Witness Statement Ref. No. 286/2

NAME OF CHILD: RAYCHEL FERGUSON (Preliminary)

Name: William McConnell

Title: Dr

Present position and institution: Retired

Previous position and institution: Director of Public Health, Western Health and Social Services Board

[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 2000 - December 2012]
See previous statement.

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]
WS-286-1 November 2012

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

Ref:	Date:	
WS-286-1	rec'd 21-Nov-2012	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

I. Queries Arising out of WS-286/1

(1) In answer to 7(c) you have referred to your responsibility to advise the Western Health and Social Services Board and its Health Care Committee of Lucy's death. Please address the following matters:

(a) Who in the WHSSB did you make verbal reports to and what did you report? I would have given reports to (i) The Chief Executive [C. Ex.] and Director of Health Care [DHC] of the Western Health and Social Services Board [WHSSB]. I would have reported to the C. Ex. and DHC the facts, as known to me at that time, about Lucy's death and related further issues of note regarding the investigation of her death by Sperrin/Lakeland Trust and that it had been reported by the Trust to DHSSPS. I would then have contributed to further reports made by the C. Ex. and/or DHC to (ii) The Health Care Committee of the WHSSB (iii) The WHSSB

(b) Was any action taken by the WHSSB on foot of the verbal reports that you made, and if so what action was taken and who took it? Discussions relating to Lucy's death and the further investigation of it were taken forward with S/L Trust staff by the C. Ex., the Director of Health Care and by me. These would have covered the action within the Trust and ongoing discussions between the Trust and DHSSPS. At a later stage, I believe in 2004 following the Coroner's inquest, the WHSSB designated Mrs Margaret Kelly, Chief Nurse of the WHSSB to represent the WHSSB on the "Root Cause Analysis" relating to events relevant to Lucy's treatment and death.

(c) (d) What was the function of the Health Care Committee of the WHSSB, how often did it meet and who was its Chairman in the period from April 2000? The Health Care Committee (HCC) was one of the main sub-committees of the WHSSB. From memory, the Chair of the Health Care Committee in 2000 was Mrs Anne Mark and, later, Ms Karen Meehan.

(d) In the period from April 2000, identify the persons who were members of that Committee. I do not now have relevant detail of its role/functions or the membership in the period from 2000 until the Board's replacement at the re-organisation of 2009 but I understand that all relevant Board papers covering that time have been provided to the O'Hara Inquiry following 2 "trawls" of WHSSB records from that time.

(e) What was your purpose in making a report to that Committee in relation to the death of Lucy Crawford? Both the WHSSB and its HCC would be advised of

major/significant events relating to the Commissioning of health care services or other health matters within the WHSSB's area in order to be aware of them and to debate, endorse and agree actions taken or proposed to be taken by WHSSB staff.

(f) **Specify the dates or the approximate dates when you made such verbal reports.** I have reviewed the records of the Board and Health Care Committee meetings as obtained from the "trawl" of available records from 2000 until 2005. These records indicate that relevant/related discussions took place on the - [Board] - 25th March 2004 – under Matters arising - [arising from Admin Services of 25th Feb 2004]; 30th September 2004 – page 6 ; 25th November 2004 Pages 4 & 5; and [Health Care Committee] – No directly related minutes found. I also contributed to related discussions at Admin. Services Committee discussions which were then followed up at Board meetings.

(g) **As precisely as possible, provide details of what you told this Committee about any issue relating to the death of Lucy Crawford on any occasion when you made a verbal report.** In addition to the "trawls" carried out which I have referred to above, I have personally inspected the records of the Health Care Committee from early 2000 until the end of 2004 and have found no detail of any report specifically given by me, the DHC or the C. Ex. The discussions in which I and others were involved related to updates on the progress of the investigations and "Root Cause Analysis" being carried out within S/L Trust and to issues such as (i) note taking and retention regarding clinical incidents and medico-legal cases, (ii) events related to the Coroner's Inquest and his further action, (iii) the O'Hara Inquiry itself and (iv) the development of formal procedures for notification of "clinical and untoward incidents"

(h) **Was any action taken by the Committee arising out of the verbal reports that you made? If so, outline the action that was taken and identify the person(s) who took it.** See answer to Question 1 b above.

