Witness Statement Ref. No. 044/4

NAME OF CHILD: Raychel Ferguson

Name: Robert Gilliland

Title: Mr.

Present position and institution:

Consultant Colorectal/General Surgeon – South Eastern Health and Social Care Trust

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

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since the date of you last witness statement]

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:	
WS-044/1	01.07.2005	Inquiry Witness Statement
WS-044/2	13.07.2012	Supplemental Inquiry Witness Statement
WS-044/3	01.02.2013	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) In respect of your post as full time general Surgeon at Altnagelvin please state whether you received a written job contract and/or description? If so please provide a copy.

I received a written job contract but I do not have a copy of this contract to my knowledge.

(2) Please detail those opportunities available in 2000-2001 to surgeons from across Northern Ireland to meet and exchange information of professional relevance by way of managed clinical network or otherwise.

I am not aware of any managed clinical networks regarding surgery that were in place in 2000-2001.

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

I do not know whether or not AHHSST had any specific policies, guidance or procedures concerning any of these areas in 2001.

(a) Clinical governance;

(b) Social care governance;

(c) Health and Safety;

(d) Adverse Clinical Incident Investigation;

(e) Complaints procedure;

(f) Performance assessment;

(g) Continuing medical education and professional development;

(h) Clinical record keeping;

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

(j) Communication with next of kin?

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?**

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

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

There was a Clinical Audit Committee to my recollection. I did not sit on that committee and cannot specify its exact remit.

(b) **Who served on the Clinical Audit Committee;**

I do not recall.

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

The process of medical/clinical audit was generally encouraged by the GMC, the Trust (via the Clinical Audit Committee) and by individual clinicians but I do not recallthere being an individual or individuals who were responsible for ensuring that audit was carried out.

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

The results would usually be reported to the clinician who had initiated the audit. Some of these results would have been presented or published in abstract or full manuscript form following peer review. The Trust held an annual Audit Symposium where individuals could submit their audit project and if chosen had the opportunity to present their work.

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

Actions taken would depend on the results of the individual audit.

(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 am not aware of any formal process to audit the quality of case notes in 2001.

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

(a) **Clinical policy setting;**

I do not know.

(b) Clinical policy monitoring;

I do not know.

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

I do not know.

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

I do not recall what systems were in place in 2001 for quality assuring the safe provision of patient care.

(7) Was there anyformalised system of:

(a) Independent external scrutiny in place of clinical performance and competence in the AHHSST;

I'm sorry I do not understand the question.

(b) Internal appraisal of junior doctors performance and competence;

Surgical registrars on formal training schemes would be formally appraised by their clinical supervisors and forms submitted to the Deanery as part of the RITA (Record of In Training Assessment) process. I do not recall a formal process of assessing juniors in the SHO grade in 2001. Junior House Officers would have to have completed their JHO year to the satisfaction of their clinical supervisors in order that they could be fully registered with the GMC at the end of their House-Officer year.

(c) Internal appraisal of Consultant clinical performance and competence?

No.

If so please detail the same.

(8) Was there any inspection of junior doctors' posts by the Postgraduate Deanery or its representatives prior to June 2001?

Yes as far as I can recall.

(9) Was Altnagelvin visited by the Royal College of Surgeons Specialist Advisory Committee prior to June 2001?

Yes as far as I can recall.

(10) In your position as both Undergraduate and Postgraduate Tutor at Altnagelvin in 2001 please state:

(a) What teaching on fluid management, vomiting, U&E testing and hyponatraemia was incorporated into instruction;

The Undergraduate program introduced in 1998 was for 3rd year students and was in place in 2001. The program was delivered through bedside teaching each morning. The topic for teaching would depend on the clinical cases available for discussion. Fluid balance forms an integral part of the management of most surgical cases and various aspects of fluid balance would be covered during the bedside teaching. In addition there was a series of 8 tutorials which were delivered by a number of facilitators, one of which (to my recollection) dealt with fluid balance. Final year undergraduate teaching was in the form of 3-4 week clinical attachments. During these attachments education was self-directed supplemented by informal bedside teaching and attendance at organised post-graduate meetings within the hospital.

