Witness Statement Ref. No. 056/3

NAME OF CHILD: Raychel Ferguson

Name: E. Millar

Title: Ms.

Present position and institution:

Retired

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

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

Ref:	Date:	
WS-056/1	30.06.2005	Inquiry Witness Statement
WS-056/2	20.06.2012	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);

Please see attachment

(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);

Meetings with Ward Managers and the Clinical Services Manager took place monthly. Ward Managers from both Paediatrics and the Maternity Department attended. Agenda included topics such as information cascaded down from Senior Management, Health & Safety issues, Infant Feeding, Breast Feeding, UKCC PIN numbers, staffing issues etc. Meetings minuted.

Paediatric ward staff meetings were held 3-4 monthly. Agenda included topics that arose from the monthly Clinical Services Manager meeting with Ward Managers, also issues pertaining to ward practice, Health & Safety, Environmental issues, Infection Control, Staffing, Training days, new equipment etc. Meetings were all minuted. For those who could not attend the minutes were displayed on staff notice board.

Meetings with staff of the Paediatric Day Care and Paediatric Outpatients also took place 3-4 monthly. These meetings were separate to the main ward as the issues that arose for discussion in these areas were different to that of the ward. Meetings minuted.

Meetings took place 3-6 monthly *with the Nursing Auxiliaries / Carers.* Meetings minuted. Agenda included Training, Environmental issues, children's menus, Health & safety etc.

(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 structures?

Nursing related committees and groups in place in 2001 were:

Northern Ireland Paediatric Benchmarking Group

Meetings held every 4 months. A nurse representative from each Paediatric Unit in Northern Ireland was a member of the group. Altnagelvin was represented by a junior sister. The group benchmarked their present practices on a topic against best practice statements that were outlined as key factors. Objectives were to improve standards of care and to standardise them throughout the Paediatric Units within the province. Some of the issues looked at were:

- Pain Management in Children

- Accident and Emergency Provision for Children

- Transfer of the Critically Ill Child

Although not an actual member of the above group I had close liaison and discussion with the nurse who represented our department.

Queens University Partnership Group

Meetings were 4 monthly, a representative from the Paediatric Department was a member of the group with whom I liaised with. The group was set up to review the practices for Paediatric Student Nurse training. The group also looked at placements for student nurses within the Paediatric Units in Northern Ireland to ensure that during their time on placement their objectives were met.

Quality Improvement Meetings

Meetings took place in late 1990's. All areas within the Paediatric and Maternity Departments were represented. The Clinical Services Manager chaired the meetings. The objective was to improve the quality and standard of care by looking at issues e.g. Self Care of the Child with Diabetes, Visiting Policy, Parents Accompanying their Child to Theatre.

Paediatric Clinical Management Meeting

Meetings held intermittently in late 1990's. The Clinical Services Manager chaired these meetings. These meetings were in liaison with the School of Nursing. A representative attended from the Paediatric wards and also the Paediatric Nurse Tutor was present. Issues included at that time:

- Paediatric Nurse Training

- Training and Development of Staff

- Staffing

- Dependency Levels of Patients

- Amalgamation of Wards 10 and Infant Unit

I attended these meetings, in my absence a representative attended.

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

Yes, AHHSST had adopted the concept of family centred care in 2001. Family centred care was always included in Paediatric Nurse Training but its importance evolved and became more emphasised from the mid 1980's.

Paediatric Student Nurse training was very much focused around family centred care and the importance of working in partnership with parents. The concept was practised daily on the Paediatric ward by involving parents in their children's care. It was also emphasised to staff on inducting them to the Unit, and in the drawing up of individual care plans for patients. The

Northern Ireland Children's Charter and the NAWCH Charter (National Association for the Welfare of Children in Hospital) had been published in the 1980's / 90's and both these included guidance on family centred care.

