	Witness Statement Ref. No. 043/3
NAME OF CHILD: Raychel Ferguson	
Name: Raymond Fulton **Title: Dr.**	
Present position and institution: **Retired 31 March 2010**	
Previous position and institution: *[As at the time of the child's death]* **Medical Director- Altnagelvin Hospital Health & Social Services Trust ("AHHSST")** **1 March 1998 - 28 February 2002** **Consultant Dermatologist AHHSST 1982-2010**	
Membership of Advisory Panels and Committees: *[Identify by date and title all of those between November 1995-present]* *Altnagelvin Trust Board March 1998-March 2002* *Altnagelvin Executive Committee March 1998-March 2002* *Altnagelvin Hospital Management Team March 1998-March 2002* *Altnagelvin Risk Management and Standards Committee Feb 2000-March 2004* *Altnagelvin Ethics Committee March 1998-March 2002* *Altnagelvin Clinical Incident Review Committee Feb 2000-March 2002* *Altnagelvin Scrutiny Committee March 1998-March 2002* *WHSSB Scrutiny Committee March 1998- March 2002* *General Medical Council Performance Assessor 2003-2010*	
Previous Statements, Depositions and Reports: *[Identify by date and title all those made in relation to the child's death]* *WS-043/1 21.06.2005* *WS-043/2 03.03.2013* *PSNI Statement of Witness 14.03.2006* *Statement to Coroner 06.02.2003*	
OFFICIAL USE: **List of previous statements, depositions and reports attached:**	

Ref:	**Date:**	

WS-043/1	**21.06.2005**	**Inquiry Witness Statement**
WS-043/2	**03.03.2013**	**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) Your qualifications as of 2001 (please also provide a copy of your CV);

B.A., M.B., BCh., F.R.C.P (London).

(b) Describe your career history;

Postgraduate training in general medicine in York and Hull, then specialist training in dermatology in Glasgow and France. Appointed Consultant Dermatologist, Western Board, December 1982.

(c) Please describe your work commitments at the AHHSST from the date of your appointment as Medical Director;

Approximately 50% clinical work and 50% managerial.

(d) What was the role of the Medical Director and what were its functions, accountabilities and responsibilities, and was this reduced to writing by 2001? If so please provide a copy of the same.

Role:

giving advice to Trust Board on any medical issues

investigating medical complaints and clinical incidents,

medical advice on litigation,

disciplinary action against doctors not meeting the professional standards of General Medical Council,

introducing doctor appraisal and training doctors in appraisal methods.

Responsible to Chief Executive

I do not have a copy of the Job Description.

(2) Who bore ultimate responsibility for the quality of care delivered by AHHSST?
I believe individuals are responsible for their own actions.

(3) Were you a member of the Association of Trust Medical Directors, or similar?
I was a member of the British Association of Medical Managers which included Medical

Directors.

(4) Please advise as to the nature and scope of your work as a Performance Assessor for the General Medical Council.

I was part of a team trained by the GMC to investigate doctors (in my field of dermatology) who had been referred to the GMC for alleged serious lapses in clinical skills and knowledge. We did a workplace assessment looking at case notes and interviewing colleagues. This was followed by a skills and knowledge test of the doctor. A separate panel made a final decision on the doctor's fitness to practice based on the results of our investigation.

(5) *"The Trust strategy for clinical governance had been developed under the leadership of Nursing Director, Miss Duddy alongside the Medical Director, Dr. Fulton and had been coordinated by Mrs. Brown"* (Ref: WS-046/1 p.3). Please describe your involvement in this work, when it was done and whether it generated any policy or strategy documents (if so please provide copies of the same)?

I advised on governance issues which related to doctors e.g. critical incident reporting, medical audit, doctor appraisal methodology. I do not have a copy of the Governance Strategy document or the dates. The process was constantly evolving during my time as Medical Director as new guidance became available from many sources.

(6) The *"Proposed Strategy for Implementing Clinical Governance"* is dated 7th September 1998 (Ref: 321-004g-001). Please advise:

(1) As to the extent of implementation of this Strategy as at June 2001;

A Critical Incident Reporting policy was in place.

A medical audit programme was well established.

Staff appraisal was being introduced.

A Risk Management department was set up.

(2) If implementation suffered delay, what were the causes thereof?

I did not feel there was any delay. Clinical governance was a new and evolving concept in the NHS at that time.

(7) In respect of the AHHSST Ethics Committee upon which you served, please state whether the issue of openness in communication with patients and their families, was ever considered, and if so whether any advice was given in respect of this?

I do not remember any specific discussion on openness in communication with patients and their families. I remember discussions about consent for operations in which communication was a central issue. There was lay representation on the committee to give patient input.

(8) Please state the identity and accountability of the individuals who had lead responsibility in AHHSST in 2001 for:

(a) Clinical governance;

Miss Duddy, Nursing Director

(b) Risk Management;

Mrs Therese Brown

(c) Claims and Litigation;

Mrs Therese Brown

(d) Complaints?

Mrs Therese Brown

All accountable to the Chief Executive.

Please also indicate what training and guidance was given to these individuals in respect of good practice and what steps were taken to monitor their procedures.

I do not know

(9) Please describe the accountability and responsibilities of the Risk Management Co-ordinator/Director and the *"Department of Nursing and Risk Management"* (Ref: 022-071-184) between 2001-2003 and if you could describe the evolution of these clinical governance offices it would be very helpful.

I do not know

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

(a) Clinical governance;

yes

(b) Social care governance;

I do not know

(c) Health and Safety;

I do not know

(d) Adverse Clinical Incident Investigation;

Yes. Based on template on page 95 book "Clinical Governance" Myriam Lygon 1999. The author was invited to give a lecture on clinical governance, including critical incident reporting, to medical staff on 25 October 2000.

(e) Complaints procedure;

Yes. Administered through Patient's Advocate Office.