I do not recall organising any formal teaching for post-graduates specifically around the subject of fluid balance in 2001.

(b) Whether you drew on NCEPOD and similar recommendations for guidance given;

Not that I recall.

(c) Whether you drew on your membership of the Queen's University of Belfast Department of Surgery, Teaching Subcommittee for up to date materials, information and approaches to teaching undergraduates and postgraduates;

The Queen's University of Belfast Department of Surgery, Teaching Subcommittee dealt with undergraduates only and was responsible for the production and updating of teaching materials mainly for the 3rd year program. This committee had no remit for the education of post-graduates.

(d) Whether your subsequent teaching was informed by the case of Raychel Ferguson, and if so in what way;

Any informal teaching delivered by me on the subject of paediatric fluid management was informed by our experience of the case of Raychel and the knowledge gained subsequently. When Dr Nesbitt developed his lecture on the risks of hyponatraemia in children he asked and was invited to deliver this talk at the post-graduate education meeting organised by myself up until I demitted from that responsibility in 2003.

(e) Whether you commended to students the Royal College of Surgeons of England Guidelines for Clinicians on Medical Records and Notes (1994)?

No.

(11) What instruction was given to junior doctors before June 2001 in respect of:

(a) Communication with parents of sick children;

I am not aware of any formal instruction on this subject prior to June 2001.

(b) The responsibility for intravenous prescription for surgical patients on paediatric wards?

I am not aware of any formal instruction on this subject prior to June 2001.

(12) **Were you aware of:**

(a) The paper and recommendations of the Working Group on *"Paediatric Surgical Services in Northern Ireland"* (1999);

Yes.

(b) The paper presented to the Association of Surgeons of Great Britain and Ireland in Birmingham on *"Peri-operative fluid and electrolyte management: A Survey of Consultant Surgeons in the UK"* (April 2001)?

No.

(13) **Please state who was responsible for ensuring that junior surgical doctors learned about inter-clinical communication, handovers, record making and liaison with Consultants?**

I do not think that any individual was responsible for ensuring that junior doctors learned about these issues.

(14) **Were there any clinical guidelines and protocols relevant to paediatric patients in place at Altnagelvin in June 2001, and if so please identify?**

I am not aware of any such policies.

(15) **What steps did you take to check the training, qualifications and competence of the junior doctors in your specialty surgical team?**

I did not take any steps to check the training and qualifications of the junior doctors on the surgical team. All these doctors had been appointed through a recruitment and selection process which would have checked that they had the appropriate level of training and qualifications to practice at the grade to which they were appointed. The assessment of the level of competence of all junior staff is a continuous process characterised by observation, inquiry and episodes of direct training.

(16) **Please state precisely when you believe you were informed of Raychel Ferguson's admission under your care, and state what information you would have been given?**

I believe that it is highly likely that I would have been informed on the morning of 8th June that a child had been admitted overnight who had undergone a standard appendicectomy for appendicitis and about whom there were no clinical concerns but I have no recollection of being informed.

(17) **How many other paediatric surgical patients had undergone appendicectomy in the week prior to the 10th June 2001?**

I do not know.

(18) **Where were you on 8th June 2001?**

I was in Altnagelvin Hospital.

(19) **Had you attended on Raychel Ferguson on 8th June 2001 do you think you would have made**

any difference to the outcome?

No.

(20) **Did you keep a file or record of your work in relation to the case of Raychel Ferguson and did you retain documentation relating thereto? If so please provide copies.**

I have kept a file of all my statements to the Trust, the Coroner and the Inquiry all of which are in the possession of the inquiry. I did not make or keep any additional documentation regarding the case of Raychel Ferguson.

