Witness Statement Ref. No. 043/2

NAME OF CHILD: RAYCHEL FERGUSON

Name: Raymond Alexander Fulton

Title: Dr.

Present position and institution:

Previous position and institution: Medical Director Altnagelvin s Health & Social Services Trust
[As at the time of the child's death]

Membership of Advisory Panels and Committees:

Previous Statements, Depositions and Reports:

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

Ref:	Date:	
043/1	21.06.05	Inquiry Witness Statement

I, Raymond Alexander Fulton, refer to my Inquiry Witness Statement reference 043. It now appears that there are specific inaccuracies which I believe are important to correct. I state on page 5 of the Statement that certain doctors and nurses were present at The Critical Incident meeting on 12.06.01 and refer on pages 6 and 7 to conversations with them at that meeting. I now believe my record to be incorrect. I wish to explain how this unintended inaccuracy could have occurred.

To fully understand the issue around the meeting of 12.06.01 I am submitting coloured copies of my original handwritten notes which are currently on the Inquiry's website only as black and white copies (Documents 026-011-012, 026-011-013, 026-011-014, 026-011-015).

The Critical Incident Meeting was set up on 12.06.01 to investigate the circumstances surrounding the death of Raychel Ferguson. I chaired that meeting. The participants in the meeting were Consultants, junior doctors and nurses who had been known to be involved in the management of Raychel Ferguson. It was not a complete list of all involved staff since some would have been invited and been unable to attend. Others may not have been identified. At that stage I had been at Altnagelvin Hospital as Consultant Dermatologist for 19 years. I knew nearly all the Consultants (around 100) and many of the senior ward nurses. However I would not have known or recognised most of the junior staff at Altnagelvin (numbers at least 150) as they change posts every 6 to 12 months. Equally they would not have recognised me. Similarly nurses below Sister level would not usually be known to me (probably at least 500 nurses). When I came to make Statement reference 043 it was 4 years after the meeting. I would have had difficulty remembering or recognising any junior doctor or nurse who was at the meeting. I do remember the senior staff present at the meeting. In making my Statement in 2005 I was heavily reliant on my notes, especially regarding the identity of junior staff and what they may have said at the meeting.

Document 026-011-012 contains a list of the names of doctors and nurses grouped in clinical areas e.g. paediatrics. This was written by myself during the meeting or shortly afterwards and is in my handwriting. I now believe it is not a complete attendance list but rather a list of those identified to have been involved at some stage in Raychel's treatment. I think most of the nurses named were present at the meeting, as were the consultants. My square brackets around Doctors Gund and Jamison suggests that they were identified as being involved in Raychel's treatment but were not present. There is a note to the right of Mr Makar which suggests he was in Outpatients (OP) for at least some of the meeting. I have no recollection of any of these junior doctors.

Document 026-011-013 has a heading "Statements" which is cut off in the black and white copy currently on the Inquiry's website. Only the underline is visible. I only noticed this heading recently (24.02.13) when re- reading my original notes after many years. I now believe that Documents 026-011-013 and 026-011-015 are summaries of the written Statements from medical and nursing staff after the meeting of the 12.06.01. Written Statements were requested from involved staff, some but not all of whom attended the meeting on 12.06.01. Others were either not invited or were unable to attend. These written Statements were submitted to Mrs Therese Brown, Risk Management Co-Ordinator at Altnagelvin. They arrived over several weeks and months following the meeting on 12.06.01. I believe I summarised the Statements in the ruled boxes as they became available. The different colour inks indicate that this happened over a period of time. The quotations in the boxes against each individual name are almost word-perfect quotations taken from the written Statements of that individual. I believe that these are my summaries of written Statements rather than records of conversations at the meeting.

When writing my statement reference 043 I would probably not have seen my original notes of the meeting of 12.06.01 for nearly 4 years. On 06.02.03 I did a report for the Coroner but did not then detail attendance

at the 12.06.01 meeting. When I came to make my Witness Statement 043 I now believe I misinterpreted my notes and especially the quotations in Documents 026-011-013 and 026-011-015 as records of conversations that took place at the meeting of 12.06.01. I now believe that the quotations came from the written Statements and not from the meeting. I assumed that all those named in Documents 026-011-013 and 026-011-015 were present at the meeting and therefore recorded them as attending on page 5 of my Witness Statement. I now believe that several of the individuals named on page 5 were not present at the meeting though they did provide written Statements at a later stage.