(f) Performance assessment;

Yes. In 2001 annual consultant appraisal was being introduced throughout the UK. Not all doctors at Altnagelvin were appraised by 2001 as the process was at an early stage and not

yet mandatory. It was based on a template provided by DHSSPS using the headings in the GMC Good Medical Practice book. I arranged for Mr Rodney Peyton, consultant surgeon Craigavon, to give appraisal training to consultants at Altnagelvin in 2001.

(g) Continuing medical education and professional development;

Responsibility of NI Postgraduate Dean and delegated to Post Graduate Tutor at Altnagelvin.

(h) Preparation for Inquests and the gathering of statements therefore;

I do not remember any specific guidance other than one lecture to doctors given by the Assistant Coroner on this subject.

(i) Clinical record keeping;

This subject came up frequently in audit. I do not remember any policies. The GMC had guidance for doctors on note keeping.

(j) Communication with next of kin?

I do not know.

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;

(ii) How the guidance, policy or procedure was distributed;

(iii) What training or assistance was given in respect of same;

(iv) How the AHHSST satisfied itself that the guidance, policy or procedure was being implemented and complied with;

(v) How implementation and compliance was enforced;

(vi) How such guidance, policy or procedure was applied in the case of Raychel Ferguson?

Raychel's death was investigated under the Critical Incident Report procedure (026-012-016.)

(11) Did the AHHSST seek or obtain accreditation, whether from Kings' Fund Organisational Audit or otherwise, and if so:

I do not know.

(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?

(12) In respect of Patient Charter standards please explain what is meant by the reference *"1999-2000... Key Achievements- ongoing monitoring of Patient Charter standards Charter monitoring Achievements- Figures"* (Ref: 321-004gt-001)?

I do not know. I do not remember seeing this document. I was not directly involved with Patient Charter standards.

(13) With reference to the Annual Report 2001-2002 claim of a Key Achievement of work continuing in the following areas: *"development of Care Pathways"* and *"documentation Audit and Improvement Plan"* (Ref: 321-004gk-042) please describe this work and indicate the impact the same might have had on Ward 6 in June 2001?

I remember that "Care Pathways" was a nursing initiative. I cannot remember the "documentation audit and improvement plan."

(14) In respect of the Key Achievement in Clinical Governance highlighted in the Altnagelvin Hospital's Annual Report 1999-2000 (Ref: 321-004gj-044) *"Staff appraisal system agreed which includes identification of individual and departmental training needs"* please advise:

(a) As to the date of this agreement;
I do not know date. This 1st bullet point applies to non medical staff. Doctors are specifically addressed in 6th bullet point "Pilot Appraisal for Senior Medical Staff"

The date of implementation of this system.
Annual appraisal for consultants was gradually introduced in Altnagelvin from about 2000.

Whether this system identified any need to offer training in intravenous fluid management?
Consultant appraisal would not have identified any training need in iv fluids unless there had been specific recent guidelines from a professional body or government body.

(15) 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:

(a) Was there a Clinical Audit Committee?

Yes.

If so, what was its remit;

To plan an annual programme of clinical audits which had relevance for the hospital. To assist such audits with organisational and secretarial support. To produce an Annual Audit Report.

(b) Who served on the Clinical Audit Committee;

A representative range of clinical staff and the full-time Audit Assistant.

(c) Who was responsible for ensuring that nursing/medical/clinical audits were carried out;

The Chairman assisted by the Audit Assistant

(d) To whom were the results of nursing/medical/clinical audits sent;

Not sure of full list but included the Trust Board, Clinical Directors and Heads of Departments.

(e) What action could be taken on foot of the results of nursing/medical/clinical audits;

The relevant departments were expected to alter practice if required and to re-audit to show improvement.

(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?

I cannot remember details of specific audits on case notes but record keeping was a recurring theme of many audits using hospital records as a source.

(16) In 2001, had the AHHST established a Medical Records Committee or like body? If so, please address the following:

I do not know.

(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?

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

(a) Clinical policy setting;

This would have been formulated by the Clinical Directors and , if major changes or resources were required, brought to the Hospital Executive and ultimately the Trust Board for approval.

Clinical policy monitoring;

I do not remember a specific monitoring structure.

(b) The adoption of policy on clinical practice as a result of NCEPOD, NICE, CREST, GMC, UKCC and other relevant bodies.

These guidelines would be expected to be implemented at Departmental level by individual staff working in the field. Appraisal, at an early stage of development in 2001,

was an opportunity to discuss national guidelines.

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

(a) The Royal Colleges;

(b) UK Central Council for Nursing, Midwifery and Health Visiting;

(c) Paediatric Intensive Care Society;

(d) Department of Health;

(e) Audit Commission;

(f) General Medical Council;

(g) DHSSPSNI;

(h) HPSS;

(i) Management Executive.

For doctors in 2001 there was no formal mechanism to enforce implementation of all these guidelines. However annual appraisal increasingly asked for evidence of knowledge of, and implementation of, national guidelines. They were often filed by doctors in their appraisal folders which gave the appraiser an opportunity to ask about compliance.

(19) Please describe all other systems in place in 2001 for quality assuring the safe provision of patient care?

Analysis of complaints to Patients Advocate.
Recommendations from Patient User Committees.

(20) Was there any system of independent external scrutiny in place to review clinical performance in the AHHSST, and if so please detail the same?
GMC and external experts for serious cases of medical underperformance.
Some departments e.g. cardiology had external reviews by a Royal College.

(21) Please advise as to the structures in place in 2001 for regular meetings between Medical Directors, Directors of Public Health, representatives of DHSSPSNI/Department and the CMO and whether the same were minuted.