(i) **Please arrange for the Inquiry to be provided with all relevant minutes of the Health Care Committee.** I understand that the Inquiry has already been provided with all relevant minutes of the Health Care Committee as a result of the 2 "trawls" of relevant paper and electronic documentation held by the WHSSB and its successor organization. I do not have these available to provide to the Inquiry.

(2) **Arising out of your answer to question 7(a), clarify the basis of your belief that there was an expectation that the Sperrin Lakeland Trust would have reported the death of Lucy Crawford to the DHSSPS.**

Arising out of your answer at question 7(a), please address the following additional matters:

(a) **To whom, or to what section or department within the DHSSPS, should the Sperrin Lakeland Trust have reported the death of Lucy Crawford?** Following the creation of Trusts throughout Northern Ireland in the 1990s, a mechanism was developed within DHSSPS, through the Permanent Secretary's office/department, for direct managerial responsibility to be handled through that line of management. Trust Chief Executives reported individually and collectively through regular meetings to

a Senior Officer within the PS's department on issues within their Trusts. Any major event, such as Lucy's death, might have been considered relevant to report within that line of management.

(b) **What should have been reported to the DHSSPS?** While there was no formal requirement at that time, I would have felt that this would include, Lucy's death, the events, as known at the time relating to it, the action which was being taken by the Trust to examine related causes and any actions which the Trust would be taking in the immediate aftermath.

(c) **Please explain why there would have been expectation that the Sperrin Lakeland Trust would have reported the death of Lucy Crawford to the DHSSPS?** As explained above, DHSSPS was the line management group to which Trusts reported.

(d) **What purpose would have been served by the Sperrin Lakeland Trust making a report in relation to Lucy Crawford's death to the DHSSPS?** In general circumstances and not, perhaps, specifically related to Lucy's death such a report could be made - (i) To ensure that the DHSSPS, as the Trust's line management body were aware of the event (ii) In order that DHSSPS would be aware of any event of significant importance, either in terms of the framework of health care in Northern Ireland or from media coverage which a Health Minister and senior officers within DHSSPS would need to be aware of.

(e) **Did you take any steps to ascertain whether the Sperrin Lakeland Trust had reported Lucy Crawford's death to the DHSSPS? If so, please account for the steps that you took.** In the information provided by the Director of Acute Services of S/L Trust, Mr Eugene Fee and by S/L Trust's Chief Executive Mr Hugh Mills, I believed that Lucy's death had been notified to DHSSPS and did not, therefore, need to take any further steps to ascertain this. This is based on my recollection and I have no record, either paper or electronic, to confirm this.

(3) **Arising out of your answer to question 8(c), please address the following matters:**

(a) **Please identify who it was that made you were aware that the Sperrin Lakeland Trust *"were already in discussion with the DHSSPS"*?** See answer to question 2 (e) above.

(b) **Insofar as you are aware when (approximately) did these discussions commence?** In the days immediately following Lucy's death.

(c) **In what forum did these discussions take place?** My understanding is that this would have been in telephone communication between the C. Ex. of S/L Trust and senior DHSSPS staff.

(d) **Describe the nature of these discussions, and what particular aspects of Lucy Crawford's death or the investigation of her death were being discussed? If you can only answer this question by reference to the generalities of what was being discussed between the Trust and the Department, then do so.** This would more appropriately be

answered by Hugh Mills but my understanding is that the fact of Lucy's death and the related actions of S/L Trust to investigate it would have been the issues covered.

(e) **Identify the persons at the Sperrin Lakeland Trust and the Department who were engaged in these discussions.** I cannot, at this point, confirm who the persons were who were involved and this would probably be more appropriately dealt with by Hugh Mills as my answers are based on recollection alone.

(4) **Also arising out of your answer to question 8(c) where you comment that you believe that you would have advised Dr. Kelly of the need for the Trust to consider conducting a wider review, please address the following matters:**

(a) **Why did you reach the view that a wider review involving experts from outside the span of your area etc. was necessary?** Any review of a medical event needs to have credibility in the eyes of the family involved, the wider public and health professionals. Until the mid to late 1990s, Paediatric services had been provided by visiting Paediatricians from Altnagelvin Hospital and Dr Quinn would have been one of those visiting Consultants. There could, therefore, be a risk that Dr Quinn's view alone could be viewed as, in some way, biased towards a service which he had once been a part of. This would not be fair either to the family or to him, despite his expertise and experience. Equally, a review conducted only by external doctors from more specialist centres might not necessarily take into account the context within which services were provided within Sperrin/Lakeland Trust and, in consequence, I felt that both perspectives would be advantageous.

