Witness Statement Ref. No. 046 /1

NAME OF CHILD: Raychel Ferguson

Name: Stella Burnside

Title: Mrs

Present position and institution:

Chief Executive
Health and Personal Social Services
Regulation and Improvement Authority (December 2004 – present]

Previous position and institution:
[As at the time of the child's death]

In June 2001 I was Chief Executive of Altnagelvin Hospitals Health and Social Services Trust. [1993 – 2004]

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

My professional and academic qualifications are:
Registered General Nurse. RGN
Registered Mental Nurse. RMN
Diploma in Nurse Education RNT
Bachelor of Philosophy. B. Phil [Hons]

I have served on many national and regional advisory and policy panels and working groups for health and social care during these years including:

United Kingdom
The NHS Research and Development Health Technology Assessment Panel for Population Screening.
The NHS Research and Development Health Technology Assessment Panel for Diagnostics and Screening.
NHS Confederation Quality Policy Advisory

Northern Ireland
Working Party on Consultant Appraisal
Working Party on In Service Nurse Education
Academic Liaison Committee for Medical Education QUB

Community Service

Broadcasting Council for Northern Ireland
Council of University of Ulster
Lay Panel For Executive Committee of Bar Council for Northern Ireland

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

I have not made a previous statement, deposition or report.

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

Ref:	**Date:**	

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

1. **Describe in detail your role at Altnagelvin hospital following the death of Raychel Ferguson, to include:**
   (i) how and when you first became aware of her death;
   (ii) the steps you directed be taken; and
   (iii) the reason you directed those steps be taken.

Following upon my role as Unit General Manager in Foyle Community Unit [1990-1993] I was appointed as Unit General Manger to Altnagelvin Area Hospital in 1993 and became Chief Executive of the newly created Trust in 1996 when the Hospital was granted Trust Status.

In that role I was the Accountable Officer for the organisation.

i] On Monday morning, June 10th 2001, I was informed that Dr Nesbit, Clinical Director for Anaesthetics and Critical Care, wished to see me urgently. I met with him immediately. Dr Nesbitt informed me of the unusual event of the sudden collapse, transfer and subsequent death of the child Raychel Ferguson.

As a result of our discussion I took the immediate decision to establish a full review of the circumstances to establish the facts. I decided to have the Review conducted under the Critical Incident Protocol which had been developed in line with Critical and Untoward Incident Reporting. [026-012-016]

In initiating the Review I was ensuring that we would meet our responsibilities and our duty of care and ensure that any necessary learning would take place.

The Trust strategy for clinical governance had been developed under the leadership of the Nursing Director, Miss Duddy alongside the Medical Director, Dr Fulton and had been coordinated by Mrs Brown. The strategy had led to an education programme and the production of policy and protocol for improving governance of clinical matters within the Hospital. The Strategy for the development of Clinical Governance was in keeping with policy emerging from the NHS where a culture of openness and a system of reporting and review of untoward clinical events was being encouraged.

ii] Immediately following discussion with Dr Nesbitt I went to the office of Mrs Therese Brown, the Senior Manager of the Risk Management department, briefed her on the issues and asked that she convene and coordinate the Review at the soonest opportunity and keep me informed of the issues as they emerged and advised on progress.

I telephoned Dr Fulton, Medical Director, who was conducting his Outpatient Clinic at another hospital, to brief him on the concerns, inform him of my decision to hold a Critical Incident Review and to ask him to Chair and lead the process of the Critical Incident Review on behalf of the Trust.

On completion of the first meeting of the Critical Incident Review which took place the following day, June 12th, Dr Fulton and Therese Brown came to my office to discuss the meeting and advised me of the issues and the actions identified from the analysis and the further information being sought to confirm information.
From the feedback discussion it was clear that there were three areas of action commended for agreement with me which would need thorough follow through:

1] First priority was a need to share learning on Intravenous Fluids for Children in the post operative recovery period.
Dr Nesbit had already made telephone contact with anaesthetic colleagues in Northern Ireland to immediately alert them to the issue identified. However it seemed clear that the learning needed to be more formalised and so in discussion with my colleagues it was determined that we would take actions to ensure that the learning was shared as widely as possible in the hope that such an event could not happen again. The process of that action was:

(i) to notify the Chief Medical Officer in the hope that a review of practice could be undertaken on a Regional basis ensuring universal awareness in Northern Ireland;
(ii) to inform the Director of Public Health in the Western Area so that the information might be disseminated through that forum;
and,
(iii) to undertake a widespread information programme within our own Trust.

