Witness Statement Ref. No. 044 /1

NAME OF CHILD: Raychel Ferguson

Name: Robert Gilliland
Consultant Colorectal / General Surgery

Present position and institution:
Consultant Colorectal / General Surgery

Previous position and institution:
[As at the time of the child's death]
Consultant Colorectal / General Surgery

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-December 2004]

Positions Held

Local

Secretary, Western Area Surgical Division, 1998-
Undergraduate Surgical Tutor, Altnagelvin Area Hospital, 1998-
Postgraduate Surgical Tutor, Altnagelvin Area Hospital, 1999-2003
Lead Clinician Colorectal Surgery, Altnagelvin Area Hospital, 1999-2004
College tutor, Altnagelvin Area Hospital, 2002-
Site-Specific Lead Clinician Colorectal Cancer, WHSSB, 2004-
Chairman, Western Area Board Colorectal Cancer Screening Implementation Group 2005-

National

Secretary, Irish Association of Coloproctology, 2000-2005
Chairman, Basic Surgical Training Committee, Northern Ireland, 2002-
Royal College of Surgeons in Ireland, Hospital Inspector 2004-

Local

Managed Clinical Networks Sub-Committee, WHSSB, 1999-2002
Chairman Colorectal Subgroup, Implementation Group for Cancer Services, WHSSB 1999-2000
Palliative Care Team Co-ordinating Committee, Altnagelvin Area Hospital, 2000-
Research & Development Committee, Altnagelvin Area Hospital, 2001-
Education Committee, Altnagelvin Area Hospital, 2003-

Site-Specific Cancer Leads Committee, 2004-
Western Area Cancer Services Committee on Colorectal Cancer Screening, 2004-

Regional

Department of Surgery, Queen's University of Belfast, Teaching Sub-committee, 2000-
Basic Surgical Training Committee, Northern Ireland 1998-
Surgical Training Committee, Northern Ireland 2002-
SHO Modernisation Group, Northern Ireland Council for Postgraduate Medical & Dental Education, 2003-2004

National

Basic Surgical Training Committee, Royal College of Surgeons in Ireland, 2003-
Basic Surgical Training Rotations Sub-Committee, Royal College of Surgeons in Ireland, 2004-
Basic Surgical Training Chairmen's Forum, Joint Royal Colleges, 2004-
Intercollegiate Assessment Panel for the Award of CCBST 2005-

044

Previous Statements, Depositions and Reports: *[Identify by date and title all those made in relation to the child's death]*		
OFFICIAL USE: **List of previous statements, depositions and reports attached:**		
Ref:	**Date:**	
012-017-120	30.01.02	Statement
012-038-176	05.02.03	Deposition at Inquest into the death of Raychel Ferguson

Particular areas of interest
[Please attach additional sheets if more space is required]

1. **Explain the practice and purpose of the allocation of patients to a named consultant.**

In 2001 the surgical consultants were on call for a period of 24 hours during weekdays i.e. from 9am to 9am the following morning. During weekends the period of on call was 9am on Friday to 9am on Monday. Patients admitted during a consultant's on call period were allocated to the care of that consultant. These patients would be cared for during working hours by members of that consultant's team but out of hours would be cared for by the on-call team.

Since that time there has been a general change in the approach to managing emergency surgical admissions in response to an understanding of the benefits of separating emergency and elective work. Thus a so-called "Surgeon of the Week" system has been introduced in several units throughout the UK and has been established in Altnagelvin Area Hospital during the past year. In our system one consultant surgeon (the Surgeon of the Week) is responsible for all emergency admissions for one week, from Friday to Friday. That surgeon starts the week with a standard weekend on call. Then from Monday to the following Friday all emergency admissions are under the name of that consultant. Other consultants cover the evening on call periods (from 5pm to 9am) and will deal with any problems that arise during that time. However, the responsibility for the ongoing care of the emergency patients rests with the Surgeon of the Week and his/her team. In order to deal with the emergencies, the Surgeon of the Week cancels all elective work for that period. On Friday a hand-over ward round takes place where patients are passed to the surgeon on call for the following week.