Occasional meetings with CMO and all Trust Medical Directors in Belfast. Agenda normally set by CMO but other items could be raised at the meeting. I do not know if these meetings were minuted. I have no records of Minutes. No other regular meetings with Department staff. I met WHSSB Director of Public Health at regular review of litigation claims against WHSSB but did not regularly discuss any other business.

(22) In relation to your meeting with Medical Directors please state whether you made or kept any note or record thereof?

No

(23) 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.

My handwritten notes are all copied to the Inquiry to the best of my knowledge. DLS holds all originals except 026-002 which I hold.

(24) With respect to the Critical Incident Review meeting held on 12th June 2001 please state:

(a) How much time was devoted to the meeting on 12th June 2001, giving approximate times of commencement and conclusion;

Started around 4pm and finished around 6pm.

(b) Who was responsible for the creation of the Critical Incident Protocol (Ref: 026-012-016);

Myself with Director of Nursing, Miss Duddy, and Risk Manager, Mrs Therese Brown.

(c) Whether Myriam Lugon gave any specific advice to the AHHSST over and above the Powerpoint presentation of 25th October 2000, and if so what; No

(d) How you divided responsibility for the Review between yourself, the Risk Management Co-ordinator and others;

I chaired the Meeting. The Risk Manager contacted relevant available staff and asked them to attend meeting.

(e) Whether the Clinical Incident Form was completed;

I do not know. I think there was a telephone report to the Chief Executive on 11.6.2001

(f) Were the Nursing Director, Clinical Services Manager (CSM) and Clinical Effectiveness Co-ordinator present at the Review meeting;

All present except Nursing Director. I think the Clinical Effectiveness Co-ordinator, as a senior nurse, may have deputised for her.

(g) Was the Clinical Audit Co-ordinator involved in the review process;

No

(h) What steps were taken to locate and secure all the documentation relating to Raychel Ferguson and her treatment;

Mrs Brown coordinated this. The case notes were available at the meeting.

(i) Who was responsible for compiling a list of the relevant clinicians involved for the purposes of Review, and how was this done;

Mrs Brown. I do not know how she compiled the list.

(j) Who was invited to attend the Review and whether any record exists to identify those who attended the Review;

Mrs Brown identified involved staff (021-072-168). Not all were able to attend. No record was kept of attendees. Document 026-011-102 is not an Attendance List as I explained in

(k) What steps were taken to trace the Paediatric and Surgical rotas for 7th - 9th June inclusive;

Mrs Brown may be able to answer this.

(l) What steps were taken to form a chronology of the care and treatment provided to Raychel Ferguson;

I did this during the first part of the meeting by questioning the staff who were directly involved in Raychel's treatment.

(m) Which members of staff were interviewed, when and by whom, and whether this process was recorded or noted;

At the meeting I remember Mrs Brown, Dr Nesbitt, Dr McCord, Mr Gilliland, Sister Millar, Nurse Noble. Mrs Witherow, Mrs Doherty. There were other nurses and junior doctors but I cannot now identify them.

Only the staff present at the Critical Incident Meeting were interviewed by myself as part of the meeting and not separately.

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 was very aware that I had to establish the facts while they were clear in everyone's memory. To make progress and reduce anxiety I therefore suggested we would not formally record the meeting. However I said we would need to produce a written Action Plan which would summarise the conclusions of our discussion. I also said I would require written Statements from all clinical staff present after the meeting which would be made available to the Coroner. All agreed. I believe the subsequent discussion was frank and based on clear recall of the recent events.

(n) Whether any statements were taken as part of the Review which were not taken for the purposes of submission to the Coroner;

Not to my knowledge.

(o) Whether and when an appreciation first arose that the case had the potential for litigation;

I believe some of the staff at the Review were aware of this potential and raised the issue of legal advice. I mentioned the need to report to the Coroner but did not mention litigation in my introduction. I stressed the meeting was not a disciplinary forum and that the only objective was the investigation of Raychel's unexpected death.

(p) What timescale was agreed for the provision of a written report to the Chief Executive, who wrote the report, when, to whom was it submitted and why has a copy of the same

not been made available to the Inquiry;

I gave the Chief Executive a verbal report just after the Critical Incident meeting on 12.6.2001.

(q) Was any note/minute/memorandum/record taken of any part of the Review meeting;

020-011-012

(r) What further investigations were carried out by the Review team after the meeting;

Further investigations were carried out by the individuals, particularly Dr Nesbitt, named in the Action Points.

(s) Were there any additional or subsequent meetings of the Review team? If so when and who attended;

No formal meetings until review on 9 April 2002. I was given regular updates particularly by Dr Nesbitt, Sister Millar and Mrs Brown. Some of these updates were in writing, all of which I believe are available to the Inquiry.

(t) In relation to your statement in respect of the Critical Incident Enquiry that *"six Action Points were agreed and circulated to all present on 13/06/01"* (Ref: 012-022-130:

- Who signified agreement;

  Verbal agreement by all present. There was no disagreement.

  To whom these points were circulated;

  To all present but there may have been other relevant staff. Mrs Brown undertook the typing of the Action Points and the circulation.

- Whether agreement was signified in writing? No

(u) Whether or not you received a report in writing into the case of Raychel Ferguson? If so please provide the same;

I received a telephone call on 11.6.2001 from the Chief Executive giving me a summary of Raychel's death. She asked me to investigate the circumstances.

(v) Whether any consideration was given to performing a detailed audit of all aspects of the case;

At the meeting of 12.6.01 Dr Nesbitt was asked to research medical publications for any reports of adverse events following the use of Solution 18 in surgical children and to do a survey of the current intravenous fluid practice in other N Ireland hospitals.

(w) Whether any consideration was given to interviewing, receiving input from or involving the Ferguson family in the Review; No

(x) Were any steps taken to obtaining the expert views of an internal/external specialist;

The Consultants at the meeting acted as internal specialists.

No external specialist was considered.

(y) Whether any consideration was given to 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;

Yes.