(3) From a 2001 perspective, please detail:

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

As I am retired I am unable to recall the exact funded establishment of the Unit at the time, however it consisted approximately of:

- 1 G Grade Senior Sister
- 2 F Grade Junior Sisters
- Approximately 15 E Grades
- Approximately 20 D Grades
- Approximately 8 - 10 Carers
- 1 Ward Clerk
- 1 Play Therapist

On an average daily basis the preferred staffing would be :

Days a minimum of 9 - 10 trained nurses

a minimum of 2 - 3 carers

Nights a minimum of 5 trained nurses

a minimum of 2 carers

As I am retired it is difficult to obtain guidelines re children's wards staffing levels at that time, 1990's - 2000

The above staffing levels may fluctuate because of staff sickness or patient dependency. If this occurred staff would be re-allocated to areas depending where the sickest patients would be. It may be necessary to allocate a 'special' (1 to 1 nursing), in these cases extra staff may also be requested to move from the Day Care Unit or Outpatient Department if they were not busy. Ward Managers almost on a daily basis have to replan staff rotas due to staff sickness or increasing numbers of patients. Patients attending Out Patient clinics in Belfast or sick children being transferred to Belfast will require a nurse escort, subsequently leaving reduced staffing levels within the department. Staffing also will require reviewing if the Unit is very busy.

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

I cannot recall exactly, however I do know that for some time prior to Raychel's death there was a difficulty in recruiting children's trained nurses, there was an overall shortage in

Northern Ireland at that time and indeed in the UK mainland. During the winter months, due to 'winter pressures' when bed occupancy could be almost 90 - 100%. Staffing levels were often below of that required. Concerted efforts to recruit were made by advertising in the Paediatric Nursing magazines to try and recruit from the UK mainland. During this time the staff on the ward were frequently requested to do extra shifts, which they undertook if they could.

In 2002 Nursery Nurses were recruited following continued difficulties to recruit Children's Nurses.

(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;

Cannot recall. Do not have access to the rosters nor to patient /occupancy levels at that time.

(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

(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);

There was no formal monitoring in place at that time to gauge parental satisfaction. The Nursing Philosophy of the Unit was wall mounted, and leaflets were available informing parents of the Patient Advocacy Service and their right to complain about any issues in the care of their child that they were not happy about. Parents had the opportunity to voice concerns to nurses, Sister, or doctors at any time. Nursing and medical staff were astute in recognising those parents who may not be happy with the care their child was receiving. As a Ward Manager, I was continually observant in recognising those parents who may have appeared to be 'anxious' and my objective was to communicate with these parents before their anxiety escalated.

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

All staff had 1-2 yearly appraisal, (IPR, Individual Performance Review) at that time. Staff had the opportunity to sit down with their line manager to discuss their individual personal and professional development. It was also an opportunity for the line manager to discuss any weaknesses in the individual's performance. From the collective IPRs the training and development needs of staff were identified and brought forward to the Clinical Services Manager who linked in with the Educational Institutions.

There was ongoing mandatory training within the Trust for all staff e.g. CPR, Infection Control, Moving and Handling etc.

Formal Clinical Supervision was not at that time established for all staff.

All new staff had a mentor assigned to them on taking up their post.

Staff also had training in the use and management of any new equipment introduced to the ward. Training was carried out by the medical reps.

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

As I am retired, I cannot recall and have no access to protocols / policies.

(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?

All registered nurses had a responsibility to maintain their knowledge and skills under the UKCC Code of Conduct. They also had a responsibility not to deliver care outside their scope of professional practice. The Trust had a responsibility to aid staff in maintaining their skills and knowledge and also to their personal and professional development. See Q3 (f).

(5) In respect of nursing matters:

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

No, on days staff were allocated to designated areas on the ward and on nights the staff worked as a team for all the patients.

(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;

No, not aware of any at that time.

(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 the whole of Altnagelvin site.

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

No

(e) How were you assured of the knowledge, competence and suitability of nurses to work with children;

All nurses achieved a 3 year Nurse Education Programme in which they attained the skills and knowledge to deem them fit to go on the Professional Register. At this time Altnagelvin endeavoured to recruit children's trained nurses for the Paediatric Department, however if unable to do so Adult Registered General Nurses were recruited and given a longer mentorship period to ensure they were competent to work with children. If mentors or indeed senior staff identified concerns relating to any staff member these were brought to my attention. These staff might require further training and mentorship.