2] The learning actions within the Trust were identified and were designated for action by the respective managers and would be reviewed and audited to ensure assimilation in to practice.

3] Our duty of care to the parents and family was identified and it was agreed to make contact with the parents to offer our sympathy and express our willingness to meet with the family when they would wish to do so.

I had spoken with staff as they left the Critical Incident meeting and was struck by their compassion and the concern they expressed for the family. This supported the approach to the family.

There was a sense of shock that a child had died so unexpectedly and there was a great sense of urgency to understand the issues. I thus agreed that Dr Fulton, as Medical Director, would act on behalf of the Trust and keep me fully informed on a regular basis. My office was in the main hospital in close proximity to Therese Brown and she, Dr Fulton and Dr Nesbitt kept me up to date on a frequent and regular basis.

Whilst being informed of the issues I also sought out literature in order to fully inform myself. From my reading of the research I noted that the issues identified in the critical incident review had been reported in a study as also, albeit also rare in incidence, affecting adults and so commented to Therese Brown, in a hand written note, on the Update on the Critical Incident Meeting Report, that there may be a need to explore the risk issues for post operative adults also.

[022-097-307]

Within the hospital the Medical Director, Clinical Director and Risk Management were working conscientiously to achieve our learning goals. Given that it was the holiday season I was concerned that there may be delay in activating the Regional assessment of the issues of hyponatraemia and so I contacted the Chief Medical Officer to emphasise my concern for the importance of the issue. [026-007-008] [email from my Personal Assistant Sally Doherty to Dr Campbell]

Dr Fulton and Mrs Brown, along with Dr Nesbitt, who was undertaking an active education programmes throughout the Hospital, [021-054-117 to 131], [021-041-086] continued to appraise me informally and formally on all aspects of progress following the Review [026-016-031] and [021-055-134] for the following years.

Contact with the issues continued through many media forms and upon reading some of those pieces of newspaper articles I was concerned that there may be some misunderstanding of facts and sequence in relation to the response of Altnagelvin Hospital as appeared to be portrayed by a Reporter who interviewed the Chief Medical Officer. [See Irish News 19th May 2004]. To clarify the facts and sequence of events I made contact with the Chief Medical Officer, Dr Campbell. I outlined the sequence of events clarifying that Altnagelvin Hospital had not been notified by any other hospital regarding the use of IV Fluids and stating the actions of the Hospital again for the record. [021-020-041 and 021-020-042]

Reason you directed those steps be taken.

iii] As Chief Executive of the Trust, and with the commitment and considered support of the Trust Board, I worked to cultivate a value system which implicitly and explicitly was to strive after excellence in the quality of diagnosis, care and treatment and to do so with compassion and kindness. To support such an approach to improvement in quality we believed it necessary to have a culture of learning. The Trust used formal and informal mechanisms to support quality improvement through learning opportunities and, in particular, through its evolving approach to clinical and social care governance.

An important part of the framework for clinical governance was the system of Critical Incident Review which was designed to encourage staff to report incidents. One outcome of this was that learning points could be identified and shared within the Trust. The context of the Review of Critical Incidents was designed to provide a neutral environment where staff could be open and honest in their account of their own, or others, actions so that learning would be identified and shared in an objective and blame free culture.

A critical or untoward incident is one where there is an unexpected outcome. The unexpected death of a child is one of the most serious critical incidents and demanded our investigation. In my judgement the findings of the Review were extremely important and presented lessons that I believed should be disseminated both internally and externally. This was done as quickly as

possible and using the channels available, as described above.

2. Give details of all communications you had with the family of Raychel Ferguson both before and after her death, to include the nature of those communications, at whose request the communications took place and the information/explanations conveyed by you to Rachel's family.

Prior to my letter of 15th June 2001 [022-085-225] I had not had contact with Mr and Mrs Ferguson.