A written order to discontinue Solution 18 in surgical children was made by Dr Nesbitt within a day.

A wall chart was displayed on the Paediatric ward showing trainee doctors how to calculate intravenous fluid requirements based on weight. Dr McCord confirmed to me that this was in place(022-096-0306). I visited Ward 6 and Sister Millar showed me the chart on a wall in a prominent place.

Dr Nesbitt obtained written agreement from his colleagues in surgery, anaesthetics and paediatrics detailing responsibility for intravenous fluid prescription in children.

Sister Millar introduced daily electrolyte sampling in surgical children on iv fluids. The nurses would inform surgical doctors of results (points 2&3 of letter 9.7.01 022-097-307).

All vomit and urine would be measured and recorded by nurses (point 4 of letter 022-097-307)

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

Dr Nesbitt, Dr McCord, and Sister Millar kept me informed of implementation of the changes.

(25) Please state whether the Critical Incident Review appraised or assessed:

(a) The record of communication with Raychel's parents; No

(b) The quality, consistency and timeliness of information given the Ferguson family; No

(c) The skill and suitability of junior surgical staff to oversee fluid management;

Yes. There was an interim agreement at the meeting that, pending a formal policy, the paediatric junior staff would supervise post operative iv fluids in surgical patients.

(d) The procedures governing consent, and whether they were complied with;

Not discussed.

(e) The records relating to the post operative care of Raychel;

Discussion took place on the interpretation of records of vomit and urine volume Action point 4&6.

(f) The clinical protocols available to nurses in Ward 6 on 8th June 2001?

It was recognised that there should be written protocols for iv fluid infusion rates, iv fluid prescribing, frequency of blood electrolyte tests, and recording of all vomit and urinary

output.

In relation to the Critical Incident Review Meeting please also confirm whether consideration was given to:

(a) The overall leadership of the clinicians treating Raychel;

The consultant in surgery stated 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. The consultants in anaesthesia and paediatrics responded promptly to requests for help from their junior staff.

(b) The absence of the consultant responsible for Raychel's care, from Raychel's care;

He said he did not expect to be contacted in a case of appendicitis.

(c) Difficulties experienced by surgical doctors in attending upon Paediatric patients;

The nurses mentioned occasional difficulty in getting junior surgical doctors to attend promptly. The nurses believed that this was because the juniors main work load involved adult surgical patients in other wards.

(d) The conduct and responsibility for post-take ward rounds;

I do not remember discussion on this.

(e) The responsibility for intravenous fluid prescription/administration as and between Anaesthetic, Surgical and Paediatric teams;

Considerable discussion on this. I asked about the normal policy for iv fluid prescribing and responsibility. I was not able to get a clear understanding. Prescribing seemed to vary depending on availability of junior surgical and paediatric staff on Ward 6. There was agreement that a new policy needed to be designed. After listening to the discussion I personally thought that paediatric junior staff should supervise iv fluids in surgical children as they were on site and had expertise with children. It was agreed by Dr McCord that the paediatric staff would do this in the short term pending an agreed policy between surgeons, anaesthetists and paediatricians. I think this interim arrangement did not prove acceptable. Dr Nesbitt got written agreement between surgeons, anaesthetists and paediatricians for a new iv policy in May 2002.

As this was a major discussion point 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. The new iv policy is a result of this action.

The extent, type and duration of the vomiting suffered by Raychel on 8th June 2001

This was described by the nurses who clearly believed it was due to prolonged post operative vomiting. They 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 said they may not have witnessed all the vomit. The nursing method of recording vomit volume on a + scale was questioned. It was decided that this was too subjective and other methods of recording should be used. (Action 6) This was to include attempting to

record and measure all vomiting, as well as urine. Sister Millar actioned the recording of all vomit and urine immediately.

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.

(f) The failure to replace abnormal electrolyte losses caused by vomiting;

I do not remember discussion on this.

(g) Possible shortcomings in the nursing care provided to Raychel Ferguson;

It was agreed that all vomit should be recorded in future by a more precise method. Also all urine should be recorded.

(h) Inter-clinician-communication (ICC);

The nurses felt that the surgical juniors should respond promptly to requests to visit patients on the paediatric ward.

(i) Whether or not intravenous fluids had been administered at a greater rate than recommended;

Dr Nesbitt calculated that, using the standard formula based on weight, Raychel had been prescribed too much fluid per hour. He thought this was acceptable before the operation but was excessive in the post-operation phase.

(j) Any shortcoming in the frequency of assessment of Raychel's electrolytes;

Sister Millar clearly stated that the blood electrolytes should have been checked in the afternoon because of the continued vomiting. She stated this was the responsibility of the doctors. There was total agreement on the need for regular electrolyte measurement while receiving iv fluids.(Action 2)

(k) Any shortcomings in the assessment and recording of urinary output and vomit;

see answer in (e) above

(l) Resolving the inconsistency of recollection as to whether 200mls or 300mls of Hartmann's solution was infused in theatre;

I do not think we were aware at the meeting of any inconsistency in recall about the volume. Dr Nesbitt told us that he had noticed that there was no record of the volume infused on the anaesthetic chart. He said he intended to ask Dr Jamison to make a retrospective record in order to clarify the volume while she remembered.

(m) The competence and training needs of those who cared for Raychel;

Not discussed in detail. The consultants did not question the management or competence

of their juniors.

(n) The content and update of episodic care plan;

I do not remember any discussion.

(o) The efficacy of the bleeper summonsing system;

I do not remember details of any discussion other than this might have been a factor in the delay in a doctor responding to a nurse call.

(p) The balance of responsibility between medical and nursing staff in respect of monitoring patients;

The nurses were clear that the doctors were responsible for iv fluid prescribing, drug prescribing and blood electrolyte testing.

