Mrs. Brown wrote in her update of 1st November 2002 to the Chief Executive and Dr. Nesbitt: *"the positive aspects of the case are that the action taken following the death and again it is hoped that Dr. Fulton will be able to give evidence in relation to his actions following the tragic incident. The other positive note is the letter dated May of this year from Dr. Campbell to Dr. Nesbitt and the Barrister is keen to exploit this issue."*[913] Accordingly,

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904 Ref: 022-090-297
905 Ref: 022-090-297
906 Ref: 060-143-002
907 Ref: 012-070k-397
908 Ref: 012-070j-394
909 Ref: 012-070f-390
910 Ref: 022-017-052
911 Ref: 012-070k-396
912 Ref: 022-019-060
913 Ref: 022-017-052

Dr. Nesbitt's letter to the CMO[914] and her reply[915] were sent directly to the Coroner himself.[916]

347. Staff Nurse Gilchrist was approached to make a statement. It will be a matter for you, Mr. Chairman, whether she was influenced in making her statement by Mrs. Brown's letter: *"Dr. Nesbitt and I met with the Barrister yesterday. The Barrister feels it is important that we counteract the comments made by Dr. Sumner, the independent expert in relation to the allegation of excess vomiting. To do this he feels it is important that we bring along the nursing staff. If nursing staff do not attend then it would be difficult for anyone to explain what is meant by the ++ in the notes. The Barrister is endeavouring to get permission from the Coroner for the nurses to attend. I require a statement from you on your involvement as soon as possible."*[917] Staff Nurse Gilchrist supplied a statement purporting to have been *"written on 10th June 2001"*[918] and gave evidence at Inquest to the effect that she had not been concerned by the vomiting as it was not unusual in post-operative children.[919] When she gave evidence to this Inquiry she agreed that *"Raychel's vomiting was severe and prolonged."*[920]

348. On 1st November 2002 the AHHSST's Solicitor commissioned an independent expert opinion from Dr. J. G. Jenkins, Consultant Paediatrician, Senior Lecturer in Child Health and a member of the CMO's Working Group on Hyponatraemia.[921] He provided an opinion dated 12th November 2002 but was unable to reach firm conclusions in the absence of specific information. He found that *"while it was possible in retrospect to form the opinion reached by Dr. Sumner that Raychel must have suffered severe and prolonged vomiting, this does not seem to have been the assessment of her condition made by experienced staff at the relevant time"* and *"having carefully studied the statements provided by the doctors and nurses involved in Raychel's care my impression is that they acted in accordance with established custom and practice in the Unit at that time. It is however important that further details are obtained of relevant nursing and medical procedures and management in relation to fluid administration and post-operative monitoring of fluid intake, urine output and other losses such as vomiting. In particular information needs to be obtained regarding the local policy for post-operative fluid administration in children. Was the prescribed regime in this case in keeping with this guidance? If it can be confirmed that the frequency and severity of Raychel's vomiting was not outwith the degree expected by experienced staff in these circumstances and that the staff involved*

914 Ref: 022-091-298
915 Ref: 022-090-297
916 Ref: 012-070k-396
917 Ref: 022-017-056
918 Ref: 098-293-771
919 Ref: 012-044-214 & 161-066-014
920 Ref: Transcript of the Oral Hearings 11th March 2013, p.134 line 6
921 Ref: WS-059/2 p.1

acted in accordance with local policies and guidance then, in my opinion, their actions do not amount to negligence."[922]

349. This Report may not have met Altnagelvin's requirements because Dr. Declan Warde, Consultant Paediatric Anaesthetist of the Children's University Hospital Dublin, was commissioned on 3rd December 2002 to prepare an independent expert Report and attend the Inquest.[923] Dr. Warde was specifically asked to *"comment on the treatment provided and the issues raised by Dr. Sumner."*[924] The Inquest was further adjourned to 5th February 2003.[925]