2. **Describe in detail your role in the treatment and care of Raychel Ferguson in June 2001**

Raychel Ferguson was admitted to Altnagelvin Area Hospital under my care as an emergency admission on the evening of 7th June 2001 (020-001-001).

Raychel had attended the A/E department at approximately 8.00pm where she was assessed by the casualty officer and by the surgical SHO on call, Mr. Makar (020-006-010; 020-007-011; 020-007-012). She gave a history of periumbilical pain for a few hours that had shifted to the right iliac fossa (020-007-011). On examination she was found to be tender with mild rebound over McBurney's point (020-006-010; 020-007-012). Investigations performed included a Full Blood Picture (020-007-012; 020-022-041) and an Electrolyte Profile (020-007-012; 020-022-045) neither of which demonstrated a significant abnormality. A diagnosis of acute appendicitis was made on the basis of the history and clinical findings (020-007-012). She was given 2mg of Cyclimorph intravenous for pain (020-006-010). Consent was obtained from Raychel's mother for the operation of appendicectomy (020-008-015) and she was admitted to ward 6. Raychel was fasted and an intravenous infusion of No. 18 solution was commenced to run at 80ml/hour (020-020-039).

Later that evening Raychel was taken to theatre and had a routine appendicectomy performed by Mr. Makar at approximately 11.40pm. The operation note records that the appendix appeared mildly congested and contained a faecolith (020-010-018). The presence of a faecolith was subsequently confirmed on macroscopic pathological examination (020-022-047). The operation was uneventful. Mr. Makar prescribed routine post-operative antibiotics (020-010-018; 020-017-033) and Raychel was returned to the ward at approximately 1.55am on 8th June 2001 (020-027-064).

The nursing records show that Raychel had a comfortable post-operative night and that there were no complaints of pain (020-015-029).

The following morning Mr. Zafar, surgical SHO, saw Raychel. His note (020-007-013) records that she had a bit of pain but was apyrexic. No causes for concern were noted and continued observation was recommended The nursing notes record that Raychel was allowed small sips of fluid as tolerated (020-027-057) and that she took

small sips of fluid during the day (020-027-060; 020-027-064).

Nursing observations continued throughout the day (020-015-027; 020-015-028; 020-015-029; 020-018-037). The nursing records document that Raychel vomited three times between 9am and 5pm on 8th June 2001 (020-018-037) and she was prescribed Zofran 2mg (020-017-035). She continued to be nauseated and vomited a further two times during the evening of 8th June 2001 (020-018-037; 020-027-064). At 21.15pm it is noted that Raychel complained of a headache (020-015-029). A prescription for Paracetamol 500mg had been made (020-017-033) and this was given at 9.30pm (020-017-036) with apparent effect (020-027-057). She was prescribed Valoid 25mg intravenous for nausea, which was given at 10.15pm (020-017-034) with effect (020-027-064). Raychel appeared to settle to sleep and had no further complaints of pain (020-027-057).

At approximately 3.00am on 9th June 2001 Raychel suffered a seizure and was attended by Dr. J Johnston, the on-call paediatric SHO (020-007-013). The on-call surgical registrar (who I now know to be Mr. Bhalla and not Mr. Zafar as in my original statement 012-017-120) was also contacted and attended Raychel (020-007-014). Dr. Johnston contacted his senior colleague Dr. B Trainor who took over Raychel's care at approximately 4.15am (020-015-023; 020-015-024). Dr. McCord, Consultant Paediatrican, also attended (020-015-025).

