LITIGATION
06 AUG 2012
SERVICES

Witness Statement Ref. No. 023/2

NAME OF CHILD: RAYCHEL FERGUSON

Name: Dr. Vijay Kumar Gund

Title:

Present position and institution:

Consultant Anaesthetist
Warrington & Halton Hospitals NHS Trust

Previous position and institution: Senior House Officer Anaesthesia, Altnagelvin Hospital
[As at the time of the child's death]

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since your Witness Statement dated 11th January 2012]

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death since your Witness Statement dated 11th January 2012]

OFFICIAL USE:
List of previous statements, depositions and reports attached:

Ref:	Date:	
023/1	11.01.2012	Witness Statement

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached

I. QUERIES IN RELATION TO YOUR MEDICAL QUALIFICATIONS, EXPERIENCE, TRAINING AND RESPONSIBILITIES

(1) As of the 7th June 2001,

(a) State your medical qualifications and the date you qualified as a medical doctor.

I qualified as a Medical Doctor in December 1992 & completed my MD in Anaesthesia in October 1998 from SMS Medical College, Jaipur, India.

(b) State the date of your appointment to Altnagelvin Hospital, and the role to which you were appointed.

I was appointed as an SHO in Anaesthesia to Altnagelvin Hospital on 10th May 2001.

(c) Describe your career history before you were appointed to Altnagelvin Hospital.

Career history before my appointment is outlined in the CV which I provided with my earlier statement in Jan 2012. It includes my Anaesthetic experience as postgraduate trainee for 3yrs & as Senior Resident for over 2yrs.

(d) Describe your work commitments to the Altnagelvin Hospital from the date of your appointment, stating the locations in which you worked and the periods of time in each department/location.

I worked just short of 3 months in Department of Anaesthesia. It required providing Anaesthetic services in theatres & also working in ITU. As an anaesthetist I was also part of the resuscitation team.

(e) Describe your duties as an anaesthetist at Altnagelvin Hospital on the 7th June 2001.

I was the 1st on call Anesthetist on that day.

(f) How much anaesthetic experience did you have by the time of Raychel's operation?

It included my Anaesthetic experience as postgraduate trainee for 3yrs & as senior resident for over 2yrs.

(g) How much experience did you have of managing post-operative fluids in childrens' cases, by the time of Raychel's operation?

I had worked in a children's hospital for 3 months during my post graduate training. During senior residency also I was involved in anaesthetizing children on few lists. As anaesthetist I prescribed initial post operative fluids in all patients including children.

(2) At the time of your appointment to Altnagelvin Hospital were you provided with training or induction and if so,

I do not recall having a formal induction. Before the start of the post Dr Nesbitt, then clinical lead gave me a tour of the hospital & acquainted me with the places I would be required to cover as an anaesthetist.

During the month of May I was only doing anaesthetic lists & ITU sessions accompanied by a consultant/associate specialist. This was my introduction to the working environment in Altnagelvin Hospital. It allowed an informal assessment of my anaesthetic practise before I went on to on-call rota.

(a) Describe the training or induction which you received.

(b) State the date or the approximate date when you received any training or induction.

(c) Identify the person(s) who delivered this training or induction.

(d) Indicate if you received any documentation at this training or induction.

(3) Provide full details of any advice, training or instruction which was provided to you at Altnagelvin Hospital in order to inform you of the appropriate approach to decision-making when considering assisting in the conduct of out of hours surgery in childrens' cases in that Hospital and state,

(a) Who provided this advice, training or instruction to you?

I am not able to identify any single person but general advice was to involve 2nd on call Anaesthetist in first instance for help & advice in all the cases out of hrs.

(b) When was it provided?

(c) What form did it take?

(d) What information were you given about the steps to be taken before agreeing to anaesthetize a child?

(4) Provide full details of any advice, training or instruction which was provided to you at Altnagelvin Hospital in order to inform you of the appropriate approach to any of the following matters:

- Hyponatraemia
- Post-Operative Fluid Management
- Record keeping regarding fluid management

And address the following:

(a) Who provided this advice, training or instruction to you?