350. Dr. Warde's Report was forwarded to the AHHSST's solicitor on 19th January 2003 and shared with Mrs. Brown the following day.[926] Dr. Warde gave it as his opinion that Raychel had *"died as a result of developing cerebral oedema secondary to acute hyponatraemia, which was itself caused by a combination of severe and protracted post-operative vomiting, SIADH and the administration of intravenous fluid with a low sodium content."*[927] This cannot have been the opinion that Altnagelvin had hoped for and was inconsistent with their denial that the vomiting was severe or prolonged. The Report was immediately sent to Dr. Jenkins who was *"to provide any further comments which you have which might assist the Trust."*[928] He responded on 27th January 2003 to the effect that *"in many aspects Dr. Warde's report does not differ significantly from previously available information... Dr. Warde again makes reference to the significance of the vomiting. I pointed out in my report of 12th November 2002 the importance of seeking further information regarding the frequency and severity of Raychel's vomiting in the opinion of senior staff, given the comments in the report by Sister E. Millar. I have also not been provided with any further details of relevant nursing and medical procedures and management in relation to fluid administration and post-operative monitoring of fluid intake, urine output and other losses such as vomiting"* and *"finally I wish to confirm my availability all day next Wednesday 5 February 2003... I will therefore be grateful if you can confirm details of my expected involvement as a matter of urgency as I have heard nothing further regarding this despite the request in my letter of November."*[929]

351. At 16:15 on 28th January 2003, the AHHSST Solicitor *"left a message with Dr. Warde's wife and advised that he was not required to attend the Inquest hearing."*[930] Dr. Warde was given no additional explanation.[931]

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922 Ref: 022-010a-041
923 Ref: 160-083-001
924 Ref: 160-083-001
925 Ref: 012-059-292
926 Ref: 022-006-026
927 Ref: 022-006-023
928 Ref: 160-045-001
929 Ref: 022-004-013
930 Ref: 160-044-001

352. Dr. Jenkins' availability for Inquest on 5th February was secured and he supplied a third and final Report dated 30th January 2003.[932] It was his third Report which was sent to the Coroner who arranged for it to be transcribed into a Deposition.[933] Dr. Jenkins has described this process as being asked to *"prepare a Report for the Coroner's Inquest. I submitted a Report and later gave evidence at the Inquest."*[934]

353. The third Jenkins' Report of 30th January 2003[935] is based on his first, or 12th November 2002 Report, but pointedly omits his earlier reference to the rates of fluid administration and the total quantity of fluids calculated as having been given.[936] Also deleted is reference to the possibility that in retrospect it was possible to form the same opinion as Dr. Sumner that Raychel had suffered severe and prolonged vomiting. Furthermore, all reference to those requests made by him for additional information was deleted. Dr. Jenkins did however add the observation that *"it is the combination of excessive loss of sodium (for example in vomitus) with water retention (as a result of excessive secretion of anti diuretic hormone) which leads to a fall in the concentration of sodium in body fluids and increased rise of brain swelling (cerebral oedema)."*[937] His guarded conclusion was that *"having carefully studied the statements provided by the doctors and nurses involved in Raychel's care my opinion is that they acted in accordance with the established custom and practice in the Unit at that time."*[938] The Coroner wrote to the CMO on 11th February 2003 to indicate that *"Dr. John Jenkins, Senior Lecturer in Child Health at Queens University also gave evidence [and] stated that he concurred with all the views expressed by Dr. Sumner."*[939]

354. That an independent medical Expert retained for an Inquest could possibly be invited to amend an opinion, or withhold information from the Coroner, must be a matter of concern, conflicting as it may do with the duty of a doctor to offer *"all relevant information to an inquest or inquiry into a patient's death."*[940] Mrs. Brown states *"I do not recall having any involvement in editing Dr. Jenkins' report."*[941]

355. Dr. Warde's Report was not sent to H.M. Coroner. No mention of the Report was made at the Inquest. The Report was relevant to the issues under consideration by H.M. Coroner and Professor Swainson believes

