Witness Statement Ref. No. 032/3

NAME OF CHILD: Raychel Ferguson

Name: Brian McCord

Title: Dr.

Present position and institution:

Previous position and institution:
[As at the time of the child's death]
Consultant Paediatrician - Altnagelvin Hospital Health & Social Services Trust ("AHHSST")

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 2001 - present]
As previously provided to the Inquiry, unchanged

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

As previously provided to the Inquiry

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

Ref:	Date:	
WS-032/1	01.07.2005	Inquiry Witness Statement
WS-032/2	20.06.2012	Supplemental 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 to your statement.

(1) **Please provide the following information:**

(a) **Please describe your work commitments at the AHHSST from the date of your appointment as Consultant Paediatrician;** *At appointment, worked with 2 colleagues providing Paediatric Medical cover both in-patient and out-patient to Altnagelvin/Tyrone County Hospital and Erne Hospital. By 2001, we were no longer providing service to Tyrone County Hospital or Erne Hospital as Paediatric Medical staff had been appointed there and we had been joined by 2 further consultant colleagues making a compliment of 5 in Altnagelvin providing General Paediatric/Neonatal Intensive Care and a range of Paediatric specialties e.g. Diabetes,Asthma,Gastroenterology etc.*

(b) **What was the role of the Consultant Paediatrician and what were its functions, accountabilities and responsibilities (was this reduced to writing by 2001 and if so please provide a copy of the same)?** *See above. No clear contract/job plan detail prior to 2005.*

(2) **With reference to your membership of the Drugs and Therapeutic Committee at Altnagelvin, please state whether liaison was maintained with like committees in other hospitals in Northern Ireland for the updating and exchange of mutually relevant information? If so please provide details.** *Not aware of any specific forum*

(3) **Please state the identity of the Clinical Director charged with responsibility for Paediatric care at Altnagelvin hospital in June 2001?** *Uncertain recollection – possibly Dr Dennis Martin*

(4) **In 2001 did the AHHSST have in place any policies, guidance or procedures governing the following:**

(a) **Clinical governance;** *Presumed but not specifically known by me*

(b) **Social care governance;** *Not known by me*

(c) **Health and Safety;** *Presumed but not known by me*

(d) **Adverse Clinical Incident Investigation;** *Not known by me*

(e) **Complaints procedure;** *Patient Advocate system*

(f) **Performance assessment;** *Not known by me*

(g) **Continuing medical education and professional development;** *As per Royal College*

(h) **Clinical record keeping;** *Presumed but not known by me*

(i) **Preparation for Inquests and the gathering of statements therefore;** *Not known by me*

(j) **Communication with next of kin?** *Not aware of specific policy*

If the AHHSST did have any such policies, guidance or procedures in place, then identify the same, provide a copy and state in respect of each:

(i) Whether it was modelled on or informed by any published guidance, and if so please identify this guidance; *Not aware*

(ii) How the guidance, policy or procedure was distributed; *Not aware*

(iii) What training or assistance was given in respect of same; *Not aware*

(iv) How the AHHSST satisfied itself that the guidance, policy or procedure was being implemented and complied with; *Not aware*

(v) How implementation and compliance was enforced; *Not aware*

(vi) How such guidance, policy or procedure was applied in the case of Raychel Ferguson? *Not aware*

(5) Did the AHHSST seek or obtain accreditation, whether from Kings' Fund Organisational Audit or otherwise, and if so: *Not aware*

(a) What was the accreditation and from whom was it sought;

(b) On what date was accreditation applied for and received;

(c) What were the standards/criteria set;

(d) What was the outcome of this process?