(b) When was it provided?

(c) What form did it take?

(d) What information were you given?

(e) In particular what information were you given in relation to the allocation of responsibility for prescribing intravenous fluids for post-operative children?

I can not recall receiving any documents on fluid management. While I worked in Altnagelvin, there was an adult patient in itu admitted with hyponatremia secondary to water intoxication due to Ecstasy use. During ward rounds there were discussions about causes & treatment options.

Fluid management was part of discussion in perioperative anaesthetic management on directly supervised lists.

II. QUERIES ARISING OUT OF YOUR FIRST WITNESS STATEMENT TO THE INQUIRY (WS 023-1)

(5) *"I had prescribed Hartman's Solution as maintenance fluid post-operatively on hrly basis according to my normal practice, but was instructed by Dr. Jamieson (sic) to cross it off and disconnect in situ infusion from the cannula. Reason I was given, was that fluid management on the paediatric ward is managed by the ward doctors. This was admitted by their recovery nurse as being normal practice in that hospital for post-operative paediatric patients. My understanding was that fluids on the paediatric ward would be prescribed by Paediatric Doctors."* (WS 023-1 page 2)

(a) Provide full details to explain what your "normal practice" had been with regard to the management of post-operative fluids for children, before to receiving this instruction from Dr. Jamison?

Normal practice was to continue intraoperative fluids(mostly Hartman's) in initial post operative period on an hourly basis in an uneventful surgery.

(b) Explain why it had been your normal practice to prescribe Hartmann's Solution as a maintenance fluid?

It had been a preferred iv fluid in anesthetic practice because of it being isotonic in intravascular compartment.

(c) Had you ever prescribed Solution No. 18 as a post-operative fluid?

I do not recall having ever prescribed Solution No. 18.

(d) If so, describe the circumstances in which you found it appropriate to prescribe Solution No. 18 as opposed to Hartmann's Solution? n/a

(e) Why had you intended to prescribe Hartmann's Solution for Raychel post operatively, as opposed to a fluid such as Solution No. 18?

Because as an anaesthetist, I am most experienced in using Hartman's solution and also it is isotonic in intravascular compartment.

(f) Confirm that the prescription that was crossed off is that document at (Ref: 020-021-040).

Yes, it was crossed off.

(g) State what you wrote on the prescription before it was crossed off.

I had prescribed Hartman's solution to be given on an hourly basis.

(h) Describe fully the discussion which you had with Dr. Jamison in relation to Raychel's post-operative fluids and in particular state whether you had any discussion about the appropriate fluid for Raychel post-operatively?

I remember that I was advised that it was current practice for the post op fluids to be prescribed on the ward.

(i) At any time before you had your discussion with Dr. Jamison in which she instructed you to cross off the prescription which you had written for Raychel, had you been made aware that post-operative fluid management was a matter for ward doctors?

No.

(j) You have referred to a discussion with the 'recovery nurse.' Who was that nurse?

From the copy of the notes I can say her surname was McGrath

(k) Describe fully the discussion which you had with the 'recovery nurse'.

I do not recall what was exactly discussed between me, Dr Jamison & the recovery nurse in the above discussion, but the impression I received was that fluids would be commenced only on the prescription from the ward. The recovery nurse admitted that fluids were to be prescribed on the ward.

(l) Describe any steps that you took in the post operative period to find out how Raychel's fluids were being managed by the ward doctors? If you did not take any such steps, please explain why you did not do so.

Her surgery was uneventful & I expected her to make a normal recovery so I did not make any specific suggestions.

III. QUERIES ARISING OUT OF YOUR DEPOSITION TO THE CORONER DATED 5th FEBRUARY 2003

(6) *"I first met Raychel Ferguson on the evening of 7 June 2001. I visited the patient to pre-assess her from my perspective. This patient was scheduled by the surgeons for emergency appendectomy on that evening."* (Ref: 012-033-161)

(a) Did you discuss with the surgeons the appropriateness of proceeding to surgery?

No.