A central part of my discussion of this Review, with the Medical Director and the Senior Manager for Risk Management, had focussed upon our duty of care and responsibility to the family.

Within the hospital it was our practice to be open with patients and their families if and when there is an untoward event. In support of this I had sought to develop a culture where we would approach families to offer explanation of relevant circumstances. In keeping with this practice, and in accordance with the views expressed by my colleagues, I wrote to the bereaved parents, at the earliest opportunity, offering our sympathy and inviting them to meet with us when they would feel ready.

This unexpected death of a child was without precedent, to my knowledge, during my years in the hospital, and it caused significant shock and sorrow to me and to my colleagues. The staff who had been involved in the care of Raychel expressed the desire to meet with the parents.

It was almost three months before the family, in response to the letter of 15th June, [022-085-225] requested a meeting and this was arranged for 3rd September 2001.

In preparation for the meeting I agreed with the Risk Manager that the purpose of the meeting was to open discussion with the family in order to facilitate their understanding and to offer support. In order to facilitate this approach we agreed not to formalise the process but respond as and how the family wished.

Staff who had been involved in Raychel's care and who wished to meet with the family attended the meeting. The meeting was attended by Mrs Ferguson accompanied by her chosen relatives and friends. The Patient Advocate, whose role is to act on behalf of patients and their family, was in attendance to support the family. The Patient Advocate made her note of the meeting. It is my judgement that this note is not a full account of the content or an adequate reflection of the atmosphere of the meeting. [022-084-215 to 022-084-224]

At the commencement of the meeting, I endeavoured to create an atmosphere of warmth, to communicate our concern for the family and to indicate that we hoped to achieve openness of communication between the family and the hospital. I then expressed, on behalf of myself and my colleagues, our heartfelt sorrow that such a tragedy had happened and assured those present that we would do all we could to ensure that it could not happen again.

We offered explanations around the following issues, namely the process of Critical Incident Review, the research findings on post operative reaction leading to hyponatraemia, our subsequent actions to prevent risk of recurrence, and the measures in place to monitor improvement.

The family representatives had many questions and staff answered all questions to the best of their ability.

I outlined the hope that the meeting offered a beginning of a process. I explained that it was our intention to be open and supportive to the family and explained that the meeting was not intended to substitute for any or all of the avenues which the family wished to pursue whether through formal complaint or legal redress.

I offered assurance that, in my opinion, the Coroner would act objectively and that the family could have confidence that their concerns would be addressed thoroughly through the Coroner's Court. As it might be a long time to the hearing, in the meantime, I suggested that we would wish to be able to support them and would invite them to contact us as and when they wished.

During the meeting a request for the Clinical Notes was made and the following morning I arranged to have the notes copied and conveyed to the family through the General Practitioner the following day. [022-083-214] and [022-082-213]. Since that time neither Mrs Ferguson or Mr Ferguson has initiated personal contact with me. All communication has been through their legal representatives.

Particular areas of interest (Cont'd)

3. Explain in detail the actions you took to ensure that the DHSSPS and other hospitals were advised of the possible cause of Raychel's death.

I discussed the detail of the internal Critical Incident Review, the Research Papers on Post Operative Hyponatraemia and our duty of Care with my respected colleagues, the Medical Director, Dr Fulton, the Clinical Director, Dr Nesbit, the Nursing Director, Miss Duddy and Mrs Brown. I additionally undertook personal research through literature review on the issues in order to assure myself that I was fully informed.

These discussions led to our unanimous view that learning from this tragic episode needed to be disseminated widely to the clinical community. Committed to this course I considered the possible courses of action to achieve the goal of disseminating our learning. The most effective method which readily presented itself within Northern Ireland was to ask for the assistance of the Chief Medical Officer: we therefore asked to use her structures of communication to ensure that the lessons would have credibility and be widely disseminated. I asked our Medical Director, Dr Fulton, on behalf of the Trust, to pursue this rigorously. This he did.

In addition to the above request for Regional dissemination, Dr Fulton advised the Director of Public Health in the Western Area so that an immediate network of communication would be created to support the communication of the information which we had to hand at that time whilst awaiting Regional Guidelines.