(21) **In respect of your statement:** *"With regards to becoming aware of dilutional hyponatraemia as a cause of Raychel's death, I believe there had been discussion between our own medical staff and the doctors in the RBHSC about the probable cause of Raychel's death. I believe I was made aware of that discussion sometime on the 11th June although I cannot recall from whom I got this information"* **(Ref: WS-044/2 p.27) please state:**

(a) Who was involved in these discussions;

I do not know.

(b) When did they occur;

I presume there was some discussion in and around the time of Raychel's admission to the RBHSC but I do not know precisely the timing of these discussions.

(c) What other information was imparted by the doctors in the RBHSC at this time;

I am not aware of any other information imparted by the RBHSC doctors.

(d) Whether this information was brought to the attention of the Critical Incident Review Meeting?

See above.

(22) *"As a team we understood that we had a responsibility to quickly, openly and honestly investigate her case in order to understand what had happened..."* **(Ref: WS-044/2 p.37) Please state:**

The team referred to in this context is the wider hospital team of those involved in the critical incident meeting rather than the surgical team.

(a) Did you have a surgical team meeting in respect of Raychel's case (and if so when and was it minuted);

There was no formal meeting of the entire surgical team.

(b) Did you obtain statements from members of your own team;

No.

(c) Were you able to identify the members of your surgical team;

I would have been able to identify those doctors on call for surgery on the 7th and 8th of June and I would have known at that stage the SHO and registrar on my team.

(d) Did you interview your team members;

As far as I can recall I spoke informally to Mr Makar and Mr Zafar.

(e) When did you first become aware that Dr.Zawislak may have been consulted by Dr.Makar in relation to Raychel's surgery;

As far as I can recall I only became aware that Mr.Zawislak may have been consulted by Mr.Makar during this inquiry.

(f) What steps did you take to ensure the attendance of your full team at the Critical Incident Review Meeting and their cooperation therewith;

The list of attendees at the Critical Incident meeting was a matter for the Medical Director who chaired that meeting.

(g) What steps did you did to ensure the cooperation of your full surgical team with H.M. Coroner's Inquest in the death of Raychel Ferguson;

I did not take any specific steps in this regard.

(h) Whether you made any attempt to locate and secure all documentation relating to the involvement of the surgical team in the case of Raychel Ferguson;

To my knowledge I was not asked to nor did I attempt to locate or secure any documentation relating to the involvement of the surgical team in the case of Raychel Ferguson.

(i) Whether you brought this information to the attention of the Critical Incident Review Meeting?

See above.

(23) In relation to your statement: ***"I also phoned Dr. Jim Crosby who was the Pathologist assigned to examine Raychel's appendix and informed him that the patient had died unexpectedly. 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"*** **(Ref: WS-044/1 p.5) please state:**

(a) What you were told by Dr. Crosby;

I do not recall being given any information at that time.

(b) **What you were told by Dr. Herron;**

I do not recall being given any information at that time.

(c) Was any record or note taken of these conversations and if so please provide;

No record was taken.

(d) Whether you brought this information to the Critical Incident Review Meeting?

See above.

(24) 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;

My recollection is that the meeting started at 4pm and lasted between 1 ½ and 2 hours.

(b) Was the Clinical Incident Form completed;

I do not know.

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

I do not recall.

(d) Was any attempt made to locate and secure all documentation relating to Raychel Ferguson and her treatment;

I do not know.

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

The Medical Director chaired the meeting and as far as I am aware was responsible for compiling a list of relevant clinicians.

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

I do not know specifically exactly who was asked to attend the review and I am not aware of any record of those who attended other than that already in the possession of the inquiry.

(g) Was any attempt made to trace the Surgical rotas for 7th - 9th June inclusive;

I do not know.

(h) Was any attempt made to form a chronology of the care and treatment provided to Raychel Ferguson;

Yes.

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

As far as I can recall the Critical Incident meeting was an opportunity to explore with each of those present their role in the care of Raychel so as to understand the series of events that led to her death. As far as I can recall a decision had been made not to minute that meeting

in order to encourage an open discussion.

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

I do not recall.