(f) How were you assured that nurses kept up to date with current practice;

1. Assessing knowledge during appraisal

2. Mandatory training attendance

3. Cascading knowledge down from groups pertaining to Paediatric Nursing e.g. Benchmarking Group

4. Provision of Education training from Education Consortium (Yearly requests made via Clinical Services Manager)

5. Feedback from staff after training

6. Updates at Handovers

7. Staff Notice Board

(g) What was your role in relation to monitoring the sickest children on the Ward;

It was the duty of the Nurse in Charge when a sick child was identified:

1. To ensure the nurse / nurses caring for the child were fit to do so

2. If a patient required specialing (1 - 1 care) allocate competent nurse to do so

3. Inform Medical staff - if they were not already aware

4. Ensure observations e.g. vital signs etc were carried out as required e.g. hourly, 4 hourly etc. and if abnormal escalate to Nurse in Charge / Doctor

5. Ensure documentation is completed

6. Communication with parents - informing them and listening

7. Reassurance of patient and parents

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

No formal monitoring in place at that time. Auditing of care and procedures was being carried out at that time but was mostly ad hoc. 'Pain Management' in children and 'care of iv cannulas' were 2 on going audits at that time that I recall.

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

I am not aware, it was a Trust decision

(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;

The guidance provided to staff was to check when patients could commence oral fluids post operatively and to record what was tolerated. Staff were also told to note when the patient first passed urine and to record same.

(b) The prescription and administration of intravenous fluids;

Nursing staff were to ensure that IV fluids they erected were prescribed by medical staff (the amount, the type of fluid, the rate per hour). Nurses were responsible for administering and erecting the IV fluids prescribed. 2 nurses checked the fluid that was prescribed on the back of the fluid balance sheet (the type of fluid, the amount, the rate per hour, serial number of pump, batch number of IV fluid bag, date of expiry) both nurses signed the prescription in

space provided and documented the time erected.

Before connecting the IV fluid both nurses checked that the correct patient was receiving the correct IV fluid by checking the name, date of birth and hospital number on the patient ID band with that on the fluid balance sheet.

(c) Recording weights in children;

Weighing all children on admission was a core requirement within the Paediatric ward. Those children too ill to weigh had their weight calculated by medical staff according to the formula within the Advanced Paediatric Life Support (APLS) Guidelines. All Paediatric nurses were aware of the importance of weighing children as all medicines, IV fluids, infant feeding requirements are calculated according to the child's weight.

A child's developmental progress is also documented using their weight and height on the appropriate growth charts. Non Registered nurses had to have the weight checked and verified by a Registered Nurse.

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

This was the responsibility of the medical staff.

(e) The treatment of vomiting in children;

1. Record episodes of vomiting in fluid balance sheet

2. Observation of vomitus, any blood, coffee ground etc.

3. Report to Nurse in Charge of Area, Ward Sister or Doctor of continuing episodes.

4. Observation of patients condition e.g. any deterioration

5. Call Doctor to give IV Antiemetic if required

6. Keep patient comfortable, personal comfort, change bed clothes etc.

7. Provide vomit bowl, tissues, mouthwash

8. Reassurance to patient and parent

(f) The documentation of vomiting;

In 2001 and up to that period it was acceptable for nurses to document vomits as small, medium, large or as +'s. On seeking information from other units at that time with regards documentation of vomiting in Paediatric Areas it appeared that this method was also used in those areas.

(g) Caring for children with headaches and listlessness;

Documentation, e.g. vital signs, description of headache if able ? age of child

Report to Nurse in Charge

Report to Doctor

Pain relief as prescribed

Reassure patient

Reassure parents

Record and report any change in patients condition, e.g. increasing drowsiness, pain, disorientation, no improvement in patients condition

Ask Doctor to see again

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

On admission, children were individually assessed and care plan allocated according to each child's individual needs. Thereafter, staff were advised to update and evaluate care against the care plans, and document the child's care and progress throughout the time frame of the nursing shift. Additional problems arising were added to the care plan or those that were no longer of consequence could be discontinued.

Nurses endeavoured to update and evaluate care plans during the shift, however a summary of care delivered throughout the shift may only have been documented towards the end of the shift.