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931 Ref: WS-339/1 p.2
932 Ref: 022-004-010
933 Ref: 012-030-153
934 Ref: WS-059/1 p.5
935 Ref: 012-023-132
936 Ref: 012-023-132
937 Ref: 012-023-132
938 Ref: 012-023-133
939 Ref: 012-064-323
940 Ref: 314-014-014
941 Ref: WS-322/1 p.24 (32h)

that it *"should have been shared with the Coroner."*[942] It was not shared with the Ferguson family. It did not form the basis of any further internal review of Raychel's case. It was not given to the PSNI to assist in Police inquiries. A decision must have been taken by or on behalf of the AHHSST to withhold the Report. Dr. Nesbitt believes *"that this would have been a decision made by the Chief Executive."*[943] Mrs. Burnside does *"not recall that I was consulted."*[944] It is a matter for you, Mr. Chairman, to determine whether this approach is consistent with the AHHSST's obligation to assist the Coroner, to openly and honestly explain the circumstances of Raychel's death to her family, and to conduct itself in a manner consonant with public service values.

356. Notwithstanding the views of Dr. Warde and the lack of actual support from Dr. Jenkins, the Altnagelvin witnesses nonetheless gave evidence that they did not consider Raychel's vomiting to have been a cause for concern because it was not unusual in post-operative children. The Coroner delivered his Verdict on Inquest on 10th February 2003 with the finding that *"the hyponatraemia was caused by combination of inadequate electrolyte replacement in the face of severe post-operative vomiting and water retention resulting from the inappropriate secretion of ADH (anti-diuretic hormone)."*[945]

357. This was essentially the view expressed by Drs. Herron, Sumner and Warde and not disputed by Dr. Jenkins. It amounted to a comprehensive rejection of the proposition that the vomiting was not severe. It held that the electrolyte replacement therapy was inadequate in the circumstances.

358. It is to be noted that the two key members of the speciality surgical team who cared for Raychel, failed to attend the Inquest. Mr. Makar, because he had been given two weeks' leave[946] and Mr. Zafar because he was sitting exams.[947] Dr. George Foster finds this to be a matter of concern because *"they must have been aware of the date of the inquest but apparently at the time of it Dr. Makar was away on holiday and Dr. Zafar was taking examinations. Whilst it is not appropriate for me to comment on inquest procedure it seems as an outside observer that these were extremely important witnesses and I cannot understand why they were not issued witness summons to be present."*[948] The Chief Executive has noted that *"the conduct of the Inquest caused considerable trauma to a number of staff who needed support following it."*[949]

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942 Ref: 226-002-009
943 Ref: WS-035/2 p.31
944 Ref: WS-046/2 p.24(25d)
945 Ref: 012-026-139
946 Ref: 161-066-002
947 Ref: 161-066-004
948 Ref: 223-002-029
949 Ref: WS-046/2 p.23(24b)

Post-Inquest

359. Prior to the Inquest, Altnagelvin had declined to provide comment to the press about Raychel on the basis that *"As an Inquest date has been set in the near future, it would be inappropriate for the Trust to comment at this time."*[950] After the Inquest, the AHHSST released a press statement stating that *"It is important to emphasise that the clinical practices used during Raychel's care, following her operation, were at that time accepted practice in all other Area Hospitals in Northern Ireland."*[951] This public statement appears to ignore the finding of H.M. Coroner that the electrolyte replacement was inadequate. It contradicts Altnagelvin's own Review findings of excess fluid administration, failure to evaluate electrolytes and poor management of fluid balance. The press release had been drafted prior to the Inquest and failed to reflect the evidence, the finding or the information known to the AHHSST. It must be a matter of clinical governance concern that a formal public communication issued in the name of the AHHSST could mislead.