(b) **Who did you envisage would establish this wider review?** Sperrin/Lakeland Trust were the appropriate body to establish such a review but obviously that would have been following discussion with DHSSPS as their line management body and with input from WHSSB as their main Commissioner of Paediatric services.

(c) **On what date (approximately) did you discuss this issue with Dr. Kelly?** I have no record of the date when this would have been but I think it would have been within a short time following Lucy's death.

(d) **Did you ever put your view in writing?** I am not sure whether I ever put my views in writing to Dr. Kelly. It would have been unusual for me to feel that would be necessary as we had a sound working relationship and I would not have felt the need to do that. Similar points had already been made to Hugh Mills soon after he had informed me of his intention to ask Dr. Quinn to review the case.

(e) **How did Dr. Kelly respond to your view that he should consider having a wider review?** From memory Dr. Kelly understood and agreed with the perspective which I had given and agreed to take the points back to discussions within the S/L Trust.

(5) **At answer 17 you have referred to a report which you made to the Chief Medical Officer/Directors of Public Health at a meeting on 2 July 2001. Please address the following matters:**

(a) **What was the purpose of the meeting of the Chief Medical Officer/Directors of Public Health which took place on 2 July 2001?** This was a regular meeting between the Chief Medical Officer/ DHSSPS Medical Department staff and the 4 Directors of Public Health. These meetings were held to discuss issues of strategic importance regarding the provision of Health Care services within Northern Ireland. The meetings took place every 2 months approximately.

(b) **Identify the persons who attended that meeting.** DHSSPS Dr H Campbell CMO; Dr P Darragh; Dr M Mark; Dr E. Mitchell; Dr L. Doherty; Mrs. J Henry (Secretariat) : Ds PH - Dr W. McConnell, WHSSB; Dr D Stewart, EHSSB; Dr A-M Telford, SHSSB; Dr J. Watson, NHSSB. Also attending for earlier part of the meeting but not for later part Mr R McMillen, Dr J Little, Professor F. Kee.

(c) **Please arrange for the Inquiry to be provided with any note made by you at that meeting, or any minutes arising from the meeting.** I do not have any notes which I made at that meeting but I have attached a copy of the relevant parts of the minutes of that meeting as produced by the CMO's office.

(d) **What did you tell the meeting about the death of Raychel Ferguson?** I advised the meeting of the death of Raychel Ferguson and that I had just in the previous few days had an extensive conversation with Dr Raymond Fulton, Medical Director of Altnagelvin Hospital, who had advised me of the concerns and actions of Dr Nesbitt, Consultant Anaesthetist, regarding the use of Solution 18 in Paediatric care and Paediatric surgery and that this had been raised and discussed at a meeting between the Deputy Chief Medical Officer of DHSSPS, Dr Ian Carson and the Medical Directors of all Trusts some days previously.

(e) **Were you personally asked to take any action arising out of the report that you made to that meeting about Raychel Ferguson's death? If so, what steps were you asked to take and did you take them.** I agreed to write formally to my colleague Directors of Public Health in the other 3 Boards in order that they could bring it to the attention of Trusts within their respective Board areas and to copy this to the CMO.

(f) **When you learnt about the circumstances of Raychel's death, did you draw any comparisons with the circumstances of the death of Lucy Crawford?** Not immediately as the circumstances regarding their illnesses were somewhat different, one relating to surgery and the other a vomiting and diarrhoeal illness. Also, the relevance of the fluid management issues was not so apparent to me in Lucy's case at that time.

(g) **Was the death of Lucy Crawford discussed at the Chief Medical Officer/Directors of Public Health meeting on 2 July 2001?** No, not to my recollection.

II Other Matters

(6) **How was clinical governance introduced across the Western Health and Social Services Board area following the publication of "The New NHS: Modern and Dependable" (White Paper, December 1997)?** I think, though I may be wrong, that the paper referred to was relevant only

to the National Health Service in England and, possibly, Wales and did not apply to services in Northern Ireland where a significantly different organisational framework applied. Here, services included Social Services and it was some time later before a paper with a similar purpose relevant to Governance for Health and Social Services in Northern Ireland was issued by the DHSSPS. It was during 2002/2003 that related circulars and guidance were issues by DHSSPS including "Best Practice – Best Care" July 2002; "Governance in the HPSS – Clinical and Social Care Governance; Guidance for Implementation" – issued 13th January 2003; Health & Personal Social Services (Quality and Regulation) (NI) Order 2003. Also see response to Q (7) below.

