Witness Statement Ref. No. 032/2 | 032/2

NAME OF CHILD: RAYCHEL FERGUSON

Name: Brian McCord

Title: Consultant Paediatrician

Present position and institution:

Previous position and institution: Consultant Paediatrician, Altnagelvin Hospitals H&SS Trust
[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 of 25th October 2011]

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death since your Witness Statement of 25th October 2011]

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

Ref:	Date:	
031/1	01.07.2005	Inquiry 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 ARISING OUT OF YOUR INITIAL STATEMENT TO THE INQUIRY (WS-032/1

(1) *"The primary aim of admission to paediatric ward is to treat in a child-friendly controlled environment and have ready access to paediatric nursing staff. Consequently a number of other children are admitted to paediatric wards who do not require paediatric medical expertise, being admitted and treated by other specialty teams e.g. general surgery and surgical sub-specialities such as ENT etc.*

"Whilst inpatients, these children remain the responsibility of their named Consultant but paediatric medical advice or assistance is readily available at both senior and junior level, upon request." (Ref: WS-032/1, page 2)

Typically, informal arrangements existed for Paediatric Medical involvement in Surgical or Surgical specialty children.
Most commonly verbal, occasionally written form requests were made. Several routes could be employed e.g. doctor to doctor (of varying grades) or even via nursing staff.

In relation to the arrangements which were in place in June 2001, state precisely what you mean by the phrase, *"paediatric medical advice and assistance is readily available at both senior and junior level, upon request"* and in particular address the following:

(a) Apart from Ward 6, identify the locations within Altnagelvin Hospital at which senior and junior level members of the paediatric medical team could be based, or where they could be working with patients?

As at present, Junior doctors, especially during "out of hours" periods could have been active in a variety of sites e.g. labour ward, post natal ward, Neonatal Intensive Care Unit, Accident and Emergency department, Children's Ward - and during routine working hours then at Out-patients Clinic or at formal teaching sessions as well.

At Consultant level, doctors provide back-up support from home during "out of hours" as has been the usual practice then and now.

(b) In respect of all such locations, describe their proximity to Ward 6?
All locations are generally within a few minutes brisk walk from Ward 6. In case of recall from home, dependent on state of sleep/awake/ traffic flow and hospital parking considerations, I could return to Ward 6 within 5-15 minutes if called.

(c) How many members of the paediatric medical team were typically on duty on the Hospital wards or working with inpatients at any time of the day in June 2001?
I am unable to recall the complement of doctors –senior or junior – at that time.

(d) Indicate how many members of the paediatric medical team on duy at any time of the day in June 2001 would have been senior level and how many would have been junior level staff?
I am unable to recall the complement of doctors – senior or junior – at that time.

(e) Clarify whether the arrangements which were in place for the purposes of introducing paediatric medical advice or assistance to the care of a surgical patient s upon request, were formal or informal, and describe the main features of those arrangements?
As stated previously, informal arrangements predominated with a variety of requests as diverse as assistance with phlebotomy sampling/IV cannulation to requesting medical assessment for a child with non-surgical symptoms.

(f) Was paediatric medical advice and assistance available upon request to the nursing staff caring for surgical patients on Ward 6? Yes, undoubtedly.

If so, please address the following:.

(i) How was a nurse expected to make a request? Typically a verbal request.

(ii) To whom was a request to be directed? Either through a more senior nurse colleague or directly to a member of Paediatric medical staff.

(iii) On what matters could paediatric medical advice or assistance be requested by a nurse? Any matter of paediatric concern.

(iv) How was a nurse to know of the arrangement by which they could make a request for medical advice or assistance?
Presumed common knowledge that Paediatric medical staff are noted for easy approachablility combined with close day to day working relationships.

(g) Was paediatric medical advice and assistance available upon request to members of the junior surgical team (such as junior house officers) caring for surgical patients on Ward 6?Yes.

If so, please address the following:

(i) How was a member of the junior surgical team expected to make a request?
Typically verbal or occasionally written, if directed by more senior surgical colleague.

(ii) To whom was a request to be directed?
Typically to equivalent or next most senior grade of Medical Staff but often the first member of Medical staff in proximity.

(iii) On what matters could paediatric medical advice or assistance be requested by a junior member of the surgical team?
Any matter of paediatric concern.