360. The press release was the work of the AHHSST *"Communications Manager [who] would have worked directly to the Chief Executive."*[952] Mrs. Burnside was bound by the code of conduct of her office and to the principles of public service values in management which dictated that *"public statements and reports issued by the Board should be clear, comprehensive and balanced, and should fully represent the facts."*[953] Communications Manager, Marie Dunn *"learned on the job"* and does *"not recall any AHHSST protocols, guidance or procedures in respect of my role."*[954] She further states that *"My guiding principles were always to act with integrity, to protect patient confidentiality, and to be open and honest in my dealings with the public and the media."*[955]

361. After the Inquest the WHSSC sought, and obtained, a meeting with the AHHSST on 19th February 2003 that it might *"learn of the Altnagelvin Trust perspective on the death of Raychel Ferguson."*[956] Altnagelvin was represented by the Chief Executive Mrs. Burnside, Dr. Nesbitt and the Director of Nursing Miss Duddy.[957] The notes of the meeting record that *"The Trust provided a copy of a press statement."*[958] Notwithstanding that more than a week had passed since the Inquest Verdict; the same press release was used without correction. Furthermore, a revised version of Dr. Nesbitt's power-point presentation was delivered to the

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950 Ref: 023-002-002
951 Ref: 014-010-020
952 Ref: WS-334/1 p.4 (7)
953 Ref: 306-096-004
954 Ref: WS-332/1 p.5
955 Ref: WS-332/1 p.5
956 Ref: 014-016-028
957 Ref: 014-016-028
958 Ref: 014-016-028

meeting. His original presentation[959] had been augmented by additional claims that Raychel's hyponatraemia *"was caused by a very rare idiosyncratic reaction to surgery and concomitant therapy with fluid having a low sodium content."*[960] In the light of all the expert and other evidence known to Dr. Nesbitt and the AHHSST, this may not be regarded as wholly transparent.

362. Mr. Stanley Millar, Chief Officer of the WHSSC having attended the meeting and reflected upon it for a week, wrote to the Coroner on 27th February 2003 about the case of Lucy Crawford: *"Following the Raychel Ferguson Inquest I, with other members of the WHSSC, received a briefing on the events which led up to Raychel's death. I was struck by the similarities in the two tragedies... I am left with two questions which you may be able to answer. (1) Are there direct parallels in the events leading up to the death of both girls? (2) Would an Inquest in 2000/2001 have led to the recommendations from the Raychel Ferguson Inquest being shared at an earlier date and a consequent saving of her life?"*[961] The question might then, as now, have been formulated to ask whether an earlier Inquest for Lucy might have saved Raychel.

363. Dr. Nesbitt was to write to the Coroner on 11th March 2004 that *"The death of this child [Lucy] occurred 1 year prior to the tragic episode of Raychel Ferguson in Altnagelvin. It is unfortunate that the earlier death was not brought to our attention in order to cause the alert throughout Northern Ireland, which regrettably only occurred following Raychel's death."*[962]

XVIII. Litigation

364. The AHHSST 'Policy for the Management of Clinical Risk (1997)' emphasises that clinical incident reporting *"acts as 'an early warning' of impending clinical negligence claims... In an environment where... we want to encourage a culture of honesty and openness where mistakes and untoward incidents are identified quickly and dealt with in appositive and responsive way."*[963] Altnagelvin must have anticipated that the Ferguson family might resort to litigation. The Chief Executive had *"explained that [Mrs. Ferguson's] contacts or complaint would not prevent any further path (litigation) she may wish to take in the future."*[964] Litigation was started by Solicitor's Letter of Claim of 1st May 2003 which made it *"clear from our clients' instructions that the death of their daughter was occasioned by the*

959 Ref: 021-054-117
960 Ref: 321-020a-001
961 Ref: 013-056-321
962 Ref: 021-042-087
963 Ref: 321-004fd-002
964 Ref: WS-046/2 p.28

negligence, breach of duty and/or breach of statutory duty... in or about the provision of medical treatment."[965]