(b) Did you discuss with any other anaesthetist whether it was appropriate to proceed to surgery in this case?

I informed Dr Jamieson about the case very soon after I had seen Raychel.

(7) *"Before transferring her to the ward, I prescribed her intramuscular Cyclimorph, Paracetemol, Diclofenac and Ondnsetron on a as required basis.*

"I then discarded the remaining fluid in the bag and left the prescription of fluids on ward protocols." (Ref: 012-033-162 & 163)

(a) What do you mean by the phrase that you, *"left the prescription of fluids on ward protocols."*

I meant to say that ...further management of the fluids was to occur on the paediatric ward according to the then current practice.

(b) What was the 'ward protocol' in respect of fluid management for a child in the post operative stage, and in particular state,

(i) Whether the protocol said anything about who held the responsibility for prescribing intravenous fluids for the patient in the immediate post-operative period, and what did it say?

(ii) Whether the protocol said anything about the type of intravenous fluids a patient was expected to receive in the immediate post-operative period, and what did it say?

(iii) Whether the protocol said anything about who would take up the responsibility for prescribing intravenous fluids for the patient and managing the patient's fluids after the immediate post-operative period had passed, and what did it say?

(iv) Whether the protocol said anything about the type of intravenous fluids a patient was expected to receive after the immediate post-operative period had passed, and what did it say?

Apart from this information that post operative fluid was to be prescribed on the ward I was not aware of any written protocol.

(c) To the best of your knowledge, was this protocol contained in a document or otherwise committed to writing?

As above.

(d) Had any member of staff at Altnagelvin discussed the ward protocol with you prior to the 7th June 2001 and if so state,

No- please see my answer at (b) (iv) above

(i) Who discussed the ward protocol with you?

(ii) When was it discussed with you?

(iii) In what setting was it discussed with you e.g. was it part of formal training or induction?

(iv) What were you told about the protocol and its operation?

(v) Were you given any document in relation to the protocol or its operation?

(e) What was your expectation of how the ward protocol would operate in Raychel's case? In particular state,

(i) Who did you understand would be responsible for prescription and management of Raychel's fluid needs in the post-operative period?

(ii) What type of fluid would you have expected Raychel to have been prescribed with in the post-operative period?

(iii) At what rate would you have expected the fluid to be given in the post-operative period?

I was not aware of any written protocol but I was advised about the then current practice being that a ward doctor would be responsible for prescribing & managing the fluids.

(f) Did you discuss Raychel's post-operative fluid needs with anyone after you left the prescription of fluids on ward protocols and if so,

No, I did not discuss this with anyone after Raychel left for the ward.

(i) Who did you discuss the issue with?

(ii) What did you say and/or what was said to you about her post-operative fluid needs?

(8) The record of your deposition to the Coroner's Inquest records you as having said:

"I then discarded the remaining fluid in the bag and left the prescription of fluids on ward protocols. After that I did not see her again and my involvement in her care terminated. In my view the surgery was uneventful." (Ref: 012-033-163)

(a) Is this an accurate note of your evidence to the Coroner? If it is not an accurate note please state the respects in which it is inaccurate.

I meant to say that *"I then discarded the remaining fluid in the bag and* further management of the fluids was to occur on the paediatric ward according to the then current practice. *After that I did not see her again and my involvement in her care terminated. In my view the surgery was uneventful."*

Assuming that this is an accurate note of your evidence:

(b) In your experience (at that time) was it unusual for an anaesthetist not to see the patient again after she left theatre?

In my experience it was not unusual for an anaesthetist to see the patient post operatively especially if there was any degree of concern.

(c) In your experience (at that time) if a patient was found to be vomiting many hours after the conclusion of the surgery, would a consultation between the surgeons and anaesthetists have taken place to determine the cause of the vomiting?

I expect a consultation would have taken place.

(9) In answer to questions directed to you by counsel at the Coroner's Inquest you are recorded as having said:

"I do not prescribe in respect of a child – only adults. I understood that the nurses would ask a paediatrician to prescribe any fluids for Raychel." (Ref: 012-033-163)

(a) Is this an accurate note of your evidence to the Coroner? If it is not an accurate note please state the respects in which it is inaccurate.