(6) In 2001, what arrangements did the AHHSST have in place to ensure that regular and systematic nursing/medical/clinical audits took place? If such arrangements were in place please advise: *Unable to recollect*

(a) Was there a Clinical Audit Committee? If so, what was its remit; *Unable to recollect*

(b) Who served on the Clinical Audit Committee; *Not aware*

(c) Who was responsible for ensuring that medical/clinical audits were carried out; *Not known*

(d) To whom were the results of medical/clinical audits sent; *Not aware*

(e) What action could be taken on foot of the results of medical/clinical audits; *Changed practice with further re-audit at a later date to assess the effect of any change.*

(f) As to whether there was any procedure or system in place in 2001 to audit the quality, clarity and completeness of clinical case notes? *Occasional casenote audits undertaken within unit but unable to remember if active in 2001*

(7) In 2001, had the AHHST established a Medical Records Committee or like body? If so, please address the following: *Not aware*

(a) What was the function of the Committee;

(b) Was its remit and operation governed by any policy/procedure;

(c) Who formed the membership of this Committee;

(d) Did you play a role in relation to this Committee, and if so what;

(e) Whether its deliberations were minuted;

(f) Did such a Committee engage with the audit or review of medical records?

(8) Please describe the structures in place in 2001, and the lines of accountability and responsibility, for:

(a) Clinical policy setting; *Not aware*

(b) Clinical policy monitoring; *Not aware*

(c) The adoption of policy on clinical practice as a result of NCEPOD, NICE, GMC, CREST, UKCC and other relevant bodies? *Not aware*

(9) Please describe the steps taken to disseminate, implement/enforce compliance with the recommendations deriving from external sources including the following:

(a) The Royal Colleges; *Usually direct communication via College newsletter etc.*

(b) UK Central Council for Nursing, Midwifery and Health Visiting; *Not aware*

(c) Department of Health; *Usually direct mailing*

(d) Audit Commission; *Not aware*

(e) General Medical Council; *Usually direct mailing*

(f) DHSSPSNI; *Not aware*

(g) HPSS; *Not aware*

(h) Paediatric Intensive Care Society; *Not aware*

(i) Management Executive. *Not aware*

(10) Please describe all other systems in place in 2001 for quality assuring the safe provision of patient care. *Peer/colleague review*

(11) Was there any system of independent external scrutiny in place to review clinical performance in the AHHSST, and if so please detail the same? *Not aware*

(12) Did you keep a file or record of your work in relation to the case of Raychel Ferguson and did you retain all documentation relating thereto? If so please provide copies. *No*

(13) Please detail those opportunities available in 2000-2001 to paediatricians from across Northern Ireland to meet and exchange information of professional relevance by way of managed clinical network or otherwise. *Not aware*

(14) With respect to the Critical Incident Review Meeting held on 12th June 2001 please confirm;

(a) How much time was devoted to the meeting on 12th June 2001, giving approximate times of commencement and conclusion; *No accurate recollection*

(b) Was the Clinical Incident Form completed; *Not aware*

(c) Were the Nursing Director, Clinical Services Manager (CSM) and the Clinical Effectiveness Co-ordinator present at the Review meeting; *Not aware of individuals by job titles*

(d) Was any attempt made to locate and secure all documentation relating to Raychel Ferguson and her treatment; *Not by me*

(e) Who was responsible for compiling a list of the relevant clinicians involved for the purposes of Review, and how was this done; *Not aware*

(f) Who was invited to attend the Review and whether any record exists to identify those who attended the Review; *Not aware*

(g) Was any attempt made to trace the Paediatric and Surgical rotas for 7th - 9th June inclusive; *Not aware*

(h) Was any attempt made to form a chronology of the care and treatment provided to Raychel Ferguson; *Yes, probably but not in detail*

(i) Which members of staff were interviewed, when and by whom, and whether this process was recorded or noted; *Not aware of any individual being interviewed – if memory is correct, it was a group meeting with individual contributions*

(j) Whether and when an appreciation first arose that the case had the potential for litigation; *Personally, as in any unexpected death in hospital, immediately after death*

(k) What timescale was agreed for the provision of a written report to the Chief Executive, who wrote the report, when and to whom was it submitted; *Not aware*

(l) Was any note/minute/memorandum/record taken of any part of the Review meeting; *Not aware*

(m) Who directed that a retrospective note should be inserted into the Medical Chart regarding the volume of Hartmann's solution administered; *Not aware*

(n) What further investigations were carried out by the Review team after the meeting; *Not aware of the sentiment of a "Team"set-up or a specific investigative role*