(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 and why has a copy of the same not been made available to the Inquiry;**

I have no recollection of such an agreement and cannot comment further.

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

I had no knowledge of a note taken at that time but I am now aware, as a result of materials made available to me by the inquiry, that Dr. Fulton made brief summary notes shortly after the meeting..

(m) **Who directed that a retrospective note should be inserted into the Medical Chart regarding the volume of Hartmann's solution administered;**

I do not recall who directed that this note should be made.

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

I am not familiar with the term "Review team" or exactly whom that term is taken to refer to. Individual clinicians who were present at the Critical Incident review accepted the responsibility of performing further investigation. Specifically Dr. Nesbitt offered to contact colleagues in other hospitals to ascertain the current usage of No. 18 solution and also agreed to review the literature concerning the routine use of low electrolyte containing fluids in children. Ms.Witherow agreed to review the fluid recording documentation in ward 6. These are recorded on document 026-004-005.

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

To my knowledge the entire complement of clinicians and others who were present at the Critical Incident meeting on 12-6-2001 did not meet again as a group. Dr. Fulton called and chaired a meeting of "relevant clinical staff"(026-003-004) on 9-4-2002 to review and revise the action plan formulated on 12-6-2001.

(p) **What shortcomings and deficiencies were identified by the Review;**

The clinical governance structures that deal with managing risk recognises that risks can only be effectively managed where there is a blame free culture that encourages staff to openly discuss problems with clinical care in order to identify areas where care can be improved. It was that atmosphere which predominated in the clinical incident meeting. I do not believe that the terms shortcomings or deficiencies would have been used during that meeting to describe any aspect of Raychel's care delivered by any individual.

As far as I can recall there was a discussion about the rate of 80ml/hr given to Raychel post-

operatively. Whilst it was acknowledged that the rate of infusion of was higher than Raychel's maintenance requirements, I believe that the slightly higher rate was not felt to be unreasonable in that she was being sick immediately post-op. I do not think there was a clear view that Raychel had a significant overload of fluid over and above her total maintenance requirements. Nevertheless it was decided to put a chart in Ward 6 that would help guide staff concerning the appropriate maintenance fluid prescriptions for children according to weight.

There was a discussion about the appropriateness of the use of No. 18 in post-operative children. Dr Nesbitt by that stage had already done some reading with regards the concerns surrounding No 18 solution and the need for careful monitoring and thus the need to perform a U+E within each 24 period was put into the action plan. Furthermore, Dr. Nesbitt offered to contact colleagues in other hospitals to ascertain the current usage of No. 18 solution and also agreed to review the literature concerning the routine use of low electrolyte containing fluids in children.

There was a discussion about the recording of fluid balance in children and specifically about the recording of volumes of vomit and urine output. Sister Miller undertook to ensure that nursing staff recorded urinary output in all post-operative children and Ms. Witherow agreed to review the fluid recording documentation in ward 6. These are recorded on document 026-004-005.

Sometime in late June/early July following inquiries by Dr. Nesbitt it emerged that the preferred fluid used in the paediatric unit was No. 18 solution. Thus if another type of fluid was prescribed then it appeared that the nursing staff would request that the prescription be changed to No. 18 solution which was the established practice in the ward. By that time there was also an understanding that the lines of responsibility for prescribing post-operative fluids were uncertain. Thus at the Critical Incident Review meeting on 9-4-2002 there was a plan made to agree who was responsible for the prescription of post-operative fluids in children.

(q) **Was the Review aware of the *"rumour"* from the RBHSC that there had been mis-management of Raychel's fluids;**

My recollection is that at the time of the Critical Incident meeting we were aware that there had been discussion between our own medical staff and the doctors in the RBHSC about the probable cause of Raychel's death and that some of that discussion had been critical.

(r) **When and how did the Review team first become aware that the RBHSC had discontinued the use of Solution 18;**

Dr. Nesbitt's letter to Dr. Fulton dated 14-6-2001 (026-005-006) states that in his discussion with the RBHSC he was made aware of the fact that they had discontinued No. 18 solution. I do not know when, how or if this fact was formally communicated to all persons present at the Critical Incident review meeting.

