Witness Statement Ref. No. | 049/4

NAME OF CHILD: Raychel Ferguson

Name: Ann Noble

Title:

Present position and institution:

Previous position and institution:
[As at the time of the child's death]
Staff Nurse, Ward 6- 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 your last witness statement]

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

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

Ref:	**Date:**	
WS-049/1	30.06.2005	Inquiry Witness Statement
WS-049/2	22.06.2012	Supplemental Inquiry Witness Statement
WS-049/3	14.01.2013	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 detail:

(a) The nursing structures in place in 2001 (and it would be of assistance if you could describe these by way of a diagram indicating lines of responsibility and accountability);

As a Grade E nurse at that time, the F Grade Sisters were Mary McKenna and Kathryn Little, Sr Millar was my Ward Manager and Irene Duddy was the Director of Nursing. Anne Witherow was the Clinical Effectiveness Co-ordinator.

(b) The nature and frequency of meetings between nursing staff, and the Clinical Services Manager, the Director of Nursing, Nurse Manager and Senior Nurse (and were such meetings minuted);

I only attended ward meetings chaired by the Ward Manager. These would take place 3-4 monthly. Minutes of these meetings were kept in a book and available on request and on the staff notice board.

(c) Whether nursing-related committees and groups were in place in 2001, and whether the meetings of such committees and groups were minuted? What part, if any, did you play in these committees/groups?

I was aware that nursing related groups and committees were in place. I did not take any part at that time.

(2) Had the AHHSST adopted the concept of family-centred care in 2001, and if so, what training was given in this regard?

In 2001 I had no particular training in family centred care but I was fully aware of the importance of it. Parental anxiety was a core element of care planning and we always worked in participation with parents.

(3) From a 2001 perspective, please detail:

(a) The composition of a Children's Ward nursing team and the minimum staffing requirements thereof;

In my position as a Grade E nurse I had no input into staffing levels.

(b) Whether any difficulty was experienced in achieving full deployment of nurses on duty in Ward 6 at any time in June 2001;

On the two nights of Raychel's stay in Ward 6 in June 2001 there was a full complement of staff. I

was not made aware of any difficulties at that time.

(c) Whether at any time during Raychel's stay in hospital the nursing workforce complement fell below a level consonant with RCN Guidance on staffing Children's Wards;

There was a full complement of staff on the two nights Raychel stayed.

(d) Whether there were at least two Registered Sick Children's Nurses on duty at all times in Ward 6 between 7th and 9th June 2001;

Yes, 2 nurses (paediatric nurses) were on duty, Staff Nurse Daphne Patterson and Staff Nurse Fiona Bryce.

(e) The steps taken to maintain and monitor parent's satisfaction with the care delivered in Ward 6 in accordance with the *"Nursing Philosophy"* (Ref: 316-023-004);

At that time there was no formal monitoring in place. Issues were dealt with at ward level where possible and if necessary forwarded on to the patients advocate.

(f) The programme of post-registration professional development, supervision and appraisal in place for nursing staff;

Appraisals occurred 2-3 yearly back then. I regularly attended mandatory training updates and appraisals. Supervision occurred but was not formally recorded.

(g) Those clinical protocols available to nurses in Ward 6?

I cannot recall exactly what was in place at that time.

(4) Please state what steps nurses were expected to take to maintain their knowledge and competence in line with the *"UKCC Code of Conduct"* and *"Scope of Professional Practice"* guidance in 2001. What training and assistance was in place to aid their continued professional development?

As professionals it is each nurses own responsibility to update their knowledge and skills required by the UKCC Code of Conduct, to ensure they were safe and effective practitioners. The Trust provided mandatory training and educational study days.

(5) In respect of nursing matters:

(a) Was there a patient-specific nurse allocated to Raychel Ferguson;

Nurses worked as a team on night duty at that time.

(b) Was there a system of independent external scrutiny in place to review nursing performance in the AHHSST, and if so please provide details of the same;

I am not aware.

(c) Was there a Night Nurse covering Ward 6 in June 2001, and if so what was her role;

There was a Night Manager on duty for all of Altnagelvin Hospital including Ward 6.

(d) Was there a policy on nurse staffing levels for the Children's Ward;

I was unaware of any policy.

(e) How was assurance provided with respect to the knowledge, competence and suitability of nurses to work with children, and that nurses kept up to date with current practice;

There were always at least 2 paediatric nurses on shift in 2001. Nurses kept up to date with current practice through study.

(f) What mechanisms were there in place to monitor the quality of care delivered to children in 2001;

Auditing of care was in its infancy at that time and I personally had no participation in that role.