3. Give details of your understanding as to whose responsibility it is to prescribe post operative fluids.

Initial post-operative fluids are usually a continuation of fluids prescribed intra-operatively. This prescription would be started by the anaesthetist in theatre and taken over by the surgical team on return to the ward. Thereafter, the prescription of intravenous fluids for patients is usually the responsibility of the Pre-registration House Officer. The nursing staff would usually inform him/her that a patient on IV fluids required a further prescription, which he/she would be asked to prescribe. However, IV fluids for patients at ward level can be prescribed by any member of the surgical team and are often prescribed by more senior members of the team during routine ward rounds. In addition, paediatric medical staff would be present on the children's ward more frequently than surgical staff and may on occasions be asked to prescribe intravenous fluids

Particular areas of interest (Cont'd)

4. Describe your role and the steps you took in relation to the investigation carried out at Altnagelvin following the death of Raychel, to include:

(i) colleagues with whom you discussed Raychel's case both at Altnagelvin and at other hospitals; and

(ii) the nature of those discussions.

On the evening of Sunday 10th June I received a phone call from my colleague Mr Neilly. During that conversation he mentioned that there had been an unexpected death of a child following an appendicectomy. He had not been directly involved and was under the impression that the child had not been under my care but under the care of another consultant.

At about 9.45am on Monday the 11th June 2001 as I was just about to start my elective operating list I became aware that the child in question was Raychel Ferguson who had been under my care. Understanding the critical nature of this incident and the need to inform senior management, I asked my Registrar to start the operating list whilst I began the process of reporting the incident. During the next 45 minutes I telephoned both my Clinical Director Mr. P Bateson and the Medical Director Dr. R Fulton who was at his outpatient clinic in Tyrone County Hospital. The Medical Director was already aware of the incident. I also phoned Dr. Jim Crosbie who was the

pathologist assigned to examine Raychel's appendix and informed him that the patient had died unexpectantly. I asked him to examine the appendix specimen as a priority. Finally I phoned the forensic pathologist assigned to Raychel's case to ask him to keep me informed of his findings, as I was concerned to know what had happened.

On the afternoon of Monday 11th June I was contacted by the Trust's Risk Management Co-ordinator and asked to attend a Critical Incident Inquiry the following afternoon at 4pm.

I attended the inquiry as arranged along with most of the medical and nursing staff who had been directly involved with Raychel's care (026-011-012). During the meeting all the individual doctors and nurses were asked to describe their role in Raychel's care from admission to her transfer to the Royal Belfast Hospital for Sick Children. As I had not seen Raychel personally, I did not have any direct input to this part of the meeting. As a result of these discussions an action plan was formulated (022-108-334). As part of this plan, all post-operative children were to have a daily Urea & Electrolyte profile performed and I was asked to bring this change of policy to the attention of the junior surgical staff to ensure that these results were reviewed promptly. As a result I spoke to all members of the junior staff. Furthermore, because of concerns over the prescription of IV fluids, Dr. McCord was asked to produce a chart out-lined suggested infusion rates for children. This chart was produced and subsequently displayed on ward 6 (026-009-010). Dr. Nesbitt was asked to review evidence with regards the use of No. 18 solution in post-operative children. As a result of his review and discussions with other colleagues, a change in policy was instituted so that Hartmann's solution became the default intravenous fluid for post-operative children. This policy notice (026-101-011) was also displayed on the paediatric ward and was emphasized in Dr. Nesbitt's letter of 3rd July 2001 to the Surgical Clinical Director Mr. P Bateson (026-014-028). This letter was shared with all members of the surgical directorate.

I inserted the policy regarding IV fluid management in children into the induction documentation that I had written and which is given to all surgical juniors on joining Altnagelvin Area Hospital. This document was updated after May 2002 to reflect the advice from the Department of Health (026-019-046; 021-049-106)(see attached document point 12). Notices reflecting these policies were also posted on the paediatric ward (021-048-104).