(o) Were there any additional or subsequent meetings of the Review team? If so when and who attended; *No recollection of any*

(p) What shortcomings and deficiencies were identified by the Review; *Don't clearly recognise this terminology but a number of action points were delineated and specific indiviuals tasked.*

(q) Was the Review aware of the *"rumour"* from the RBHSC that there had been mis-management of Raychel's fluids; *No, not to my knowledge, but "chinese whispers" not uncommon*

(r) When and how did the Review team first become aware that the RBHSC had discontinued

the use of Solution 18; *Not sure, but possibly mentioned at original review. No specific detail of timing or reason provided*

(s) Whether or not you received a report in writing into the case of Raychel Ferguson? If so please provide the same; *No*

(t) What steps were expected to be taken by you to ensure that the recommendations arising from this Review were implemented?

(15) In relation to the Critical incident Review meeting please also confirm whether any consideration was given to:

(a) Performing a detailed audit of all aspects of the case; *Unable to recollect*

(b) The record of communication with Raychel's parents; *Unable to recollect*

(c) The quality, consistency and timeliness of information given the Ferguson family; *Unable to recollect*

(d) The overall leadership of the clinicians treating Raychel; *Unable to recollect*

(e) The absence of the consultant responsible for Raychel's care, from Raychel's care; *Unable to recollect*

(f) Interviewing, receiving input from or involving the Ferguson family in the Review; *Unable to recollect*

(g) Obtaining the expert views of an internal/external specialist; *Unable to recollect*

(h) The skill and suitability of junior surgical staff to oversee fluid management; *Unable to recollect*

(i) Difficulties experienced by surgical doctors in attending upon Paediatric patients; *Unable to recollect*

(j) The conduct and responsibility for post-take ward rounds; *Unable to recollect*

(k) The responsibility for intravenous fluid prescription/administration as and between Anaesthetic, Surgical and Paediatric teams; *Unable to recollect*

(l) The extent, type and duration of the vomiting suffered by Raychel on 8th June 2001; *Unable to recollect*

(m) The failure to replace abnormal electrolyte losses caused by vomiting; *Unable to recollect*

(n) Possible shortcomings in the nursing care provided to Raychel Ferguson; *No*

(o) Inter-clinician-communication (ICC); *Unable to recollect*

(p) Whether or not intravenous fluids had been administered at a greater rate than

recommended; *Noted*

(q) Whether or not there had been any shortcoming in the frequency of assessment of Raychel's electrolytes; *Unable to recollect*

(r) Whether or not there had been any shortcoming in the assessment and recording of urinary output and vomit; *Unable to recollect*

(s) Resolving the inconsistency of recollection as to whether 200mls or 300mls of Hartmann's solution was infused in theatre; *No*

(t) The procedures governing consent, and whether they were complied with; *No*

(u) The records relating to the post operative care of Raychel; *No*

(v) The competence and training needs of those who cared for Raychel; *No*

(w) The content and update of nursing care plans; *No*

(x) The efficacy of the bleeper summonsing system; *No*

(u) The balance of responsibility between medical and nursing staff in respect of monitoring patients; *No*

(v) The failure to include Post Operative Nausea and Vomiting in the Episodic Care Plan; *No*

(w) The clinical protocols available to nurses in Ward 6 on 8th June 2001; *No*

(x) A review of ward practices and conventions to determine whether they were appropriate, and whether they might better be reduced to writing as clinical protocols; *Unable to recollect*

(y) Whether there were any broader systemic failings in the provision of the care given Raychel? *No*

(16) In respect of the *"Update for Chief Executive Re: Critical Incident Meeting"* (Ref: 022-097-307) please state what steps were taken to review the *"further action required"* and to ensure it was achieved. Please also state what steps were taken to address the concerns of nursing staff with respect to surgical inability to commit to children on Ward 6? *Not aware on the initial point as this would have been an arrangement between Surgical/Nursing staff.*
With regard to the second, whilst this might have been a desirable outcome in some eyes, it was not possible due to resource limitations

(17) Please describe the extent to which you believe the Ferguson family was fully informed of the causative factors of Raychel's death. *At the time of Raychel's death, yes, in the context of the information available*