(g) Why was the use of the Episodic Care Plan discontinued?

The Episodic Care Plan was discontinued by the Trust. I am not aware of the reasons why.

(6) What guidance was provided to nursing staff, at and prior to 2001, in respect of:

(a) The monitoring and recording of post-operative fluid balance;

Guidance was given by the surgeons and anaesthetists in the post-operative period. It was the staff nurses responsibility to record intake and output and ensure that a child had passed urine in the post-operative period.

(b) The prescription and administration of intravenous fluids;

It was the responsibility of the medical staff to prescribe IV fluids. 2 nurses were responsible for erecting and administering the fluids prescribed after checking the type, rate, lot number and expiry date. We also checked and documented the type of pump and asset number of the pump used. All information was documented on the fluid balance sheet, dated, timed and signed.

(c) Recording weights in children;

A child's weight was recorded on admission as part of their initial assessment. This was necessary to calculate drug doses and fluid requirements on an individual basis.

(d) Monitoring urea and electrolyte levels and electrolyte management in children;

It was the medical staff who requested and carried out bloods at that time.

(e) The treatment of vomiting in children;

The treatment of vomiting, if excessive was an anti-emetic if prescribed and this was administered by a doctor. IV fluids were considered if clinically warranted.

(f) The documentation of vomiting;

If vomitous was saved in a receptacle dish it should have been measured, otherwise it was documented as small, medium or large or in plus form (+, ++, +++).

(g) Caring for children with headaches and listlessness;

Nurses would carry out clinical observation, temperature, pulse, respiratory rate and blood

pressure. If any concerns, doctor would be informed. Parent and child would be reassured, analgesia given and observed for effect.

(h) Updating, amending and compiling nursing care plans/ episodic care plans;

The care plan was allocated on admission and updated during each shift. Any other problems identified were included according to the individual progress and deterioration.

(i) Communication with parents;

There was no formal guidance in respect of communicating with parents at that time.

(j) Recording communication with parents;

The guidance was to record that parents were kept up to date with the care plan.

(k) Providing information to senior doctors and consultants in respect of patients and the documentation of the same;

Nurses were guided to inform senior doctors and Consultants if they had any concerns regarding patients and their care. They should be aware to document concern in the evaluation and episodic care plan and the outcomes of same.

(l) Recording contact and attempts to contact junior doctors, and the information given to such doctors and advice received from them;

In my professional practice I would have documented the necessity to contact a doctor outside ward rounds. If there were any problems contacting them I would not hesitate to contact more senior doctors and carry out what they would advise. Unsuccessful attempts would be documented in the evaluation. Nurses were guided to contact junior doctors initially, explain concerns, seek advice, follow instruction and record in the nursing evaluation.

If unsuccessful in contacting a junior doctor, the next most senior doctor would have been contacted and the same pattern followed. Unsuccessful attempts were not recorded at that time.

(m) The conduct of handovers;

Official handovers were at the end of every shift. Handovers on every child were given at the beginning of day and night shifts. Nurses continued to update other team members during their shift and if there were changes to report.

(n) The identification of senior doctors and consultants with individual responsibility for the patient;

On admission children were allocated a Named Consultant. This would be the Consultant on call.

(o) The completion of patient records;

The guidance for nurses on the completion of patient record was that they were recorded accurately, timely, concisely and fully informatively and dated, timed and signed by the nurse giving care.

(p) Raising concerns about short comings in medical practice and patient treatment, and or whistle blowing;

If nurses had any concerns they would pass them onto their Nurse in Charge / Ward Manager or Consultant.

(q) Summoning the on-call team and the consultant;

The on call team and Consultant were easily accessed through the hospital switchboard.

(r) Deciding when to refer children to an appropriate doctor;

In 2001, nurses would initially contact the junior house officer who in turn would communicate with his senior house officer and registrar and if necessary the Consultant.

(s) The investigation of nursing issues arising in a serious untoward incident such as the death of a patient following surgery?

This was the first serious untoward incident I was aware of. I understood Risk Management would usually initiate any nursing issues in any serious untoward incident.

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

(a) Who was responsible for ensuring that nursing/multidisciplinary audits were carried out;

(b) To whom were the results of nursing/multidisciplinary audits sent;

(c) What action could be taken on foot of the results of nursing/multidisciplinary audits;

(d) As to specific systems for the audit of nursing practices or procedures;

(e) As to whether there was any procedure or system in place in 2001 to audit the quality, clarity and completeness of clinical case notes?