Further changes on policy with regards the timing of wards rounds in ward 6 was agreed and issued on 2nd May 2003 (021-044-091). This memo recommended that the on-call surgical team would attend ward 6 first thing each morning to review the paediatric patients. However, in practice this policy proved impossible as there were often much sicker patients, in other clinical areas, which demanded the immediate attention of the on-call team. Nevertheless, other policies regarding the type of fluid used and the measurement of Electrolytes are strictly followed. Furthermore, the recent changes to surgical practice with the introduction of the surgeon of the week as I have previously outlined means that paediatric patients are often reviewed promptly.

5. Give details of all communications you had with the family of Raychel Ferguson either before or after her death, to include the nature of those communications and the information conveyed by you.

I had no direct communication with either Raychel or her family either before or after her death. I was aware that Raychel's family had been invited to meet with Mrs. Burnside in order that she might offer sincere sympathy on behalf of the staff involved, and answer any questions that they might have about Raychel's treatment.

Other points you wish to make including additions to any previous Statements, Depositions and or Reports
[Please attach additional sheets if more space is required]

Signed: Robert Gilchrist **Dated:** 1-7-05

General Points For Induction Day

Welcome to the Surgical department at Altnagelvin Area Hospital.

There are 7 Consultants and 1 Staff Grade whose main interests are summarised below.

Mr. Panesar	Ward 8	Upper GI
Mr. Bateson	Ward 9	Vascular
Mr. Thompson	Ward 8	Breast
Mr. Gilliland	Ward 9	Colorectal
Mr. Dace	Ward 8	Breast
Mr. Mulholland	Ward 7	Urology
Mr. Schattka	Ward 7	Urology
Mr. Zawislak	Ward 43	Ambulatory

As well as wards 7-9, there are surgical beds in Ward 6 (Paediatrics). You will also be asked to see patients in A/E (Ground floor) and ICU (1st floor) and you should be familiar with these areas.

There are 2 SpR's, 2 Trust Assistant Surgeons, 4 SHO's (+ 2 further posts with RCSI approval) and 5 PRHO's.

The on call rotas are:-

Registrar	1 in 5 (locum cover on 5th night)
SHO's	1 in 4 (pm off after night on call)
PRHO's	Full shift

Here are some important points that you should note.

1.Altnagelvin Area Hospital doctors handbook.

- Read the AAH doctors handbook.
- No complaints will be accepted if the information is available and hasn't been read.

2.Audit

- Audit is held monthly on a rolling basis for 2 hours
- You are expected to attend. This is a statutory requirement. Attendance will be recorded.
- Every junior (except PRHO's) is encouraged to be involved in an audit/research topic. The best will be selected for presentation at the hospital's annual audit symposium.
- Presentations at local, national, and international meetings are encouraged.

3.Teaching

- Altnagelvin Area Hospital is a teaching hospital. It is therefore everyone's responsibility to be involved in the teaching.
- A detailed program will be produced for the 3rd year students. It is your responsibility to be at your allotted session. If you cannot be present due to leave, clinical commitment etc. you MUST organize cover.
- Final year students start in January. There is some formal teaching delivered by the registrars. Same rules apply.
- Students should be directed to appropriate cases.
- You must remind students to ask permission prior to examining a patient.

4.Notes

- A note must be made in the chart of **every** patient **every** day. This is the responsibility of the PRHO on the morning round. If they are not available then the next in command must make a note. Notes must also be made to document any:-
    - Alteration of treatment.
    - Complication.
    - Discussion with patient/ relatives.
    - Discharge.

5.Leave

- All leave **must** be booked through Mr. Dace and confirmed with the Clinical Services Manager (Mrs. McCrory). It is not sufficient to get permission from your supervising consultant. Leave requests must be lodged with Mr. Dace before arrangements have been made. Holiday/study leave arrangements **cannot** be presented as a fait accompli. Doing so will run the risk of leave being cancelled.