(18) How was the Priest (who administered the Last Rites to Raychel) alerted to her condition? *Not aware*

(19) Was there any reference to Raychel's case at Trust Board level or at other hospital committee meetings? If so, please provide any record thereof. *Not aware*

(20) With respect to the meeting with Mrs. Ferguson and others (minuted Ref: 022-084-215):

(a) What was the purpose of you meeting with Mrs. Ferguson; *Attended at request/invitation of Mrs Stella Burnside. Also an opportunity to offer sympathy/commiseration to parents as last contact had been pre-mortem*

(b) State whether, before attending this meeting, you were briefed as to the outcome of the Critical Incident Review; *Present at review meeting of 13/06/01*

(c) Do you believe that the representatives of the AHHSST answered the questions posed; *Yes*

(d) Do you believe that the representatives of the AHHSST gave a full account of their understanding of the principle causes of Raychel's death; *Yes, to the best of their understanding*

(e) Do you believe that the representatives of the AHHSST gave a full account of their understanding of the deficiencies in the care and treatment of Raychel; *Yes*

(f) Why did you not tell Mrs. Ferguson of the hospital's agreed action plan (Ref: 026-008-009) and the review of procedures; *Unaware of this omission, but would not have considered it my role to do so*

(g) *"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"* (Ref: 022-084-221). Please state:

- Whether you informed Mrs. Ferguson that excessive fluids had been administered and if not why not; *Have no recollection as to why this was not discussed*
- What you meant by the term *"innate sensitivity"*? *Term used in an attempt to describe the SIADH process in a previously healthy child. There was no inference of blame attached to Raychel in the use of the term - rather an attempt to describe the variability in physiological response between individuals*

(h) *"Dr. McCord thought he could see a trickle on the brain scan. Doctors in Belfast were contacted. They had a different expertise and the scans were faxed to Belfast. A second brain scan was requested. There were no new findings on the second scan. Arrangements were made to transfer Raychel to Belfast."* Please state:

- Whether or not the second scan confirmed cerebral oedema; *This statement causes me concern. I am unable to recall seeing Raychel's CT image in any detail, -nor would I consider myself able to report on CT films and would depend on the expertise of others. Additionally, I was unaware that a second CT scan had been performed. Presumably I was relating what I thought had happened on the morning of Raychel's transfer*
- Whether this information in respect of the second scan was received prior to the transfer of Raychel to the RBHSC; *Not aware,but presumed so*
- What you informed Mr. and Mrs. Ferguson about the second scan; *Not aware that a*

second scan performed and have no recollection of speaking to parents again after initial CT

- **Who you spoke to in Belfast and what advices you were given;** *Did not speak to anyone in Belfast as I had no further clinical contact after transfer from Radiology department to Intensive Care Unit pending transfer to Belfast.*

- **Whether any record was kept of these conversations/communications;** *Not aware*

- **What was the basis for the decision that it was necessary to transfer Raychel to Belfast, and were you involved in the decision making process;** *Raychel required intensive care and it would be routine to transfer intubated children to Paediatric Intensive Care Unit at RBHSC*

- **What was the point of transferring Raychel to Belfast when she already had fixed and dilated pupils;** *Same reasoning as above but also to offer Raychel every chance of survival. This was a situation vastly outside the normal "comfort zone" and previous experience therefore extremely difficult to make definitive judgements.*

- **Was Altnagelvin Hospital capable of performing a brain stem death test in June 2001?** *Not to my knowledge in children*

(i) **Did you advise Mrs. Ferguson that the Patient Advocate was an employee of the Trust and accordingly lacked independence? If not please explain why not;** *No, it would not have been my role to do so*

(j) **Please indicate whether you consider the minute of the meeting to be accurate? If not please detail those respects in which you consider it to be inaccurate;** *No, I believe there are factual and contextual inaccuracies – see prior comments*

(k) **In respect of the meeting to be held at the end of September 2001 to look *"at fluids given to children"* (Ref: 022-084-223) please detail who met, when, where, why and with what result?** *Not aware*