(a - e inclusive) As a Grade E Staff Nurse I was unaware of any arrangements to ensure regular audits took place.

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

I am unable to recall all other systems in place in 2001 for quality assuring the safe provision of patient care.

(9) Please describe the steps taken to disseminate and implement/enforce compliance with the recommendations deriving from the UK Central Council for Nursing, Midwifery and Health Visiting?

Information was cascaded down through Senior Nursing Management. Nurses were informed at ward meetings, through NMC updates posted out to all registered nurses and via the notice board on the ward.

(10) Please particularise all steps that you were aware of taken to investigate the care, treatment and death of Raychel Ferguson.

Risk Management took the lead in investigating the care, treatment and death of Raychel as far as I was aware.

(11) Was there any discussion of Raychel's case in nurse meetings, nursing reviews, nursing audits or learning sessions? If so, please provide any record thereof and describe:

(a) The learning derived therefrom;

Raychel's case was definitely discussed in learning sessions for the management of IV fluids.

Sol 18 was discontinued from use.

Baseline bloods to determine electrolytes taken and checked regularly whilst on IV fluids post operatively.

Accurate fluid balance and the measurement of fluid losses emphasised.

Parents asked to keep nurses informed of any vomiting, diarrhoea and other losses children would have so we could measure them.

Weight checks to determine fluid required as per body weight.

(b) Those steps taken to utilise the learning.

This learning became the formal nursing care plan for the patient on IV fluids.

(12) 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;

I cannot recall the exact times but think the meeting was in the afternoon.

(b) Whether the Clinical Incident Form was completed;

I am unsure.

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

I cannot recall exactly who was there.

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

I am unsure.

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

I am not sure.

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

I don't know who was invited.

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

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

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

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

(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;**

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

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

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

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

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

(q) **Whether consideration was given to interviewing, receiving input from or involving the Ferguson family in the Review;**

(r) **Were any steps taken to obtain the expert views of an internal/external specialist;**

(s) **Whether 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;**

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

(g - t inclusive) I was not part of the review team and cannot answer these questions.

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

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

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

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

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

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

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

(a - f inclusive) As a Grade E Staff Nurse I was not party to any appraisal or assessment re questions (a) - (f).

(14) 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;

I do not recall.

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

I do not recall.

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

Sr Millar was vocal about her concerns in getting surgical doctors to review patients.

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

I do not recall.

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

This was discussed but I cannot recall the exact details of the conversations.

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

This too was discussed, I don't remember all the details.

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

This was discussed, again the details are not clear.

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

It was noted that the documentation on the Fluid Balance Sheet had possible shortcomings.

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

I do not recall.

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

I recall the amount being discussed as being approximately 15mls/hr more than recommended for a child of Raychel's weight. In total approximately an amount equivocal to that of a can of coke (330mls). I remember this example being used. I remember that it was thought that a child should be able to cope with such an amount.

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

I cannot recall the exact details but it was discussed.

(l) Any shortcoming in the assessment and recording of urinary output and vomit;

I cannot recall.

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

I cannot recall.

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

I cannot recall.

(o) The content and update of the episodic care plan;

I don't recall exactly.

(p) The efficacy of the bleeper summonsing system;

I do not recall.

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

I recall Sr Millar voicing her concerns.

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

I recall hearing that a nurse told the Ferguson family that Raychel got the wrong fluids in Altnagelvin. I do not know who said this.

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

I cannot recall the exact conversation.

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

I cannot recall.

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

I was not aware of the short comings and deficiencies identified by the Review until the Inquiry.

(16) With reference to the *"Update for Chief Executive Re: Critical Incident Meeting"* (Ref: 022-097-308) please advise as to the following:

(a) Were you involved in the nursing discussions relating to fluid balance management in the light of the Critical Incident Review Meeting;

I was not involved but was aware of the shared learning from Review meetings.

(b) What steps were taken to review the *"further action required"* and to ensure it was achieved;

I do not know.

(c) In relation to 4a *"Fluid balance sheet must be correctly completed"* please advise as to who had been responsible for permitting incorrect completion of these sheets prior to this date;

As it was not recognised that the fluid balance sheets were incorrectly completed at that time, no one person had allowed this to happen.

(d) In relation to 4g please describe the training devised for staff in relation to the matters agreed at paragraph 4;

It was communicated over a long period of time all the changes that needed to be made from Sr Millar down through the Senior Staff Nurses.