I meant to say that as an anaesthetist I did not prescribe in respect of a child whilst I worked at Altnagelvin Hospital. *I understood that the nurses would ask a paediatrician to prescribe any fluids for Raychel"*

Assuming that this is an accurate note of your evidence:

(b) When you said you *"do not prescribe in respect of a child,"* was this in reference to fluids only or did it apply to anything else?

It was in reference to fluids only.

(c) Explain why you did not prescribe in respect of a child at that time, and in particular state what it was that prevented you from prescribing for a child?

Because I was advised that the fluid management of a child post operatively was the responsibility of the ward doctors .

(d) Who prescribed the fluid (Hartmann's) which was used intra-operatively, referred to at (Ref: 020-009-016)?

I had commenced the fluid which was used intra operatively.

(e) Who prescribed the drugs that were used intra-operatively, referred to at (Ref: 020-009-016)?

I used the drugs intra- operatively in referred document.

(f) With regard to your understanding that the nurses would ask a paediatrician to prescribe any fluids for Raychel post operatively state,

(i) Confirm how you arrived at this understanding.

I understood that a paediatric doctor would be asked on a paediatric ward.

(ii) Was the practice of nurses asking a paediatrician to prescribe fluids for children post operatively a general practice in Altnagelvin Hospital at that time, or was it limited to Raychel's case?

I did not expect it to be any different in Raychel's case.

(iii) What was your understanding of the role of the anesthetist in prescribing intravenous fluids for children at Altnagelvin Hospital in the immediate post-operative period in 2001?

I understood that anesthetist did not prescribe post operative fluids routinely.

(iv) What was your understanding of the role of the surgeon (or the surgical team) in prescribing intravenous fluids for children post operatively in 2001?

I expected it to be a part of their post operative management.

(10) In answer to questions directed to you by counsel at the Coroner's Inquest you are also recorded as having said:

"I knew Raychel had received fluids prior to surgery – including Solution 18. These had been disconnected prior to surgery. The fluids used during surgery were stopped when she was transferred to the ward." (Ref: 012-033-163)

(a) Is this an accurate note of your evidence to the Coroner? If it is not an accurate note please state the respects in which it is inaccurate.

Yes, this is accurate.

Assuming that this is an accurate note of your evidence:

(b) Why were the fluids used during surgery (Hartmann's) stopped when she was transferred to the ward?

Because I was advised that it was normal practice for post operative fluids to be prescribed on paediatric ward & then commenced on that prescription.

(c) What is your understanding of why Raychel received Solution 18 when she returned to the ward, as opposed to being recommenced on Hartmann's?

I am unable to answer this question because I was not involved in this part of Raychel's care.

(11) With regard to the prescription for Raychel which you crossed off on the basis of an instruction from Dr. Jamison (as stated at WS-23/1 page 2):

(a) Were you ever asked by anyone else at Altnagelvin Hospital to explain why you had begun to write and then cross off the prescription for Hartmann's (Ref: 020-021-040)?

No.

(b) If so, who asked you for the explanation and what did you say? n/a

(12) If you had been responsible for managing Raychel's initial post-operative fluids which type of fluid would you have prescribed? Please give reasons for your answer.

I would have chosen Hartman's solution for initial post operative period. This is the fluid I am most experienced with & in my understanding makes up for the initially increased third spacing losses (loss of fluid into the interstitial and out of intravascular spaces)

IV. QUERIES RELATING TO THE ROLE OF THE ANAESTHETIC TEAM AT ALTNAGELVIN HOSPITAL

(13) At that time (June 2001) were you aware of the conclusions of the National Confidential Enquiry into Perioperative Deaths (NCEPOD) which in its 1989 report found, inter alia, that trainee anaesthetists should not undertake any anaesthetic on a child without consultation with their consultant?

No. I was not aware of this finding of the NCEPOD at that time.

(14) Whether or not you were aware of this finding of the NCEPOD, how do you consider this conclusion applied to you in your role in Raychel's surgery?