(7) **What steps had been taken by April 2000 to implement a clinical governance strategy in the Western Board area?** I do not have access to any detail from that time of the various steps and their timing towards implementing a Governance Strategy for Health and Social Care in Northern Ireland. This documentation may be available through WHSSB records held from that time. I do recall the Health and Social Care Governance Committee of the WHSSB being developed in the early 2000s but I do not have any detail of exactly when it was created. There was considerable work involving the 4 Health and Social Services Boards working collectively to ensure that the framework developed would be the same across services in Northern Ireland in order that Trusts would not have to produce different quality reports to their Commissioners and that comparisons could also be made across Northern Ireland.

(8) **What was the responsibility of the Western Health and Social Services Board to ensure that the Sperrin Lakeland Trust (and in particular the Erne Hospital), provided quality care?** In Commissioning services on behalf of the resident population within the area covered by the WHSSB, the Board needed to ensure that the organisations with whom we set contracts had the capacity to deliver an appropriate and agreed range of services and had the numbers of trained staff and relevant settings in place to provide those, frequently on a 24 hour a day and 365 days a year basis.

(9) **What actions did the Western Board routinely take to monitor the quality of care provided at the Erne Hospital?** Within the contract reporting system, a number of relevant parameters were set out on which the Trusts provided regular reports to the Board. These would have included numbers of patients treated by specialty, delays in treatment, readmission rates and many other similar factors. I do not have access to all of the issues which were reported upon but the framework developed for different services would have given an overall perspective on the quality of the service being provided.

(10) **Please outline the <u>criteria</u> or <u>factors</u> which you would have taken into account when determining whether issues identified as a result of a critical incident needed to be disseminated to others in the NHS in Northern Ireland?** Examples would be - Did the incident have contributing issues which were likely to be unique to that event or were there issues of process, application of surgical/medical procedures, medication use or staff training/expertise which might apply in other settings? Were there issues of equipment problems, failure or lack of maintenance which could also apply elsewhere?

(11) **Did you give any consideration to whether any of the issues arising out of Lucy Crawford's case warranted dissemination to a wider audience in the NHS in Northern Ireland? If so, please explain the consideration you gave to this matter, the conclusions which you reached and any action that you took.** Not initially, as the events relating to Lucy's death did not appear to have wider significance until the implication of the use of Solution 18 in Paediatric care became more apparent. It is my understanding that the use of Solution 18 was still part of some guidelines for fluid management in children. It was really only after Raychel Ferguson's death and the emergence of the concerns which had been expressed elsewhere relating to the use of this fluid replacement regime that the wider implications became recognized and Drs Nesbitt and Fulton at Trust level and I at Board level felt that wider dissemination and discussion of the issues and related action needed to occur.

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

Signed:  **Dated:** 31st January 2013.

MINUTES OF THE MEETING OF THE DIRECTORS OF PUBLIC HEALTH / DHSSPS HELD ON 2nd JULY 2001, IN ROOM C5.15 CASTLE BUILDINGS, STORMONT.

PRESENT:

Mr R McMillen
Dr J Little
Professor F Kee

DsPH

Dr W McConnell
Dr D Stewart
Dr A M Telford
Professor J Watson

DEPARTMENT

Dr H Campbell
Dr P Darragh
Dr M Mark
Dr E Mitchell
Dr L Doherty
Mrs J Henry (Secretariat)

1. **WELCOME**

The Chairman welcomed all members to the meeting especially Professor F Kee, Mr R McMillen and Dr J Little.

2. [redacted]

3.

4.

[redacted]

13. **ANY OTHER BUSINESS**

i. [redacted]

ii. [redacted]

iii. **Hyponatraemia**

Dr McConnell highlighted a recent death in Altnagelvin Hospital of a child due to Hyponatraemia caused by fluid imbalance. Current evidence shows that certain fluids are used incorrectly post operatively. It was agreed that guidelines should be issued to all units.

[redacted]

There being no other business CMO thanked everyone for their participation and closed the meeting.

JULY 2001