(i) Communication with parents;

There is ongoing communication with all parents both by medical and nursing staff during a patient's stay. Caring for sick children is very much in partnership with the parents or indeed, aunts, grandparents if present. It is a continual process during a patients stay.

Doctors see each child on the daily ward round, and nurses would go back to parents to explain treatment and care if a parent requests or indeed if there were doubts with regards the parents understanding of their child's condition.

Parental anxiety was included in the core care plans and any known fears or concerns parents have was documented. Nurses also observed if parents were anxious and documented accordingly and also reported to the Nurse in Charge if they themselves couldn't successfully reassure the parents.

(j) Recording communication with parents;

All verbal interactions with parents were not documented. However where concerns were noted or if parents had complaints or concerns with regards their child's care, this was documented under parental anxiety in the care plan. If a doctor spoke to parents by request of a nurse or parent this should be documented by both nurse and doctor in the notes. Doctors and nurses when seeing a patient on the ward round or at any other time were expected to date and time the visit / examination in the patient's notes.

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

The ward rounds were the opportunity to report on general patient's progress to senior doctors and Consultants.

Outside of the ward rounds, nurses contacted junior medical staff in the first instance at that time if there were concerns that needed escalated.

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

Recording contact, attempts to contact and information given to junior doctors was not always recorded as it was unusual for a doctor not to respond to his / her bleep. Nurses would persist in contacting doctors if they had difficulty in getting a response from a bleep. Nurses were advised to follow through on the doctor's advice and if they had concerns about the doctor's advice they were told to escalate it to the Nurse in Charge.

(m) The conduct of handovers;

Main formal handovers were at changeover of staff at 7.45am and 7.45pm. The Nurse in Charge of each shift would give the handover to all the staff.

Following the morning ward round it was the custom to give a handover to the staff caring for the patient in each area. There was continuing communication between nursing staff during the day outside of formal and informal handovers.

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

On admission each patient was allocated a Named Consultant as per on call rota. The name of the patients Consultant was on a card at the head of the patient's bed. To contact a senior doctor within the Consultants team, nurses went through switchboard and asked for the surgical registrar or paediatric registrar.

(o) The completion of patient records;

All records should be completed appropriately, concisely and timely, dated and signed.

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

Nursing staff were advised if they had concerns with regards the care and treatment of patients by medical staff, to voice their concerns to senior nursing staff including myself.

During my time as a senior nurse and Ward Manager I had from time to time reason to raise such issues with medical staff. It was not a frequent scenario but it was a responsibility that nurses in Paediatrics took seriously. People did raise concerns, but it was not known as whistleblowing.

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

Doctors were bleeped if there was a delay in their arrival for ward rounds. Outside this, doctors were bleeped via switchboard, if you had patient concerns. However if you had the bleep number of the doctor you entered it, followed by your extension and an automated message told you if your bleep call was successful.

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

At that time nurses were advised to contact the junior doctor in the first instance.

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

In the death of a patient following surgery, I had never experienced such an incident at that stage in my career. I would expect that all aspects of nursing care would be examined in such an untoward incident. The untoward incident form would be forwarded to the Risk Management Department with the appropriate statements. The investigation would be led by Risk Management Department in conjunction with relevant others. Nurse management would also be informed.

(7) Please describe your role and responsibility in respect of clinical governance and quality assurance, as at 2001.

Clinical governance was new terminology in 2001. As a manager it was my responsibility to ensure safe and effective practices were in place on my ward. Standard setting and auditing practices were in place although not continuous.

(8) 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;

Regarding 8 (a) - 8 (d), at that time I was not aware of there being a corporate systematic approach to nursing / multi-disciplinary audits. The organization had been through a model within nursing of standard setting and auditing against the standards that were developed in the different departments. At that time within Paediatrics we were also auditing and gathering information on workforce related matters to provide evidence on what were the gaps in our service.

(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?

I cannot recall.

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

See answer to Q (8)

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

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

(b) Paediatric Intensive Care Society;

(c) Department of Health;

(d) Audit Commission;

(e) General Medical Council;

(f) DHSSPSNI;

(g) HPSS;

(h) Management Executive.