365. Just as the Experts' Reports and the finding at Inquest should have provoked further investigation of Raychel's care within Altnagelvin so too should the initiation of clinical negligence litigation. The 1996 HPSS Complaints Procedure 'Complaints... Listening... Acting... Improving' advises *"In all prima facie cases of negligence, or where the complainant has indicated that they propose to start legal proceedings, the principles of good claims management and risk management should be applied, there should be a full and thorough investigation of the events. In any case where the Trust/Board accepts that there has been negligence, a speedy settlement should be sought."*[966] The AHHSST 'Policy for the Management of Clinical Risk'[967] stresses that *"It is extremely important that claims for negligence are managed appropriately to increase public confidence and respect."*[968]

366. DHSSPSNI guidance enjoined all HPSS bodies to *"ensure that the complete clinical negligence compensation process from incident through to legal settlement is managed professionally."*[969] Mrs. Brown, now the *"Risk Management Director"*[970] forwarded the Letter of Claim to the Director of Legal Services on 5th June 2003 with the explanation *"As you are aware this is an Inquest case. I will endeavour to obtain reports from the medical staff involved."*[971] The DLS Solicitor acknowledged her letter and noted *"that you are obtaining reports from the medical staff involved and will list the case for consideration at the next Clinical Negligence Review Meeting."*[972] Mrs. Brown replied *"I feel it is better if we discuss at the Review Meeting first and then see what outstanding information is needed. Do you agree?"*[973] The Inquiry is unable to discover any trace of additional information being sought or of further reports from medical staff being supplied. Furthermore, no specific action was planned at the Clinical Negligence Case Review Meeting attended by the DLS Solicitor, Dr. Nesbitt and Mrs. Brown on 22nd July 2003.[974] The Writ of Summons was issued on 5th May 2004.[975]

367. The AHHSST denial of liability was comprehensive. The DLS wrote to Mr. and Mrs. Ferguson's Solicitor to emphasise that the AHHSST does *"not accept that it, or its staff, were negligent or that, if there was any failure*

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965 Ref: 024-001-001
966 Ref: 314-016-017
967 Ref: 321-004fd-001
968 Ref: 321-004fd-004
969 Ref: 317-037-008
970 Ref: 024-002-002
971 Ref: 024-002-002
972 Ref: 024-004-004
973 Ref: 024-005-005
974 Ref: 024-008-009
975 Ref: 024-019-031

to apply appropriate standards, that the failure caused or contributed to the death of Raychel Ferguson and therefore liability is denied."[976]

368. The AHHSST responded to a press inquiry by stating: *"Trust representatives met with the family following Raychel's death. The Trust legal advisers recently met with the Family's legal advisers to discuss the matter. The matter is now the subject of litigation and the Trust is not therefore in a position to make any comment in the public arena. 1st October 2003."*[977]

369. However, following the broadcast of UTV's Insight programme in 2004 the AHHSST moved swiftly to produce a public statement "*provided by the Communications Department"* with advice from the DLS solicitor[978] and with the authority of the Chief Medical Officer[979] to recite all that had been done following Raychel's death and to state: *"The Trust believes that it acted professionally and honestly following Raychel's death."*[980]

370. Given the Verdict at Inquest, the Experts' opinions and the findings at Review; it is not immediately apparent why liability was not admitted. However, it was not, and this has remained the AHHSST position throughout the many intervening years, the PSNI Investigation and the deliberations of this Inquiry. The depth of the feelings of Raychel's parents about the AHHSST's failure to concede liability for their daughter's death is reflected in the opening submissions delivered by their Senior Counsel[981] and their own testimony.[982]

371. An unjustified denial of liability is not only a clinical governance matter and an issue touching upon public confidence in, and respect for, the NHS but, as you might find Mr. Chairman, is of concern because of any additional and unnecessary hurt and distress that might be caused the Ferguson family by any such failure to admit fault.

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976 Ref: 326-002-002
977 Ref: 024-015-023
978 Ref: 023-017-027
979 Ref: 023-022-049
980 Ref: 023-007-011
981 Ref: Transcript of the Oral Hearings 1st February 2013 p.113
982 Ref: Transcript of the Oral Hearings 26th March 2013 p.179 line 13 *et seq*