(s) **Please confirm 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?

Following the meeting of 12-6-2001 I was asked to inform surgical staff of the need to check the daily U+E result on all post-operative paediatric patients.

(25) 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;

Not that I recall.

(b) The record of communication with Raychel's parents;

Not that I recall.

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

Not that I recall.

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

Not that I recall.

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

Not that I recall.

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

Not that I recall.

(g) Obtaining the expert views of an internal/external specialist;

Not that I recall, other than the discussion Dr. Nesbitt planned to have with anaesthetic colleagues in other hospitals.

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

Not that I recall.

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

Not that I recall.

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

Not that I recall.

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

Not that I recall.

(l) **The extent, type and duration of the vomiting suffered by Raychel on 8thJune 2001;**

To my recollection the extent of vomiting suffered by Raychel was discussed.

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

Not that I recall.

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

To my recollection nursing care was discussed but it was not discussed in terms of short-comings.

(o) **Inter-clinician-communication (ICC);**

Not that I recall.

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

The rate of intravenous fluid prescription was discussed as outlined in 24 (p).

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

To my recollection the need for and frequency of U+E assessment was discussed but it wasnot discussed in terms of short-comings.

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

To my recollection the assessment and recording of urinary output and vomit was discussed but it was not discussed in terms of short-comings.

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

To my recollection this was discussed.

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

Not that I recall.

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

To my recollection Raychel's post-operative records were discussed.

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

Not that I recall.

(w) **The content and update of nursing care plans;**

Not that I recall.

(x) **The efficacy of the bleeper summonsing system;**

Not that I recall.

(u) **The balance of responsibilitybetween medical and nursing staff in respect of monitoring patients;**

Not that I recall.

(v) **The failure to includePost-operative Nausea and Vomiting in the Episodic Care Plan;**

Not that I recall.

(w) **The clinical protocols available to nurses in Ward 6 on 8th June 2001;**

Not that I recall.

(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;**

To my recollection there was a discussion around some ward practices. I do not recall any discussion concerning the writing of clinical protocols.

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

Not that I recall.

(26) **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?**

I do not know what steps were taken by Ms. Witherow with regards keeping documentation under review.

I do not recall specifically what steps were taken to address the nurses concerns but as far as I am aware surgeons maintained overall responsibility for paediatric patients.

(27) **Who had responsibility for communicating information to Mr. and Mrs. Ferguson from 9th June 2001 onwards?**

I do not know.

(28) **Did you advise Raychel's General Medical Practitioner as to the fact and circumstances of her**

death and the diagnoses?

As far as I can recall I did not speak to Raychel's GP at the time in and around Raychel's death. I have subsequently spoken to her GP.

(29) **Was there any discussion of, or reference toRaychel's case at any other meeting, whether Committee, Mortality or Training meetings etc? If so, please provide any record thereof.**

Not that I recall.

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

(a) Who invited you to attend this meeting, and did you explain your reasons for non-attendance at that time (if so to whom);

I do not recall who invited me to this meeting. I do remember discussing my non-attendance with Dr. Fulton.

(b) Did you consider sending a representative of your surgical team to the meeting;

No.

(c) Did you consider meeting with her at any other time?

No.

(31) **In respect of the Critical Incident Review Meeting's Agreed Action Plan (Ref: 022-108-334) and your undertaking to inform junior surgical staff to assess U&E results promptly, please indicate what steps you took in this regard and describe how you monitored staff compliance?**

As far as I can recall I spoke to the junior surgical staff to inform them of the need to assess U+E results. I included this information in the induction document that I devised and which was given to all SHOs and Registrars on joining the surgical team. With regards monitoring staff compliance I was able to ensure that U+E results were monitored on any patients under my care but there was no method for monitoring staff compliance overall. Thus it will have been the responsibility of the Consultant in charge of each case to ensure that paediatric patients were appropriately monitored and U+E results were reviewed.