I was not aware of this finding of the NCEPOD, I consider it applied in Raychel's case.

(15) In June 2001 did Altnagelvin Hospital have any protocol, written or unwritten, or any other form of guidance which required the on duty anaesthetist to inform either of the following persons that consideration was being given to conducting out of hours surgery:

(a) The Consultant Anaesthetist;

(b) The Consultant Surgeon?

I was not aware of any protocol but my understanding was to involve 2nd on call anaesthetist for all the cases out of hours.

(16) Insofar as you are aware, was the on call Consultant Anaesthetist or Consultant Surgeon informed about Raychel's admission on 7th June 2001?

I am not aware if Consultant Surgeon/Anaesthetist was informed.

(17) If so,

(a) Identify the on-call Consultant Anaesthetist or Consultant Surgeon who was informed; n/a

(b) State whether the decision to operate was discussed with either of them; n/a

(c) Identify the person(s) who held these discussions with either Consultant. n/a

(18) Are you aware whether any steps were taken by Consultant Anaesthetists at Altnagelvin Hospital to ensure that you had acquired sufficient knowledge to carry out all of the duties expected of you when working without supervision? If you are aware that steps were taken,

(a) Specify to the best of your knowledge the steps that were taken.

Before going on on-call rota, during month of May 2001, I was only scheduled on accompanied lists & sessions with Consultants/Associate specialist across the department. I was assessed on those lists by providing direct & indirect supervision during this period.

(b) Identify the Consultant(s) who took any particular steps to ensure that you had acquired sufficient knowledge.

Dr Nesbitt had informed me of the above arrangement before I was scheduled on the rota.

(c) Explain how you demonstrated that you had acquired sufficient knowledge to enable you to perform the duties expected of you without supervision

By actively participating in procedures & discussions during accompanied sessions. I also made efforts to accompany on call person to emergency cases during daylight hours. I had also attended in house basic life support & defibrillation training.

IV QUERIES ON THE ISSUE OF FLUID MANAGEMENT

Please provide clarification and/or further information in respect of the following:

(19) In June 2001 who in Altnagelvin Hospital was responsible for organizing the structure and allocation of responsibilities for post-operative fluid management for paediatric cases?

I do not know answer to this question.

(20) Prior to 7th June 2001:

(a) State your knowledge and awareness of the cases of Lucy Crawford, Claire Roberts, or Adam Strain, and the issues arising from those cases.

(b) State the source(s) of your knowledge and awareness and when you acquired it.

(c) Describe how that knowledge and awareness affected your care and treatment of Raychel.

I was not aware of these cases.

(21) Since 7th June 2001:

(a) State your knowledge and awareness of the cases of Lucy Crawford, Claire Roberts or Adam Strain, and the issues arising from these cases.

(b) State the source(s) of your knowledge and awareness and when you acquired it.

(c) Describe how that knowledge and awareness has affected your work.

I did not become aware of above named cases until I was asked to present my statement to HM Coroner Belfast, but much prior to that, one of the presentations possibly during the induction programme at Pinderfields & Pontefract Hospital in 2001 made me aware of hyponatraemia related deaths in children. Close attention to the perioperative fluids & avoiding hyponatraemic fluids was advised. This knowledge was further reinforced during my training posts through various hospitals. There was a session dedicated to Hyponatremia related deaths in above children during the Midland Society of Anaesthetists meeting in 2006. I have become increasingly aware about the circumstances around their deaths as the Inquiry has progressed. Apart from issues around type of fluids used, these cases have highlighted training & governance issues. This knowledge has helped me in being aware of departmental guidelines with regards to perioperative anaesthetic & fluid management in children.

(22) Prior to Raychel's death were you aware are of the literature which highlighted the dangers posed by the administration of hypotonic fluids to children during the immediate post operative period? eg. Arieff AI, Ayus JC. British Medical Journal 1992: 304; 1218-1222. Hyponatraemia and death or permanent brain damage in healthy children,or Halberthal M, Halperin ML, Bohn D. British Medical Journal 2001: 322; 780-782. Lesson of the week: acute hyponatraemia in children admitted to hospital: retrospective analysis of factors contributing to its development and resolution.