If communication / recommendations were to be shared from the sources cited in (a) - (h) the process in place at that time was that the Clinical Services Manager shared any relevant information with Ward Managers either at the Sisters meetings forum or individually. The Ward Manager then shared the information with ward staff either at the staff ward meetings, at handovers or noticeboard.

(11) Please particularise all steps taken to investigate the care, treatment and death of Raychel Ferguson, and specify those steps taken by you.

Risk Management Department took the lead in investigating the care, treatment and death of Raychel. I carried out any requests made to me from the Department i.e. requesting statements from staff. I attended the Critical Incident Review Meeting on June 12th 2001.

(12) 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;

Following Critical Incident Meeting:-

1. Sol 18 is no longer suitable for use and was taken out of the ward

2. Surgical patients to have electrolyte profile prior to theatre, intraoperatively and 12 hours thereafter, and every subsequent 24 hours thereafter if patient stable

3. Accurate documentation of Fluid Balance Sheet

4. Strict measurement of urinary intake and output

I am aware that Raychel's case was highlighted at teaching sessions on IV fluids however I have no access to records.

(b) Those steps taken to utilise the learning?

Informing staff of changes by educational sessions within Altnagelvin Hospital (Dr Nesbitt)

At Handovers

Staff Meetings

Notice Board

At induction for new staff

(13) Regarding the Chief Executive's email to the Chief medical Officer dated 3rd June 2004 (Ref: 023-021-048) and her statement that ***"Altnagelvin heard a 'rumour' from Paediatrics Intensive Care Unit that the 'wrong fluids' had been used. This 'rumour' emerged from a nurse in Paediatrics Intensive Care Unit responding to an enquiry from Altnagelvin's Ward Nurse on the child's state, on the Sunday."*** **Please detail:**

(a) The identity of the Ward Nurse;

I do not know.

(b) Whether a record was made of this;

Do not think so.

(c) All that you know about this;

I did hear this 'rumour' on return to the ward on the morning of June 12th. I initially thought that a nurse from the Paediatric ward had accompanied Raychel to Belfast but this was not correct as it was apparently a nurse from ICU. The 'rumour' was vague and I was not familiar with nurses in the ICU and Theatres in Altnagelvin. I was not aware of the enquiry on the Sunday.

(d) Whether it prompted any further communication with the Paediatrics Intensive Care Unit?

Not that I am aware of.

(14) 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;

Do not recall, it was in the afternoon.

(b) Whether the Clinical Incident Form was completed;

Do not recall.

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

Cannot recall, but think the Director of Nursing and the Clinical Services Manager were in attendance. Clinical Effectiveness Co-ordinator - cannot recall.

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

All records / documentation relating to Raychel were forwarded to Risk Management Department or collected from ward, immediately.

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

Not sure. I understand this may have been compiled by Risk Management Department.

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

I did not organise the meeting, and therefore did not compile the lists of invitees. I do not know if any records exist to identify those present.

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

I do not know.

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

I do not know.

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

I do not know.

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

I had no knowledge of potential litigation at any time.

(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 knowledge.

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

Do not recall. I took no notes.

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

Do not recall, I did know that Dr Nesbitt was to contact other hospitals to ascertain what their practice was regarding Sol 18 in their Paediatric Areas.

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

I had no recollection of other meetings but was prompted by other statements that a Review meeting was held on April 9th 2002 at which I was present. My name was on list of those who were present.

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

I did not receive any report.

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

I do not recall.

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

I cannot recall, but do know that the family were contacted after the Clinical Incident Meeting inviting them to meet with the senior management from AHHSST and those who cared for Raychel. The Ferguson Family did meet in September 2001 with Hospital Management and some of those who cared for Raychel. I do not know why the meeting did not take place earlier.

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

I do not know.

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

Initial action to be taken by me after Critical Incident Meeting was:-

1. Arrange daily u/e on all post-operative children receiving IV fluids on Ward 6.

2. All urinary output to be measured and recorded while IV fluids in progress.

I did the above by informing staff through notices on the ward, at handovers and at ward meetings.

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

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

Do not recall.

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

No, do not recall.

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

Don't recall.

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

I remember the vital signs observation sheets and fluid balance sheet being discussed. I do not recall exact discussion. Concerns were raised regarding the documentation on the fluid balance sheet e.g. urinary output, oral intake and description of vomits.