(32) **With regard to the Review meeting of 9th April 2002 (Ref: 022-092-299) please advise:**

(a) Whether you attended this meeting;

Yes as far as I can recall.

(b) Whether you made any note thereof (if so please provide copy of the same);

Not that I recall.

(c) Whether the role of the surgical team in IV prescription and administration was discussed?

According to materials provided to me by the inquiry there was a discussion about the responsibility for prescribing post-operative fluids in children which will have included the responsibilities of the surgical team but I do not recall the exact details of that discussion.

(33) **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 do not recall.

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

I do not recall.

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

Not that I recall.

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

I was not consulted.

(e) If you gave any directions in respect thereof;

See above.

(f) In relation to the memorandum to you dated 31st December 2001 from Therese Brown (Ref: 022-060-159) please state what you advised her and why?

I have no recollection of that memo or the actions taken.

(34) **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/record was taken of the same?**

I have no recollection of attending that meeting and therefore cannot comment further.

(35) **In respect of the letter by Dr. Nesbitt dated 3rd July 2001 (Ref: 021-057-037) and the assertion that *"some clinicians evidently feel that no. 18 solution is the fluid they wish to prescribe, and have disagreed with the regime suggested... I am concerned that my attempt to put in place a safe policy has met with resistance so quickly. Perhaps you could discuss this urgently within the Surgical Directorate so that a regime can be agreed"* please state:**

(a) Whether members of the Surgical specialty team disagreed with the discontinuance of the use of No. 18 Solution;

As far as I can recall Mr. Neilly had concerns about the discontinuation of No. 18. Solution.

(b) If so why;

As the Consultant post in Altnagelvin required the management of general surgical paediatric patients, Mr. Neilly, prior to taking up his post in August 2000, completed a 6 month period of paediatric training in RBHSC from February to July 2000 where I believe he had seen the routine use of No. 18 solution in post-operative patients. My recollection is that Mr. Neillywas concerned re: the dangers of high solute, low glucose containing solutions in post-operative patients. I presume this was on the basis of the training and experience he had received during this 6 month attachment.

(c) Who disagreed with its discontinuance;

Mr. Neilly.

(d) Whether urgent discussions were pursued within the Surgical Directorate as suggested;

I do not know.

(e) Whether any record or minute was made of these discussions (and if so please provide)?

(36) 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);

In and around the time of the Coroner's inquest as far as I can recall.

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

In and around the time of the Coroner's inquest as far as I can recall.

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

In and around the time of the Coroner's inquest as far as I can recall.

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

In and around the time of the Coroner's inquest as far as I can recall.

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

I do not recall being aware of this report until very recently.

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

I do not know if any consideration was given to sharing these reports.

(37) ***"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"*** **(Ref: 021-057-137) please state whether you agree with this and if so:**

I do not have any direct experience of this happening as far as I can recall but there seems to be a consensus that Dr. Nesbitt's description of the practice of fluid prescribing on the paediatric

ward in 2001 was correct.

(a) How, to the best of your knowledge, did this *"problem in the Children's Ward"* become established, and when;

I do not know.

(b) Who was responsible for implementing and monitoring this practice;

I do not know.

(c) Why was it permitted to continue;

I do not know.

(d) Was it reviewed?

I understand that the practice was reviewed sometime after Dr. Nesbitt's memo but I was not directly involved as far as I can recall.

(38) 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;

I do not recall.

(b) Whether there was any disagreement of approach between the surgical and paediatric specialty teams?

Not that I recall.

(39) Had you experienced any difficulties with excessive workload or inadequate staffing levels within the surgical team at or before June 2001?

The fluctuations in surgical workload from times of relative calm to times of excessive workload means that on occasions all surgical services experience periods of difficulty where staff are overstretched. I do not remember any specific instances at or before 2001.

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

In or around the time of the UTV program of October 2004 as far as I can recall.

(41) 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: Robert Caldwell **Dated:** 5-7-13