- Leave must be booked 4 weeks in advance so that clinics can be canceled/covered as appropriate.
- Ensure that fixed sessions (especially clinics) are covered. It is not enough to tell your consultant who will probably forget. Ensure that someone else will physically be at your session or arrange to have it canceled.
- **No more than 1 person can be on leave from any tier of the rota.** This is an absolute imperative and any deviation from this principle will only be in exceptional circumstances. Therefore you must make holiday arrangements early so that everyone does not try to take leave in January or July. Doing so will run the risk of missing out on annual leave for which there is no monetary recompense.
- BST SHO's are on a 6-month attachment. Therefore those SHO's on a 1-year attachment must take 2.5 weeks leave in each 6-month spell.
- Job interviews outside AAH are on your own time - do not take all your leave and then expect to be allowed to attend a job interview.
- Emergency cover, sick leave, bereavement etc. If a member of staff cannot cover a night as planned at short notice then under contract you are expected to provide emergency cover. This should be arranged within your tier and should not be the responsibility of medical personnel, whose duty it is to find a locum employee as soon as is practicable. Personnel and switchboard should be informed of the changes immediately. Pay back for sick leave is not compulsory but is probably within the spirit of teamwork.

6.Educational meetings

- PRHO's have protected time at lunch times and you must attend 75% of these meetings
- Friday morning has been set aside as an educational half day and all members of junior staff are expected to attend. Mr. Dace (post-graduate surgical tutor) is the program director. Formal X-ray teaching, grand rounds, journal clubs, and the surgical X-ray meeting (SHO's take note) form part of this teaching. You will be expected to participate in the program. SpR's and FTTA's **MUST** attend the centrally arranged teaching program on Friday pm.

7.Study leave

- SpR's have a large amount of study time scheduled. You are expected to produce evidence of study/research/audit on a regular basis. If no evidence of work is seen, this privilege may be withdrawn.
- Approval for study leave **WILL** be withdrawn if there is poor attendance at 'in house' postgraduate meetings.

8.Educational contracts

- Both SpR's must have an educational contract signed and submitted to the Surgical Training committee. It is **YOUR** responsibility to ensure that you organise a time with your supervising consultant within the 1st month and strike a contract.

- Your progress **MUST** be appraised at the end of each 3-month training period. Again this is **YOUR** responsibility to organise a time to meet with your consultants for that period to have you appraisal.
- At the end of the year your RITA assessment form will be filled in. If there are deficiencies in your performance, ensuring that you have had regular appraisals may allow you to correct these deficiencies before this formal assessment takes place.
- SHO's do not have to sign a formal educational contract but your progress **MUST** be appraised at the end of each 3-month attachment with a final assessment performed at the end of a year or 6 months dependent on your tenure. Again the organization of these meetings is the responsibility of the SHO.

9.Waiting lists

- When placing a patient on a waiting list you must dictate to the secretary a note detailing medication that must be stopped, and a telephone no. if the patient is willing to attend at short notice. Waiting lists are long so patients should not be promised a date at out-patients. The waiting list for endoscopy is under pressure so no patient should be added without approval of the consultant.

10.Scrub's

- Theatre blues must not be worn on call. "Doctor on call" scrub suits are available.

11.Personnel

- If there are problems with this department re: payments etc. and you are getting no satisfaction then refer these to the clinical director (Mr. Bateson).

12.Children

- The default IV fluid for children is ½ Normal Saline (0.45%)
- Anaesthetists will write up IV fluids for 1st 12 hours post-operatively.
- If IV fluids are to be continued for more than 12 hours then a senior doctor must make the decisions and a U+E must be obtained.
- Protocols are on display in ward 6.

13.Analgesia for cancer patients

- Guidelines for the prescription of analgesics are encapsulated in "Control of pain for patients with cancer" and are available from www.dhsspsni.gov.uk
- The use of Pethidine and Tramadol by any route is discouraged.
- PRN analgesia for cancer patients is usually inappropriate.
- An induction lecture is often organized which is compulsory.