(q) The rumour from the RBHSC that there had been mis-management of Raychel's fluids;

This was brought up by the nurses who were very distressed by the allegation. An Altnagelvin nurse had spoken to a nurse at the RBHSC and was told by the RBHSC nurse that Raychel had been given the "wrong fluid". The nurses were aware that the Ferguson Family had been given similar information by staff at RBHSC.

(r) The reported discontinuance of the use of Solution 18 at the RBHSC;

I cannot remember if someone told us this at the meeting on 12.6.01 or whether it was discovered the next day by Dr Nesbitt's telephone survey of hospitals.

(s) Whether there were any broader systemic failings in the provision of the care given Raychel?

A lack, in 2001, of a national database to analyse all aspects of critical incidents involving very rare conditions such as hyponatraemia. The National Patient Safety Agency now does this and in 2007 issued Alert 22 on hyponatraemia. This highlighted the risk of hyponatraemia in surgical children and included a ban on solution 18. This is, in my opinion, the most effective way of analysing adverse reactions which are too rare to be detected by standard hospital audit methods.

(26) What shortcomings and deficiencies were identified by the Review?

I have described the shortcomings and remedial action above.

(27) In respect of the *"Update for Chief Executive Re: Critical Incident Meeting"* (Ref: 022-097-307) please state what steps were taken by you 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?

The paediatricians were unable to take responsibility for surgical children as they believed the surgeons were responsible for the continuing care of surgical children..

I do not remember a discussion with the surgeons regarding any lack of commitment to surgical children. The surgeons never expressed this view to me and I was not aware of subsequent concerns from the nurses.

(28) **Please describe the extent to which you believe the Ferguson family was fully informed of the causative factors of Raychel's death?**

I was not involved in any meetings with the family.

(29) **In relation to the Memorandum issued by the Risk Management Co-ordinator dated 12th March 2002 (Ref: 022-036-097) please state whether the Trust's Clinical Incident Review had identified such *"factual inaccuracies."***

I have never been shown any details of these " factual inaccuracies".

(30) **In relation to Dr. Nesbitt's PSNI Statement (Ref: 095-010-040) please state whether he informed you that the Tyrone County Hospital had discontinued the use of Solution 18, and whether or not you made any enquiries of the Tyrone County Hospital when you were there or as part the Review process?**

I was not aware that Tyrone County had discontinued solution 18.

(31) **In relation to the letter from Dr. Nesbitt dated 14th June 2001 (Ref: 026-005-006) please state whether your Review made any enquiry into the *"several deaths involving No.18 solution"*? If so please provide full details of the same.**
No.

(32) **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.**

I think I gave a report to the Trust Board afterwards. I do not have copies of the Minutes.

(33) **In respect of the letter dated 3rd July 2001 from Dr. Nesbitt and sent to you (Ref: 021-057-138) please identify those clinicians who disagreed with the suggestion of the introduction of Hartmann's as the default solution?**
Mr Neilly, consultant surgeon, (now deceased)

(34) ***"On 14 January 2002 the CMO visited Altnagelvin in connection with another matter. I arranged for her to meet with Dr. Nesbitt to view a Powerpoint presentation on hyponatraemia. Dr. Nesbitt had prepared this presentation himself and had previously shown it to me. I found it very helpful in understanding the complex subject of hyponatraemia* (021-054-117 *up to* 021-054-133)" (Ref: WS-143/1 p.11). In relation to this, please confirm that the Powerpoint conclusion that the patient *"received excessive maintenance fluids"* (Ref: 021-054-128) was a finding in respect of Raychel Ferguson and was made by the Critical Incident Review?**

See answer 26(j). Dr Nesbitt, as specialist in anaesthesia, gave this opinion at the meeting based on the standard formula based on weight. No-one disagreed. The Powerpoint case report referred to Raychel.

(35) **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.**

I have a copy of the typed 2 page summary of the discussion. 022-092-299, 022-092-300

I do not have Minutes. Mrs Brown may have further information as I think she arranged the typing.

(36) Please state:

(a) Whether you attended any of the pre-Inquest consultations arranged by the Risk Management Co-ordinator (Memorandum Ref: 022-029-073);

I cannot remember but likely.

(b) If you were supplied with any of the witness statements obtained for H.M. Coroner;

I read the statements that I requested at the Critical Incident Meeting on 11 June 2001 but I do not remember any other statements.

(c) Whether you were briefed in respect of the commissioning of expert reports from Drs. Jenkins and Warde;

No. I do not remember seeing these reports.

(d) If you were consulted about the release of Dr. Warde's report to the Coroner;

No

(e) If you were consulted about the release of Dr. Warde's report to the PSNI;

No

(f) If you were consulted about the release of Dr. Warde's report to this Inquiry;

No

(g) If you gave any directions in respect thereof?

No

(37) Please advise as to the purpose of the pre-Inquest meeting convened by yourself on the 9th April 2002 (Ref: 022-029-073) and please state whether any note/memorandum/minute/record was taken of the same.

I do not remember this meeting or its purpose or whether it took place. I have no records of a meeting other than a copy of Mrs Brown's letter. The second Critical Incident Review Meeting took place on the same date(022-092- 299). It may be that the pre-Inquest meeting was the Review Meeting under a different name.

(38) 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); December 2001

(b) The report of Dr. Sumner to the Coroner (Ref: 012-001-001); I do not remember seeing this.

(c) The report of Dr. Loughrey (Ref: 014-005-014); December 2001

(d) The reports of Dr. Jenkins (Ref: 317-009-002 and 317-009-004); I do not remember seeing

this.

(e) The report of Dr. Warde (Ref: 317-009-006)? I do not remember seeing this.

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

I was not involved with any consideration about sharing information with the family.