(e) Please state why you permitted the fluid balance to be recorded on a Neonatal Intensive Care Unit sheet;

I believe it was because we had no stock left off the Children's Ward input / output charts. This was what all intake and output had been recorded on from early morning and throughout the day. It was accepted that if a ward intake and output chart had run out, the neonatal chart could be used, as they were very similar.

(f) Did you share the concern of the nursing staff that surgeons were unable to give a commitment to children on Ward 6 and is so please describe when this became a concern, what steps you took to address it and whether you brought it to the attention of your immediate superiors (if so when and how)?

I was not at that meeting.

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

(a) What was the purpose of you meeting with Mrs. Ferguson;

I was present at that meeting so that I could answer any questions the family wanted to ask me regarding Raychel.

(b) Do you believe that the representatives of the AHHSST answered the questions posed;

Yes, I do.

(c) Do you believe that the representatives of the AHHSST gave a full account of their understanding of the principle causes of Raychel's death;

I believe so.

(d) Do you believe that the representatives of the AHHSST gave a full account of their understanding of the deficiencies in the care and treatment of Raychel;

I believe they gave a full account with the understanding at that time.

(e) Why did you not tell Mrs. Ferguson of the hospital's agreed action plan (Ref: 026-008-009) and the review of procedures;

As there were 2 Consultants (Anaesthetic and Paediatric), the Chief Executive and Sr Millar at that meeting, I did not feel it was my place.

(f) Please indicate all respects in which the minute of the meeting is inaccurate;

I feel the minutes at the meeting were accurate.

(g) In respect of the meeting to be held at the end of September 2001 to look *"at fluids given to children"* (Ref: 022-084-223) please detail who met, when, where, why and with what result?

I do not recall being involved at that meeting.

(18) 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);

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

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

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

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

(a - e inclusive) I became aware of the content of these reports a few weeks prior to the beginning of the Inquiry.

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

I was not party to any discussion regarding sharing these reports with the Ferguson family.

(19) Please provide the following information:

(a) Was there any appraisal/review of staff performance in the aftermath of Raychel's death;

Not that I am aware but appraisals continued as before.

(b) When you were first asked to make a statement in relation to the case of Raychel Ferguson, by whom and for what purpose;

I cannot recall exactly but I remember it was stressed to make a statement after any serious untoward event while details fresh in my memory.

(c) Whether you would have expected nursing staff to pursue an investigation into the death of Raychel Ferguson and whether you would have expected statements to have been obtained from the nurses in respect of same;

I thought this was the role of the Risk Management Department.

(d) When you first became aware that the Royal Belfast Hospital for Sick Children had discontinued the use of Solution 18 intravenously? Please indicate how you first discovered this, when, and from whom;

I cannot recall exactly.

(e) Do you think there was any imbalance in the responsibilities borne by medical and nursing staff in respect of monitoring patients;

In 2001 I cannot recall exactly.

(f) Was there any experience of communication difficulties as and between clinicians resulting from an incomplete mastery of the English language;

Not that I was conscious of.

(g) Was there any attempt to review ward practices and conventions to determine whether they were appropriate, and whether they might better be reduced to writing as clinical protocols;

I was not responsible for this.

(h) Were you aware that there had been a ward practice in place in 2001 which favoured the use of Solution 18? If so please describe your understanding of this practice, from whom or where it originated, and who was responsible for implementing and monitoring it;

When I started in the Children's Ward, Sol 18 was always used unless specified by the prescribing doctor. There were never any problems identified with Sol 18 until Raychel's case.

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

I felt that Dr Nesbitt and Dr MCCord gave an open and honest account of what caused Raychel's death. As the meeting was on 3 September, I thought the Ferguson family were aware that Raychel's death was due to hyponatraemia. I recall Dr Nesbitt saying that she had got a little bit too much fluid but I cannot recall the exact conversation.

(20) With respect to the following statements: ***"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"*** **and** ***"some clinicians evidently feel that No.18 is the fluid they wish to prescribe, and have disagreed with the regime suggested"*** **(Ref: 021-057-137) please state:**

(a) How and when did this ***"problem in the Children's Ward"*** **become established;**

I was not aware it was a problem at that time.

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

The practice was in place when I joined the Children's Ward.

(c) Why was it tolerated to continue;

It was not apparent that it was problematic.

(d) Was it reviewed;

I was unaware.

(e) Who disagreed with the suggested regime change and for what reason?

I do not know.

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

(a) Whether you attended this meeting;

No, I did not attend.

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

No.

(22) 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 did not attend.

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

No.

(c) Whether you were aware of the commissioning of expert reports from Drs. Jenkins and Warde?

No.