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

Do not recall.

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

Not that I recall.

(16) 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;

Do not recall.

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

Do not recall.

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

Yes, I spoke frankly with regards to this problem. It was difficult to get doctors to come to do ward rounds in a timely manner, and I also referred to when challenges arose if surgical doctors were in clinics or theatre.

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

Do not recall.

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

I cannot recall the detail of the conversation, but from other statements I do believe it was mentioned.

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

Discussion did take place with regards Raychel's vomiting e.g. the amount, frequency and documentation as far as I can recall.

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

Discussion did take place regarding electrolytes but I cannot recall what was said exactly.

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

Documentation of the fluid balance sheet was deemed to be unacceptable regarding urinary output, oral intake and vomiting.

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

Cannot recall.

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

Cannot recall, but do not think so.

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

See point (g)

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

See point (h)

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

Do not recall.

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

Cannot recall.

(o) The content and update of episodic care plans;

Cannot recall.

(p) The efficacy of the bleeper summonsing system;

Cannot recall.

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

I was vocal in saying that I felt the nursing staff at times had more responsibility than they should have in caring for the surgical children, e.g. initiating care such as prompting introduction of oral fluids, discontinuation of IV fluids etc. (also see 16(c))

(r) 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;

I cannot recall.

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

'Rumour' was mentioned, I cannot recall what was said but I think Dr Nesbitt was to contact RBHSC.

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

Only the 'rumour' as of 16 (s).

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

I do not recall.

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

See Ref 026-004-005

See Ref 022-097-308

(18) 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 attended as the Senior Nurse on Ward 6, I was also on duty on June 8th when Raychel was a patient. I was notified of the meeting, I cannot recall if I was aksed to attend. I was not sure of my role but I was open to answer any questions / explanations if required. I understand the meeting would be chaired / led by Mrs Burnside and medical staff.

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

I cannot recall the questions asked by representatives of the Ferguson family, but I do remember Dr Nesbitt and Dr McCord answering questions put by a lady member of the family, not Mrs Ferguson. I believe those questions were answered sympathetically and factually so the family would understand the medical terms involved.

(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;

Cannot recall exactly what was said but I think that Dr Nesbitt and Dr McCord were open and honest, that is the overall feeling I came away with.

(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;

As said I cannot recall details of the meeting but my overall impression at the time was that they did. I recall Dr Nesbitt saying 'we have learned lessons' so to me he was acknowledging deficiencies.

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

I believe I did not discuss this action plan, as a lot of information had been shared at this meeting and it was my opinion that I was only going to be repeating things that had been said by others, which would have served no purpose.

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

I did not receive a minute of the meeting at that time. As so much time has lapsed in the interim period I do not have clear recollection.

(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 am not aware of meeting in September 2001, I do know that Dr Nesbitt was involved with others within the Trust and outside in deciding the way forward with the administration of IV fluids in children.

(h) With respect to your statement "*I felt I was not able to give the family the reassurance and explanations that I would have wished*" (Ref: WS-056/1 p.7) please outline those explanations?

See Ref W5-056/2 Page 17, 11 a and b

(19) 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)?

Regarding 19 (a) - 19 (e), I received copies of these reports a few weeks prior to the Inquiry, not sure of the date.

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 consideration was given to sharing the content of these reports to the Ferguson family.

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

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

Mrs Witherow was involved with others in reviewing the IV fluid sheet. Over time the sheet used had amendments made.

(b) Were you involved in the nursing discussions relating to fluid balance management in the light of the Critical Incident meeting;

Yes, see Ref 022-097-308 Point 4

(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;

No one person was responsible for 'incorrect' completion of the fluid balance sheet, it was acceptable at that time to allow nurses to use +'s to document vomit and urinary output. After Raychel died it was recognised that more specific documentation was required, e.g. measurement of urinary output, oral intake, and all urinary output documented not just the first urinary output following surgery.

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

I believe the stock for the Children's Ward was depleted. The stationery stock was ordered through the Stationery Department in Supplies Department in Gransha. The fluid balance sheets were supplied to the Stationery Department by Limavady Printing Company. There were times

when there was a problem in obtaining these from the Stationery Department but these episodes were infrequent. The Neonatal Unit used the same fluid balance sheet as the Children's Ward, the only difference being the heading and the colour of the sheet.