(39) Was the Clinical Negligence case brought by the Ferguson family referred to either:

(a) The AHHSST Scrutiny Committee; I do not remember it while I was on this committee
(b) The Cases Committee? I remember the name of this committee but cannot remember how, or if, it differed from the Scrutiny Committee. It may have been the same committee with a change of name.

If so please provide details of reference and recommendations.

(40) Please state what you would have done had you received information prior to June 2001 in relation to:

(a) The facts surrounding the treatment and death of Adam Strain;

I am not familiar with the facts so I cannot comment.

(b) The facts surrounding the treatment and death of Lucy Crawford;

I am not familiar with the facts so I cannot comment.

(c) The information that the RBHSC had abandoned the use of Solution No.18 for paediatric intravenous administration?

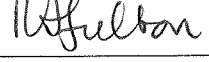
I would have asked the Clinical Director of Anaesthesia, Dr Nesbitt, to find why RBHSC had ceased using Solution 18 and to make recommendations for change in practice at Altnagelvin.

(41) When did you first hear of the death of Lucy Crawford?

I cannot remember but certainly long after the death of Raychel.

(43) 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:  **Dated: 30.6.2013**

Curriculum Vitae

Dr Raymond Alexander Fulton

Born [redacted] **in Northern Ireland.**

[redacted]

Home residence: [redacted]

School: [redacted]

University: Trinity College Dublin. October 1967 - June 1974.

B.A. (II Hons. 1 Division) in Physiology 1971.

M.B., B.Ch., B.A.O. (II Hons. in Medicine, Surgery, Obstetrics and Gynaecology) 1974.

O'Brien Prize in Dermatology 1974.

Burton Memorial Prize in Surgery 1974.

President of the Mountaineering Club

Postgraduate Medical Training

Pre Registration

House Surgeon,
County Hospital, York. *August 1974 - January 1975*
(6 months)

House Physician,
City Hospital, York. *February 1975 - July 1975*
(6 months)

General Professional Training

S.H.O. Dermatology,
City Hospital, York. *August 1975 - January 1976*
(6 months)

S.H.O. Psychiatry,
Clifton Hospital, York. *February 1976 - July 1976*
(6 months)

Trainee General Practitioner,
Clifton Health Centre, York *August 1976 - January 1977*
(6 months)

S.H.O. General Medicine,
City Hospital, York. *February 1977 - July 1977*
(6 months)

S.H.O General Medicine
Rotation Scheme,
Hull Royal Infirmary. *August 1977 - October 1978*
(15 months)

1978 - Membership of the Royal College of Physicians, London
1993 - Fellowship of the Royal College of Physicians, London

Posts held in Dermatology

S.H.O.
City Hospital, York *August 1975 - January 1976*

Sole junior doctor on 28 bed dermatology ward with responsibility for all inpatients together with 4 weekly clinics with average of 80 patients weekly.

Established and catalogued a departmental collection of dermatology histology specimens.

Registrar
Royal Infirmary, Glasgow *November 1978 - May 1981*

4 outpatient clinics weekly with an average of 80 patients with a wide range of dermatological conditions. On a rotational basis 1 weekly outpatient clinic at Kilmarnock Royal Infirmary. Experience of a special Steroid Clinic for the management of patients on long term systemic corticosteroids, a Methotrexate Clinic and a Dermatitis Herpetiformis Clinic. Shared responsibility for the management of inpatients in a 25 bed dermatological ward. Regular biopsy clinic with experience in minor dermatological surgery.

Regular teaching of dermatology to the following:
Medical undergraduates, M.R.C.P. candidates, Chiropody students, Pharmacy students, student nurses.

Senior Registrar
Royal Infirmary, Glasgow *June 1981 – December 1982*

4 outpatient clinics weekly with an average of 80 weekly new and return patients. Full responsibility for care of my own outpatients. Regular teaching as above.

Responsibility for organisation of clinical cases and paper presentation at regular symposia for junior staff, general practitioners, and the Annual Meeting of the Scottish Dermatology Society held at Glasgow Royal Infirmary in October 1981.

Consultant Locums

October 1981 **York District Hospital.**
Single consultant post with clinics in York and Scarborough.

May 1982 **Royal Infirmary, Paisley.**
Single consultant post with clinics in Greenock, Paisley and Glasgow.

Special Experience in subjects recommended by the Specialist Advisory Committee on Dermatology of the JCHMT

Histopathology:	Weekly review of biopsy specimens with Skin Pathologist, Dr. Mac Gregor, Glasgow.
Plastic Surgery:	Attendance at minor operation sessions at Canniesburn Hospital, Regional Plastic Surgery Centre, Glasgow.
Patch testing:	Participation in the assessment clinics at the Contact Dermatitis Unit, Belvidere Hospital, Glasgow.
Mycology:	Practical instructions in the Medical Mycology Department, Glasgow University, under the supervision of Professor Gentles.
Venereal diseases:	Instruction once weekly January - March 1979 at Black Street Clinic, Glasgow.
Photobiology:	Visit to Photobiology Unit, Ninewells Hospital, Dundee, arranged with Dr. Frain-Bell.
Oral medicine:	Weekly instruction in oral medicine by Dr. Scully, Senior Lecturer, Glasgow Dental Hospital. June - December 1981.
Radiotherapy:	Instruction at Institute of Radiotherapy, Western Infirmary, Glasgow. November 1981.
Paediatric Dermatology:	Weekly Paediatric Dermatology Clinic at Royal Hospital for Sick Children, Glasgow, with Dr. Morley.

Overseas Experience

Awarded Medical Research Council "French Travelling Fellowship" to spend 1st April 1980 - 31st March 1981 in the Department of Dermatology at the Hospital Edouard Herriot, Lyon, France, under the supervision of Professor J. Thivolet.

Jointly awarded the John Milne Travelling Fellowship by the University of Glasgow to visit other French Dermatology Departments while in France.