I think this explains the apparent conflict between several Witnesses who stated that they were not at the meeting, but they were recorded as attending in my Witness Statement. I will not contest any of the witnesses who have said they were not at the meeting 12.06.01.

Since my notes in Documents 026-011-013 and 026-011-015 were summaries taking from the individuals' written Statements there is no conflict over clinical evidence. My error in 2005 in recording attendance at the meeting 12.06.01 would not have had any impact on the speed or the nature of the investigation.

I would also like to correct an error on page 8 of my statement reference 043. I say in Point 1, quoting Document 026-010-011, "In the interim Hartman's Solution would be used". I should have quoted Document 026-011-014 which refers to my handwritten notes summarising the 6 Points. Point 1 of the Document 026-011-014 mentions "Change to Hartmans". I believe the reference to Hartmans is an error as I have clear recollection that the 12-6-01 meeting agreed to continue Solution 18 until evidence from medical publications was reviewed by Dr Nesbitt. This explains the reference to "Evidence". The typed 6 point summary Document 026-008-009" was the correct agreement as at 12-6-01.

I apologise for any confusion this has caused both to the Inquiry and to any Witnesses. My intention was always to quickly investigate the tragic death of Raychel Ferguson and to make changes to existing practices to minimise the chances of a recurrence.

Signed:- M Fulton

Dated: 3 March 2013

(12.6.01 THE

Dr Bernie Trainor Reg } Paeds
Dr Brian McCord
Dr Jeremy Johnson SHO

Mr Makar SHO } Surgery — x CP
Mr Zafar SHO
Robert Gilliland

~~Jeffrey~~ Geoff Nesbitt Anaesth
[Claire Jamison] Anaesth
Gund

Sister Millar
Margaret Doherty

SN Ann Noble Night Nurse
SN Fiona Byrne "
SN Elizabeth Lynch UA Friday night
SN Sandra Gilchrist Friday night

026/062

STATEMENTS

Mr MAKAR	7/6/01	A+E ? Appendicitis Rx HARTMANS etc (in A+E) Changed to Soln 18 in Wd 6 by Mr Makar at request of SN Noble in accordance with protocol. EP named in A+E.
Dr JAMISON (SHO Anaes)		IV cannula in situ. No fluids on arrival in theatre 300 ml Hartmans in theatre
SN Noble (night duty Thurs + Friday)		Pre-op: Confirmed asked Dr M. to change Hartmans (in A+E) to Soln 18. Post op: "Solution 18 in progress 80/ml hr" Continued until SN Noble returned to night duty on 8/6/01
Sr Mulaela Rice (Day Friday)		IV Soln 18 80 ml/hr "Asked/Paged SHO to write up the another bag of Soln 18"
Dr Johnston (SHO Paeds)		dealt with fits - sent off U+E
Dr Trainor (Reg Paeds)		Called by Dr Johnston Na 119 Reg 0.59 fluids changed to 0.9% NaCl + Rate ↓ 40 ml/hr

ACTION SHEET 12/6/0:

1.	Evidence ✓ Change to Hartmans	Dr Nesbitt
2	Daily VTE all past ap	Sister Miller
3	Inform junior surgical staff	Mr Gilliland
4	Monitor urinary (+? vomit) output	Sister Miller
5	Chart fw in fluid rate	Dr McCord
6	Fluid balance documentation	Mrs Gilkerson

Dr Gund
J Anaes

THEATRE : set up 1 L Hartmans

"about 200ml Hartmans given during surgery."

"Discarded the remaining fluid and left the prescription of fluids on ward protocols"

SUMMARY

Dr Nakan	Rx IV Hartmans in A+E 2000 THURSDAY 7 JUNE 2001
Dr Nakan	changed to Soln 18 in Wd 6 [23.40 appendicectomy]
Dr Gund	gave 200ml Hartmans in theatre (300ml Dr Jamison)
SN Noble Rice Sister Millar	} Soln 18 given post op @ 80ml/hr throughout Friday 8th until early 9th Saturday