(iv) How was a junior member of the surgical team to know of the arrangement by which they could make a request for medical advice or assistance?
Presumed common knowledge that Paediatric medical staff are noted for easy approachability.

(h) In general, were any arrangements in place to promote good communications between the paediatric medical team and the surgical team with regard to the care of surgical patients? If so, please describe those arrangements?
Nil specific, but in a District General Hospital of Alnagelvin's size there existed a good atmosphere amongst juniors commonly sharing on-call area and facilities that fostered informal discussions and general discourse.

(2) *"My immediate advice was to commence high dose intravenous antibiotics i.e. meningitis treatment dose (ref: 020-017-034), to seek Anaesthetic assistance if further deterioration (ref: 020-015-024) and that I was returning to Hospital to assist (ref 020-015-024)."* (Ref: WS-032/1 page 2)

(a) Are you aware of any contact having been made with a Consultant Surgeon to advise him/her that Raychel (a general surgery patient) had suffered an epileptiform episode?
No.

(b) In what circumstances should a Consultant Surgeon be contacted to be advised of a deterioration in the condition of a general surgical patient?
It would be inappropriate for me to comment as I do not possess surgical expertise.

(c) In what circumstances should a Consultant Surgeon be asked to return to the Hospital to assist with a general surgical patient?
It would be inappropriate for me to comment as I do not possess surgical expertise.

(3) *"I formally met again with family on 3 September 2001 at a planned meeting between the family and hospital staff arranged by Mrs. Stella Burnside...Information provided to the family at that meeting are minuted and are a combination of fact, comment and opinion."* (Ref: WS-032/1 Page 4)

(a) What was your understanding of the purpose of the meeting between members of Raychel's family and hospital staff?
Information sharing to inform family and allow staff involved to express sympathy and support to family.

(b) Did you contribute to the meeting and if so, in what way?
My recollections are scant but I may have spoken to explain some medical terms or procedures, but did not have a major role.

(c) Do you know why no member of the surgical team was in attendance at that meeting? No.

(4) *"My understanding of the prescription of intravenous fluids post operatively in children's ward was that this was the responsibility of the named Surgical Clinician. The responsibility sometimes being shared in*

the short-term ie. immediate post operative period between Anaesthetic and Surgical staff. Paediatric medical involvement was ad hoc and advisory."(Ref: WS-032/1 Page 4)

(a) In 2001, please explain how the arrangements for the prescription of intravenous fluids post operatively in children's ward were communicated to staff?
I am not aware of exact details but I presume a written fluid balance /IV fluid prescription sheet was returned from theatre with patient.

(b) Do you know whether the arrangements for post operative fluid precribing which you have described were the subject of any written guidance, or were these arrangements otherwise taught at an induction?
I am not/was not aware of any written guidance or induction teaching of this topic.

(c) How did you reach your understanding thatprescription of intravenous fluids post operatively in children's ward was the responsibility of the Surgical Clinician, perhaps shared initially between surgical and anaesthetic staff?
Unaware about how I reached this understanding - it is probable that I discussed the matter with nursing staff who were much more intimately involved in post-operative management than I was.

(5) *"For a time there was a distinct divergence between IV fluid management between post operative surgical children and paediatric medical inpatients* (Ref 026-005-006) *with blanket use of Hartman's solution for the former and continued use of Solution 18 for the latter unless indicated otherwise by clinical condition."* (Ref: WS-032/1 Page 5)

(a) Please explain the reasons for this divergence of approach.
Presumably differing clinical scenarios - e.g. medical(eg meningitis/pneumonia/bronchiolitis etc)versus surgical conditions and differing clinical specialities - e.g. Paediatric Medicine versus Surgery/Anaesthetics with different training backgrounds.

(b) Was the continued use of Solution 18 for paediatric medical inpatients (unless otherwise indicated) the subject of discussion with you and if so, please address the following:

(i) Who else was party to these discussions?
There was a general Paediatric medical censensus.

(ii) What views were expressed by those who were party to those discussions in relation to the continued use of Solution 18 for paediatric medical patients (unless otherwise directed)?
Unable to recall

(iii) Was the continued use of Solution 18 for paediatric medical patients (unless otherwise directed) the subject of agreement with you? If so, who was in agreement with this course?
There was a general Paediatric medical censensus.

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

Signed: **Brian McCord** **Dated:** 31/05/12

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