In Lyon, I took part in a regular clinical programme of the department including outpatient clinics, ward rounds, histopathology reviews and venereology clinics. I learned the surprisingly different French system of diagnosis, investigation and treatment of skin diseases.

I attended weekend meetings of the Societe Francaise de Dermatologie in Bordeaux, Strasbourg, and Lyon.

I spent approximately half of my time in laboratory research on retinoid drugs and the study of Sezary's Syndrome.

Present appointment

I was appointed consultant dermatologist to WHSSB on 13th December 1982. Single-handed for 4 years, covering all WHSSB area, I now hold clinics in Altnagelvin, Roe Valley and Tyrone County Hospitals.

Service Innovations

I designed a new integrated in-patient/ out-patient Dermatology Unit at Anderson House, Altnagelvin Hospital. This was opened by the Chairman of WHSSB in October 1992. This is the only such unit in Northern Ireland (and one of very few in the UK) where in-patient and out-patient care is co-ordinated in one building by the same medical and nursing staff. A 6-day out-patient treatment facility is offered to patients to minimise time off work.

A PUVA machine was installed in 1988, extending out-patient therapy to working patients with a reduction in need for in-patient treatment.

TL01 phototherapy was added in 1997.

A Photoderm laser machine was purchased in 1995 for treatment of vascular lesions and hirsutism.

Information Technology in Dermatology

In 1992 I made a successful bid to the Regional Audit Committee to pilot a dermatology computer system at Altnagelvin. This is currently installed in the Dermatology Department and is one of the first UK computer systems to store diagnostic and procedural data on out-patients. It is based on a local area network linked to the hospital Patient Administration System. The pilot has been successful and is being recommended for use in other dermatology departments in N. Ireland.

It is only one of four such dermatology outpatient computerised patient records in the UK (others in Cambridge, Manchester and Brighton).

Contribution to Regional / National Dermatology

1. Vice-Chairman, Regional Dermatology Audit Committee 1991 - 1993

2. Chairman, Regional Dermatology Audit Committee 1993 - 95

3. Member of UK Specialty Working Group in Dermatology 1990 - 1995

This was one of 40 UK specialist groups set up within the NHS to design Read Codes for each specialty in medicine. 6700 diagnoses in dermatology were collected and arranged in hierarchies. The dermatology group met in London every three months since 1990 and reported to the Executive of the British Association of Dermatologists.

4. Member of Executive of the British Association of Dermatologists 1994 - 1997

I represented all the dermatologists of N. Ireland and Eire on this committee. It met four times a year in London to plan and agree the professional strategy for dermatology in Britain and Ireland.

5. Secretary, Irish Association of Dermatologists 1994 - 1996

I arranged two national meetings per year (alternating between N. Ireland and Eire) for all the consultant dermatologists and juniors in Ireland. I dealt with all correspondence with other national and international dermatology societies. I was also the Treasurer of the Irish Association of Dermatologists and was responsible for the management of the Association funds. I successfully negotiated Charitable Status for the Association.

6. Dermatology representative, GP Minor Surgery Committee 1995

7. Dermatology representative to Royal College of Physicians 1995 – 1997

I advised the Royal College on dermatology affairs in Northern Ireland especially on future dermatology training and manpower requirements.

8. Member of Clinical Governance Committee of British Association of Dermatologists 1999 –

I am a member of a group which advises the Executive of the British Association of Dermatologists on recent initiatives in clinical governance and professional regulation.

8. Managerial positions at Altnagelvin Hospital

Secretary, Medical Division 1983 - 1987

Chairman, Medical Division 1989 - 1993

Clinical Manager, Medical Division 1990 - 1993

As Clinical Manager, I was responsible for General Medicine, Geriatrics and Dermatology (11 consultants) and

- **designed and implemented new Medical Admission policy requiring major changes in practice.**
- **designed shift system for junior doctors.**
- **was medical member of Strategic Review Committee with Coopers & Lybrand which prepared a successful bid to DoH for a major re-organisation of the hospital facilities to see Altnagelvin into the next century (£45 million).**

Hospital Medical Audit Co-ordinator 1994 - 1998

I was responsible for promoting medical audit among all consultant and junior medical staff at Altnagelvin. This involved contact with all specialities and attendance at divisional audit meetings. I organised an annual Medical Audit Conference at Altnagelvin at which a range of projects is presented. I produced the Altnagelvin Audit Report which detailed all medical audit activity by speciality.
I planned an annual symposium where junior doctor audit projects were presented, with a prize to stimulate interest.

Area Medical Advisory and Audit Committee 1994 - 1997

I represented the views of Altnagelvin staff on audit subjects on this committee, which in turn advised the WHSSB on audit strategy.

Altnagelvin Clinical Audit Steering Group 1995 - 1997

I was the medical representative on this multi professional committee which was set up to plan and encourage clinical audit at Altnagelvin.

GP Minor Surgery Courses

I represented Northern Ireland Dermatologists at the Central Committee to draw up new regulations to assess competence of GPs to carry out minor surgical procedures. I organised courses at Altnagelvin to enable GPs to comply with the new regulations.

Chairman of Area Medical Division 1996 – 1998

The Area Medical Division is a group of all the consultant physicians in the Western Health Board area which advises the Board on strategic issues through the Area Medical Advisory Committee.

Medical Director, Altnagelvin Hospital March 1998 –

As Medical Director I am responsible for providing professional advice to the Trust Board. I am responsible for professional standards for all grades of medical staff at Altnagelvin Hospital.

I am a member of the following committees.