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

There was no formal training. The method of sharing these messages with staff was communication. Nursing staff were to ensure surgical doctors signed when discontinuing IV fluids for children. Staff were informed of the above at handovers, staff meetings, notices being put on ward noticeboard. Senior nurses initially were involved in ensuring all staff were informed. I had the responsibility of ensuring the above was initiated and carried out. This practice of sharing this communication was in place for many months. Thereafter staff returning from sick leave / maternity leave were informed on their return.

(f) How the agreement in respect of fluid balance management was implemented and reviewed;

Implemented through informing staff verbally, at handovers, ward meetings, ensuring those who took charge or ward were aware of same and could cascade information down. Snap shot audits initially and formal audit later.

(g) 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 cannot recall if this was raised at the meeting (Ref Point 4) 022-097-308, and who made this point.

(21) Please provide the following information:

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

There had been on going appraisal and review of all staff performance who worked on Ward 6 before and after that time. This enabled Ward Manager and senior staff, to identify any concerns relating to staff performance and if identified to act on these concerns.

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

Cannot recall, but after June 12th or thereabouts.

(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;

Risk Management took the lead in the investigation of Raychel's death. Nursing staff participated in providing statements and any other information requested at that time. As we never had experienced any unexplained deaths, some nurses prepared a summary of their involvement and recollection promptly.

(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;

Cannot recall when. Dr Nesbitt did contact other hospitals including RBHSC after Raychel died to ascertain their use of IV fluids in children. I assume he was the one who informed me, I had ongoing communication with him following Raychel's death regarding IV fluids.

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

See 16 (c) and 16 (q)

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

Some clinicians may not have been very fluent in the English language, but I had no adverse experience of communicating with them or understanding them.

(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;

Until the regional chart came out actions were shared - Ref 026-010-011, and 026-009-010. A policy was drawn up for the Trust but it was not until after the regional chart was shared.

(h) Did you play any role in the revision or production of clinical protocols;

No.

(i) 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;

The practice was in place when I came to Altnagelvin in 1976 from the RBHSC where the same practice was in place, i.e. IV Sol 18 was the fluid of choice in children requiring IV fluids. It was seen as the 'safe' fluid as it contained some dextrose. I do not know who implemented the practice prior to 1976 and where monitoring was concerned I assumed the senior clinicians were responsible. As I had 35 years of nursing experience at that time and had never experienced any problems with the fluid I had no concerns regarding its use as I understand the medical staff had likewise.

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

I cannot recall exact details of the meeting with the family but came away with the impression that Dr Nesbitt had been open and honest about what caused Raychel's death and what we were doing as a Trust to try to ensure this would never be likely to happen again. Questions had been put to Dr Nesbitt and Dr McCord by a lady member of the Ferguson family in addition to Dr Nesbitt's explanations.

(22) ***"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;

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

(c) Why was it tolerated to continue;

(d) Was it reviewed;

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

The practice had been in place since I came to Altnagelvin in 1976. See question 21 (i)

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

(a) Whether you attended this meeting;

I do not recall the meeting of April 9th 2002.

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

No.

(c) Whether the monitoring of U&E values and fluid outputs was discussed?

I understand from the minute Ref 022-092-0299 that the u/e was mentioned. See Point 2 and 3. Urinary output was discussed Ref 022-092-0299 Point 4.

(24) Please state:

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

No.

(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.

(25) Please state whether you were responsible for the administration of drugs and intravenous fluids on Ward 6? If not please state to whom such responsibility was delegated.

All trained staff had the responsibility of administering drugs and IV fluids and as Registered nurses were accountable for their practice. Administration of drugs (medicine rounds) was undertaken by delegated senior member of staff. All medication administered to children was checked by 2 trained staff.

All administration and erection of IV fluids was checked by 2 trained staff.

I also had the responsibility of administering drugs and IV fluids when involved in the care of children. From the mid 90's onwards my involvement became less as I moved more into management.