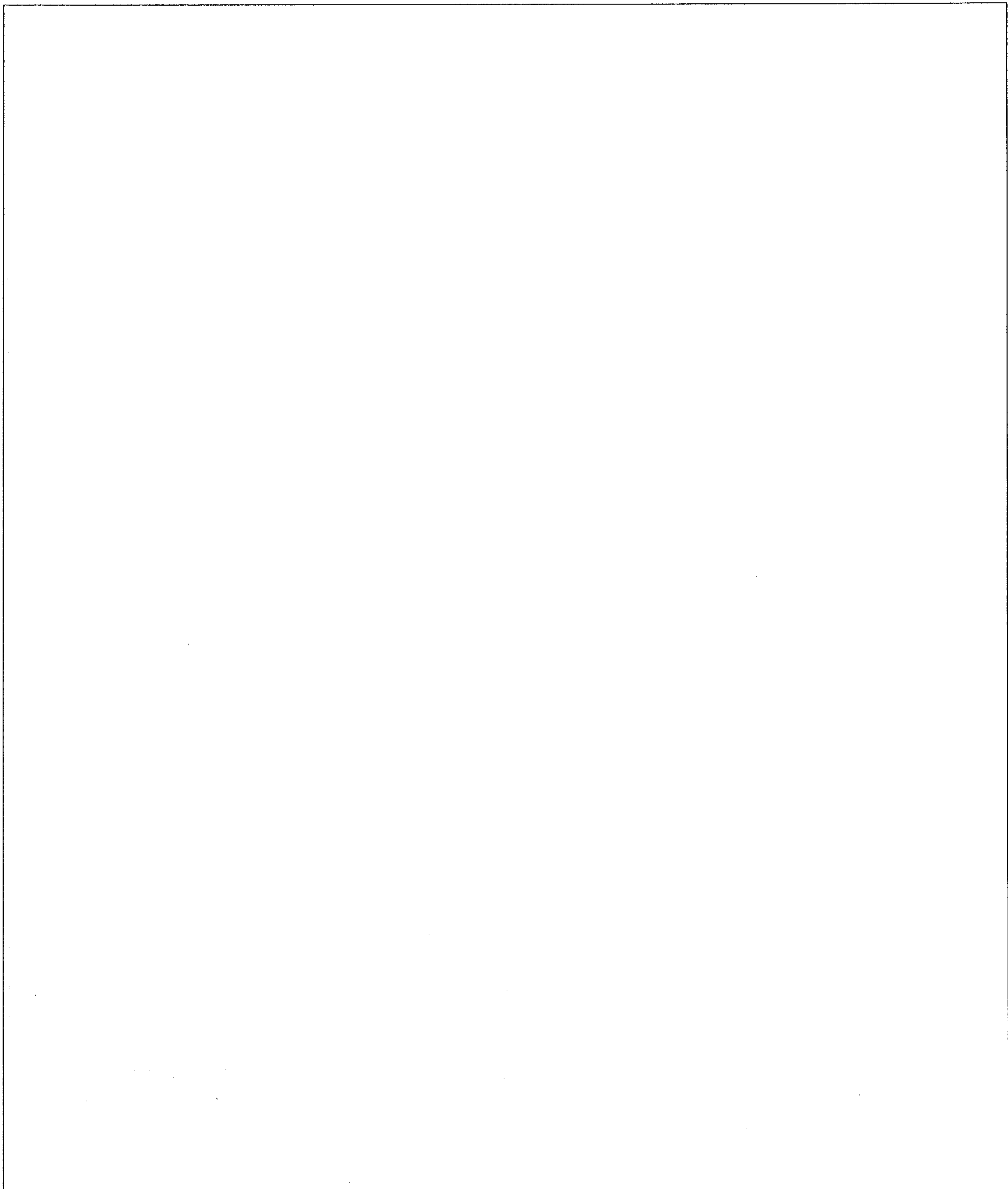
(23) Please confirm whether the *"Textbook of Paediatrics"* by Forfar and Arneil was available to clinicians and nurses on Ward 6? If not please confirm which textbooks were available.

The 'Textbook of Paediatrics' was available on the Children's Ward.

(24) Please outline all training you had received and your relevant experience in drug administration as at June 2001.

I was trained in drug administration throughout my student nurse training (April 82 - 85). I regularly administered medications on Ward 6 and had attended IV drug administration training at that time.

(25) Please provide such further comment as you think relevant. It would be of very considerable assistance if you could attach any documents you may hold which may be relevant to procedures, strategies, policies or any such issues as you think may be relevant.



THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed:	Jill Noble	Dated:	25/6/13