1. **Trust Board**
2. **Hospital Executive**
3. **Hospital Management Team**
4. **Ethics Committee**
5. **Cancer Implementation Group**
6. **IT Steering Group**
7. **Local Task Force (Chairman)**
8. **Palliative Care Group (Chairman)**
9. **Scrutiny Committee**
10. **Clinical Incident Review Committee**
11. **WHSSB Scrutiny Committee**
12. **Planning Principles and Pathways Group**
13. **Nucleus Steering Group**
14. **WHSSB Contract Review Group**
15. **Sperrin Lakeland Collaboration Group**
16. **Causeway Collaboration Group**
17. **Letterkenny Collaboration Group**

Publications

1. **Vomiting as a diagnostic aid in acute ischaemic cardiac pain.**
   Ingram D.A., Fulton R.A., Portal R.W., Aber C.P.
   British Medical Journal 1980; 281: 636-637

2. **Bone formation in a cutaneous pyogenic granuloma.**
   Fulton R.A., Smith G.D., Thomsom J.
   British Journal of Dermatology 1980; 102: 351-352

3. **Dermatologie au Royaume - Uni.**
   Fulton R.A.
   Ann. Dermatol Venereol 1980; 107: 1083-1085.

4. **Retinoides orales en dermatologie.**
   Souteyrand P., Fulton R.A., Thivolet J.
   Lyon Medical 1981; 245: 12-14.

5. **Treatment of parapsoriasis en plaques and mycosis fungoides with an oral retinoid (RO 10 9359)**
   Souteyrand P., Thivolet J., Fulton R.A.
   International Symposium on "Retinoids: advances in basic research and therapy". Berlin - October 1980. Published in 'Retinoids'. C.E. Orfanos et al (Eds.) Spinger-Verlag 1981

6. **Les sous populations de lymphocytes T. "Helper" et "Suppressor" etudiees par les anticorps monoclonaux dans diverses dermatoses.**
   Fulton R.A., Thivolet J., Garcier F., Gaucherand M.
   Ann, Dermatol Venerol 1981; 108: 243-250.

7. Helper phenotype of the Sezary cell: direct ultrastructional evidence using monoclonal antibodies.

Schmitt D., Thivolet J., Souteyrand P., Fulton R.A., Germain D.

Arch. Dermatol Residents. 1981; 270: 487-490

8. Ultrastructural demonstration of the helper phenotype of Sezary cells using monoclonal antibodies.

Thivolet J., Schmitt D., Fulton R.A., Souteyrand P.

Proceedings of Symposium on Cutaneous Lymphoma, Kiel 1981. Published in "Lymphoproliferative Diseases of the Skin". Editors M. Goos and E. Christophers. p.137-141. Springer-Verlag 1982.

9. Human Helper and Suppressor T. Lymphocytes: immunoelectron-microscopical characterisation in mycosis fungoides and the Sezary Syndrome.

Schmitt D., Thivolet J., Souteyrand P., Fulton R.A.

Communication to the European Society for Dermatological Research, Amsterdam. May 1981.

10. Another hazard of gold therapy?

Fulton R.A., Sturrock R., Capell H.

Annals of Rheumatic Diseases. 1982; 41:100-101

11. Use of monoclonal antibodies to demonstrate a T helper lymphocyte excess in the Sezary Syndrome.

Fulton R.A., Thivolet J.

Communication to the Scottish Dermatological Society, Dundee. June 1981.
(Scottish Med. J. 1981; 26; 4; 373-Abstract)

12. Sezary Syndrome: Relative increase in T helper lymphocytes demonstrated by monoclonal antibodies.

Thivolet J., Fulton R.A., Souteyrand P., Gaucherand M. Claudy A.

Acta. Dermato-Venereologica 1982; 62: 337-340.

13. **Retinoids enhance cell-mediated immunity in vivo.**
Fulton R.A., Souteyrand P., Thivolet J.
Paper presented to S.D.S. Glasgow. Oct. 1981.
(Scottish Med. J. 1982; 27: 95-Abstract)

14. **Influence of Retinoid RO 10-9359 on cell-mediated immunity in vivo.**
Fulton R.A., Souteyrand P., Thivolet J.
Dermatologica 1982; 165: 568-572.

15. **Nail bed immunoflourescence in Pemphigus Vulgaris.**
Fulton R.A., Campbell I., Carlyle D., Simpson N.B.
Acta. Dermato-Venerologica 1982

16. **Two clinical cases presented at the Annual Meeting of the British Association of Dermatologists at Dundee in July 1982.**
(Supplement 22, British Journal of Dermatology)

17. **The treatment of rosacea with 13 cis retinoic acid.**
Fulton R.A., Dick D., Mackie R.
Papers presented to the Investigative Group of the British Association of Dermatologists in Keele in September 1982 and to the Texas Dermatological Society in Dallas in October 1982.

18. **Benign Chronic Bullous Disease of Childhood in an Indian Child.**
Lever R.S., Morley W.N., Dick H.M., Fulton R.A.
Scot Med J 1985; 30:114-115

19. **Megoloblastic anaemia and Methotrexate treatment.**
Fulton R.A.
Br J Dermatol 1986; 267-268

20. Kyrle's Disease
Cunningham S.R., Walsh M., Matthews R., Fulton R.Burrows D.
J Am Acad Dermatol 1987; 16:117-123

21. Skin rash associated with accidental addition of excess aluminium sulphate to the water supply.
Tohani V.K., McCann R., Fox M., Fulton R.A.
Ulster Med J 1991; 60:108-110

22. Allergy to the ethylenediamine component of aminophylline.
Toal M., Kinney A., Fulton R.
Ulster Med J 1992; 61:205-206

23. Goals and methods of audit should be reappraised.
Fulton R.A.
BMJ 1996; 312: 1103

24. Haemorrhagic bullae in a patient with lichen sclerosus et atrophicus treated with streptokinase.
Dunn H.M., Fulton R.A.
Heart 1996;76(5):448

25. Audit: The Emperor's New Clothes
Fulton R.A.
Journal of Evaluation of Clinical Practice 1996;2:1-3

26. Audit: time to re-think
Fulton R.A.
Ulster Med J 1997; 66: 77

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