Whilst appreciating the importance of the Network of Clinical Specialty and that the communications from Directors of Public Health would informally spread the information related to Hyponatraemia I remained concerned to ensure the formal and rigorous pursuit of the issues and thus sent an email to the Chief Medical Officer to emphasise the importance of this. [026-007-008]

With the guidance of Medical Director and Clinical Director and our Clinical Audit department, with the active participation of the staff from the Children's Department, we implemented an internal educational programme and audit programme to ensure continuous learning and assimilation into improved practice in Altnagelvin Hospital.

One example of this is the Explanation of Hyponatraemia lecture prepared by Dr Nesbitt and presented throughout the Trust. [021-054-117 to 021-054-131]

The Trust maintained its interest in and pursuit of openness to ensure dissemination of the available information to all relevant health related organisations. The Trust had developed a practice of sharing depth of information with the Western Area Health and Social Services Council. An example of this is the briefing on the detail of these issues in February 2003. The Chief Officer of the Council provided a note of the meeting to his council members. I observe from that Note a reference to the Accident and Emergency department which I believe should refer to Operating Theatre.

The Trust maintained formal and informal contact with the DHSSPS to the completion of the new guidelines and Dr Fulton and Dr Nesbit kept me appraised of the progress through our regular meetings and through written communications.[021-055-134], [021-049-106] and [021-041-086]

4. Describe the procedure at Altnagelvin in 2001 for the family of a patient to discover information/discuss concerns they may have in relation to the treatment or possible cause of death of a family member.

The Trust regarded Complaints as an important part of quality improvement and as an opportunity for feedback and as a basis for open communication; and in pursuit of this the Trust provided easy access to information on how to make a complaint or express a concern.

Where a family of a patient has a concern or complaint regarding any aspect of service, care and treatment they had access to the following approaches to secure information, have discussion about concerns and receive a written response.

The Formal Complaints Procedure:
Following the principles of good practice from the Wilson Report on Complaints Management the Trust would have the concern or complaint investigated on behalf of the patient or family and would respond in writing.

Where the issues were more complex and where there had been untoward outcome then the family would be offered the opportunity to meet with the Chief Executive.

All written responses to complaint contain the information on how to seek recourse to Independent Review if the family or patient continued to feel dissatisfied.

Expressed Concerns
Where a family expressed serious concerns but did not wish to pursue the Formal Complaints procedure their concerns would be investigated and the opportunity to meet for a discussion would be offered. Dependent upon the nature of the concern the meeting or sometimes series of meetings could be with the Chief Executive, or with the Chief Executive and relevant staff involved in the issue. On occasions the meetings may be with the relevant Clinical Director.

Patient Advocate
The Trust employs a full time Advocate who acts on the behalf of patients or their family.

Untoward Events
The Trust had a policy of informing a patient or relative where it was believed that an untoward event had occurred. This practice had grown out of a belief that honesty and openness is fundamental to the trust necessary for good clinical care and conduct and that it is the right of the family to have access to their clinical information.

The development of our approach in Altnagelvin Hospital was alongside a growing awareness of and commitment to improved care through sound governance of clinical matters and our efforts to ensure that we were developing in line with emerging modern best practice elsewhere.

Clinical Governance was emerging as a basis for quality improvement in England and abroad and I developed a strategy which would cultivate awareness of and commitment to improvement through Clinical Governance.

An early part of this development was a Working Group for development of Clinical Governance which included staff from the Western Health and Social Services Board as well as Trust Staff.

The Director of Nursing, Miss Duddy, the Medical Director, Dr Fulton and Mrs Brown, Risk Manager, coordinated and developed the strategy and education programme to support the framework for Clinical Governance well in advance of it being made a requirement in Northern Ireland.

The evolving framework and the growing culture of commitment to clinical governance

informed our approach to the Critical Incident Review of the circumstances surrounding the death of this little girl. It was in this context, and in the hope of helping the family of the late Raychel Ferguson, that I wrote to offer sympathy and to invite Mr and Mrs Ferguson to meet with us to provide an always open door to deal with these important issues and to help them in their grief.

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: [signature] **Dated:** 1st July 2005.