Witness Statement Ref. No. 093/1

NAME OF CHILD: RAYCHEL FERGUSON

Name: Mr Stanley Millar

Title: Mr

Present position and institution: Retired WEF 1 June 2003

Previous position and institution: Chief Officer, Western Health and Social Services Council
[As at the time of the child's death]

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

- **Sargent Cancer Care for Children NI Advisory Committee (June 2000 - May 2003)**
- **Disability Living Allowance Advisory Board (NI) (January 1998 - December 2004)**

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

- **Reference to Raychel Ferguson in Statement on Lucy Crawford to PSNI on 25 April 2005**
- **Statement to UTV Insight Programme Recorded 16 June 2004**
- **Statement to BBC Radio Foyle Morning Show 19 March 2004**

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

Ref:	Date:	

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

1. **Explain the role and function of the Western Health and Social Services Council.**

The Western Health and Social Services Council was established out of "The Health and Social Services Councils Regulations (Northern Ireland) 1991" which came into operation on 1 April 1991.

Section 15 states "it shall be the role of each Council to keep under review the operation of the health and personal social services in its area and to make recommendations for the improvement of these services"...

The role includes advisory and support work on the operation of the NHS Complaints Procedure.

The Council does not investigate complaints. It does assist complainants in the documenting of complaints details and provides advice and support in lodging a complaint with the respective provider of the service for investigation.

In some circumstances the Council can advise a complainant to consider setting aside the NHS Complaints Procedure and directly seek legal advice on "alleged" negligence.

2. **How and when did you first become aware of the deaths of Raychel?**

On 23 August 2001 at approximately 9.20am a phone call was received in the offices of the Western Health and Social Services Council from a Kay Doherty. She explained she was calling on behalf of her sister Mrs Marie Ferguson who had a child die on 10 June 2001.

I personally returned the telephone call at 9.45am.

Kay Doherty explained:-

- **Her niece Raychel Ferguson (9 years) complained of a sore stomach on 7 June 2001.**
- **She was taken to Foyledoc GP Centre at Great James Street in Londonderry.**
- **The duty GP suspected appendicitis and arranged admission to Altnagelvin Area Hospital.**
- **The staff in the hospital were unsure of a diagnosis and admitted the child overnight.**
- **At 11.00pm the hospital telephoned her home to advise Raychel had been taken to Operating Theatre.**
- **She was back in Ward 6 after surgery at 2.00am on 9 June 2001.**
- **Later that morning it was reported she was in 'good form'.**
- **After lunchtime she vomited and complained of a sore head.**
- **Nursing staff advised the symptoms were routine after surgery.**
- **At 8.00pm she went to sleep and the parents went home.**

- **At 3.40am on 10 June 2001 the ward phoned the home to advise Raychel had "a seizure".**
- **Mr Ray Ferguson – father of the child rushed to the hospital and witnessed another fit.**
- **Raychel was intubated in Intensive Care Unit and a reference was made to *low sodium levels*.**
- **Her pupils were fixed and she was transferred to the Royal Belfast Hospital for Sick Children.**
- **At 12.10pm on 10 June 2001 the life support system was switched off.**
- **A Coroners Post Mortem examination was completed and the brain was removed.**

Kay made a reference to "queries/suspicions about the frequency of sodium level checks in Altnagelvin".

Particular areas of interest (Cont'd)

3. Describe in detail your concerns when you first heard about the death of Raychel Ferguson to include the steps you took to communicate your concerns to others and the reasons for the same.

I explained the two possible routes to follow with a complaint:-

(1) To invoke the NHS Complaints Procedure or

(2) A legal challenge of alleged negligence.

On further reflection on the details shared by Kay I advised the following approach:-

(1) To go to a solicitor with a request to follow up an allegation of negligence.

(2) This action would however have negated the formal NHS Complaints Procedure and informal contact with Altnagelvin would cease.

(3) I undertook to draft a letter to the State Pathologist Professor Crane for Mr Ferguson to sign. The letter to request sight of the PM Report.

(4) I undertook to draft a second letter to the Patient Advocate in Altnagelvin Hospital for Mr Ferguson to sign. The letter to request a copy of Raychel's Case Notes.

(5) I pledged the continuing support and advice of the Western Health and Social Services Council.

(6) I suggested Derry City Councillor and Member of the Western Health and Social Services Council Mrs Helen Quigley would make contact with the family and provide a local support.

I telephoned Mrs Quigley to advise of the case and on 30 August 2001 faxed her a copy of the memo of my initial conversation with Kay Doherty. I was aware Mrs Quigley did establish and maintain a contact with the Ferguson family.

I learned Mr Ferguson was invited to attend a meeting with Altnagelvin staff during the week following the contact with the Council.

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]

On 18 October 2001 I telephoned Mr and Mrs Ferguson to check on progress with the complaint. Due to the legal process the Council was a third party and had no direct access to information.

I understood the Post Mortem reports were completed in November/December 2001.

On 22 January 2002 I telephoned Kay Doherty to acknowledge receipt of a copy of the PM reports. On reading the details I shared with Kay rumours circulating in HPSS in NI regarding the use of drip solutions. I suggested questions which had to be asked:-

Did Royal Belfast Hospital for Sick Children withdraw use of the solution given to Raychel?

If so what was the date of the withdrawal?

Were other hospitals including Altnagelvin notified?

Kay advised an inquest was to be scheduled. I reflected on the contrast to the Lucy Crawford death. The family were also to meet Mr Lecky Coroner for Greater Belfast.

On 4 July 2002 I telephoned Kay to establish whether the Coroner's Inquest had been scheduled on Raychel Ferguson. Kay confirmed the Inquest had been postponed at the request of Mrs Marie Ferguson until October 2002 at the earliest.

On 28 January 2003 Mr Billy Page Derry City Councillor and Member of the Western Health and Social Services Council telephoned to ascertain what financial support was available for Mr and Mrs Ferguson to meet an anticipated cost of £2,500 for the "Inquiry" - which I understood to be the Coroner's Inquest into Raychel's death. I alerted Mr Leckey's office to this matter on 5 February 2003 by letter.

Following the completion of the Coroner's Inquest in Belfast I was confident it was timely to engage with the Altnagelvin Trust to discuss concerns held by the Western Health and Social Services Council. I wrote to Mrs Stella Burnside Chief Executive of the Trust on 14 February 2003 to request a meeting.

The request was granted and I with a representative group comprising the Council Chairman and five Members met the Trust Chief Executive, Director of Nursing and the Medical Director in the hospital boardroom on 19 February 2003.

The Council representatives had an opportunity to enquire about the care provided to Raychel, the input by senior doctors, the monitoring of sodium levels, the reporting procedures to the Chief Medical Officer in DHSS, and the issuing of guidelines to other hospitals. The meeting received copies of the Trust's Press Release.

Mrs Burnside shared details of the Coroner's Inquest. Dr Nesbitt through a PowerPoint presentation explained the sequence of circumstances which led up to Raychel's death. This was the first explanation of the condition Hyponatraemia.

The details shared by Dr Nesbitt confirmed a suspicion in my mind of a similarity with the events leading up to the death of Lucy Crawford.

I felt I carried a heavy responsibility of being perhaps the only person who was in a position to understand the events of both tragedies. I wrote to Mr Lecky on 27 February 2003 to pass on my suspicions of the similarities as I understood them.

I did not have any contact with the Ferguson family after the telephone conversation on 4 July 2002. I retained a confidence that their interests were being protected through their legal representatives.

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

Signed: Stanley E McMillan **Dated:** 13 August 2005