(21) **Who had responsibility for communicating information to Mr. and Mrs. Ferguson from 9th June 2001 onwards?** *No specific individual identified*

(22) **Please state why you were charged with the responsibility for preparing a chart of IV infusion rates for use in Ward 6? Why was this included in the Action Plan of the Critical Incident Review?** *Volunteered for this task as an aid to junior staff prescribing intravenous fluids in ward 6*

(23) **With regard to the Review meeting of 9th April 2002 (Ref: 022-092-299) please advise whether any note, formal minute or memorandum was created? If so please provide copy of the same.** *Not aware and unsure if present at meeting*

(24) **Please state:**

(a) **Whether you attended any of the pre-Inquest consultations arranged by the Risk Management Co-ordinator (Memorandum Ref: 022-029-073);** *Presume so, but unable to recollect any detail*

(b) **If you were supplied with any of the witness statements obtained for H.M. Coroner;** *No*

(c) Whether you were briefed in respect of the commissioning of expert reports from Drs. Jenkins and Warde; *No*

(d) If you were consulted about the release of Dr. Warde's report to the Coroner; *No*

(e) If you gave any directions in respect thereof? *No*

(25) Please advise as to the purpose of the pre-Inquest meeting convened by Dr. Fulton on the 9th April 2002 (Ref: 022-029-073) and please state whether any note/memorandum/minute/record was taken of the same? *Presumed attendance but no recollection of purpose or if notes or minutes kept*

(26) *"The problem in the Children's Ward seemed to be that even if Hartmann's was prescribed, it was changed to No. 18 by default"* and *"some clinicians evidently feel that No.18 is the fluid they wish to prescribe, and have disagreed with the regime suggested"* (Ref: 021-057-137) please state whether you agree with this and if so:

(a) To the best of your knowledge, how did this *"problem in the Children's Ward"* become established, and when; *No knowledge of this. My presumption was that intra-operative fluids(usually Hartman's solution) would be continued post-op for some hours*

(b) Who was responsible for implementing and monitoring this practice; *Presumably this would be discussed between Surgical/Anaesthetic/Nursing staff*

(c) Why was it permitted to continue; *Unaware of the practice, but I suspect that like me, others made presumptions too*

(d) Was it reviewed? *Yes*

(27) With reference to the letter to you dated 28th May 2002 from Dr. Nesbitt (Ref: 077-003-004) please state whether you confirmed that the *"Consensus Statement will be incorporated into a Ward Protocol"*? *Displayed on Ward 6 for a time and copy filed in policy folder*

(28) Please state when you first became aware of the content of the following:

(a) The Autopsy report provided by Dr. Herron (Ref: 014-005-006); *2013*

(b) The report of Dr. Sumner to the Coroner (Ref: 012-001-001); *2002*

(c) The report of Dr. Loughrey (Ref: 014-005-014); *2013*

(d) The reports of Dr. Jenkins (Ref: 317-009-002 and 317-009-004); *Unable to recollect*

(e) The report of Dr. Warde (Ref: 317-009-006)? *Unable to recollect*

Was any consideration given to sharing the content of these reports with the Ferguson family? And if not why not? *Not by me*

(29) In relation to the Memorandum of 2nd May 2003 (Ref: 021-044-091) and the *"uncertainty regarding the management of surgical paediatric patients"* please state:

(a) What this uncertainty was and how it manifested itself; *Not authored by me, but presumably refers in part to the various presumptions regarding matters such as responsibility for intravenous*

fluid prescriptions in Surgical children and clarify lines of communication between Nursing/Surgical/Paediatric staff amongst others.

(b) **Whether there was any disagreement of approach between the surgical and paediatric specialty teams?** *Different teams treating different conditions so generally ran side-by-side independently in the same area but each assisting the other in areas of overlap*

(c) **When did you first hear of the death of Lucy Crawford?** *Unable to recall but not before Raychel's death*

(30) **Please provide such additional comment as you think relevant. It would be of very considerable assistance if you could attach such documentation as you may hold which relates to procedures, strategies, policies or other issues of relevance.**

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

Signed: [signature] **Dated:** 15/07/17