I was not aware of the above literature.

(23) Describe in detail the education and training you have received in fluid management (in particular hyponatraemia) and record keeping, to include any particular training relating to fluid management in children, and provide dates and names of the relevant institutions/bodies, by reference to the following:

(a) Undergraduate level.

Not in particular hyponatremia, but the importance of close monitoring of input & output balance was emphasised during my posting as final year student of MBBS & also as intern in Children's Hospital, SMS Medical College, Jaipur.

(b) Postgraduate level.

As post graduate trainee during my MD in anaesthesia at SMS Medical College Jaipur, training occurred through discussions during accompanied sessions with Consultants. Main emphasis was intraoperative management of fluids & through these discussions I was aware of the risks associated with use of hyponatraemic fluids & they were avoided.

During my training in UK, training & education was delivered through experience during accompanied sessions and tutorials & electrolyte & fluid balance was closely discussed during my attachment with PICU at Birmingham Children's Hospital

(c) Hospital induction programmes.

I am not able to date them but each hospital I have been attached to, since Jul 2001, had highlighted the importance of careful fluid management in children & advised avoiding hyponatremic fluids perioperatively. Also I became increasingly aware of emphasis on use of Glucose with ½ Normal saline (0.45% NaCl) with or without potassium as maintenance fluid, input output balance, close monitoring, investigations & choice of replacement fluids.

(d) Continuous professional development.

Through Midland Society of Anesthetists meetings during my registrar training. One meeting was dedicated to paediatric anaesthesia & in one meeting we had a session highlighting above cases. In 2009 one of the audit meetings was dedicated to an update by a paediatric anaesthetist highlighting factors to be considered for perioperative fluid management in children & adults. My current work place has guidelines for prescribing intravenous fluids in children.

(24) Prior to 7th June 2001, describe in detail your experience of dealing with children with hyponatraemia, including the:

(a) Estimated total number of such cases, together with the dates and where they took place.

(b) Nature of your involvement.

(c) Outcome for the children.

I had never been involved in a child with hyponatraemia.

(25) Since 7th June 2001, describe in detail your experience of dealing with children with hyponatraemia, including the:

(a) Estimated total number of such cases, together with the dates and where they took place.

(b) Nature of your involvement.

(c) Outcome for the children.

I have never been involved in the care of a child with hyponatremia.

V GENERAL

Please address the following:

(26) After Raychel's death were you asked to take part in any process designed to learn lessons from the care and treatment which he received, to include any issue about her fluid management? If so,

(a) Describe the process which you participated in.

(b) Who conducted it?

(c) When was it conducted?

(d) What contribution did you make to it?

(e) Were you advised of any issues relating to your role in Raychel's care and treatment?

(f) Were you advised of the conclusions that were reached, and if so, what were they?

(g) Describe any changes to fluid management practice that you were made aware of at Altnagelvin Hospital following Raychel's death.

I was never involved in any such process but through the Inquiry documents I have become increasingly aware that Dr Nesbitt has done presentations relating to the case to generate awareness of Hyponatremia in Children & has done extensive work to develop guidelines to address this issue.

(27) Provide any further points and comments that you wish to make, together with any documents, in relation to:

(a) The care and treatment of Raychel in Altnagelvin Hospital between the 7th – 9th June 2001.

(b) Record keeping.

(c) Communications with Raychel's family about her condition, diagnosis, and care and treatment.

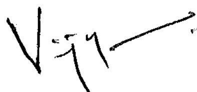
(d) Lessons learned from Raychel's death and how that affected your practice at Altnagelvin or elsewhere.

(e) Current Protocols and procedures.

(f) Any other relevant matter.

I am very sorry about the unexpected & sad demise of Raychel & have great sympathy towards her family. Her death is always on my mind since I have come to know about it. I always think of her when it comes to anaesthetising a child.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed:  **Dated:** 31-7-12.