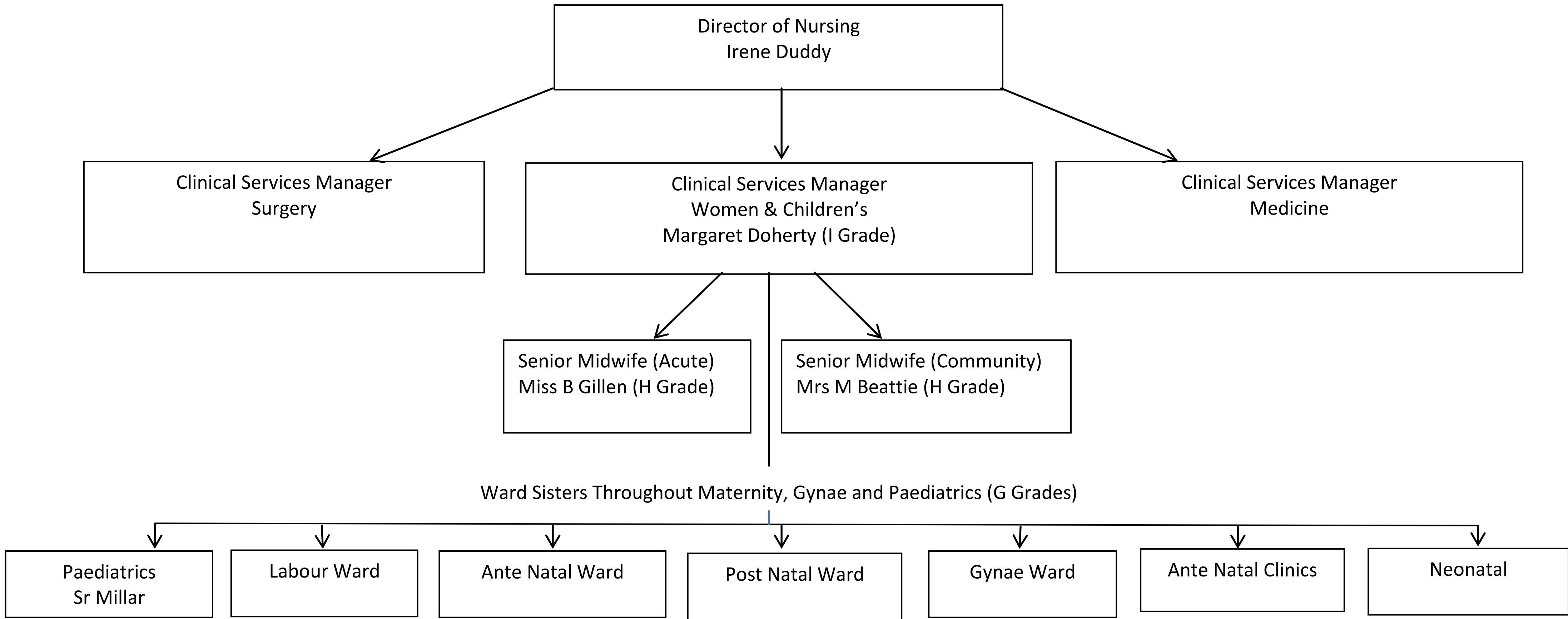
(26) Please confirm whether the *"Textbook of Paediatrics"* by Forfar and Arneil was available to clinicians and nurses on Ward 6? If not please confirm which textbooks were available.

'Textbook of Paediatrics' by Forfar and Arneil was available on the ward as were other textbooks and journals pertaining to the care and treatment of sick children.

(27) 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: E. T. Millar **Dated:** 8/7/13.



Director of Nursing
Irene Duddy
Clinical Services Manager
Surgery
Clinical Services Manager
Women & Children's
Margaret Doherty (I Grade)
Clinical Services Manager
Medicine
Senior Midwife (Acute)
Miss B Gillen (H Grade)
Senior Midwife (Community)
Mrs M Beattie (H Grade)
Ward Sisters Throughout Maternity, Gynae and Paediatrics (G Grades)
Paediatrics
Sr Millar
Labour Ward
Ante Natal Ward
Post Natal Ward
Gynae Ward
Ante Natal Clinics
Neonatal