Witness Statement Ref. No. | 312/1

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Esther Millar

Title: Mrs

Present position and institution:

Retired

Previous position and institution: Clinical Services Manager, Erne Hospital

[As at the time of the child's death]

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

14/17 April 2000 – Clinical Incident Report Form

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

Ref:	Date:	

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.

(1) Please address the following matters:

(a) Outline your professional qualifications, and the date when you received them;
Professional Qualifications:
Registered Nurse 1967
Registered Midwife 1968
National District Nursing Certificate 1976

(b) On what date were you appointed as Clinical Services Manager at the Erne Hospital;
Appointed Clinical Services Manager in 1996.

(c) Identify all professional posts held by you before and since you were appointed to the Erne Hospital as Clinical Services Manager.
Professional Posts before 1996 –
1992-1996 Nursing/Midwifery Services Manager, Omagh
1978-1992 Nursing Officer Midwifery, Omagh
1974-1977 District Nurse/Midwife, Omagh
1972- 1973 Staff Nurse, Omagh
1971 Relief Bank Nurse, Omagh
1968-1970 Staff Midwife, Omagh
1967 Staff Nurse, Omagh
Professional Posts after 1996 –
1996-2005 Clinical Services Manager
2005-2006 Senior Nurse – Clinical Governance

(2) Please refer to the Critical Incident Report at Ref: 036a-045-096, and answer the following questions:

(a) What was the purpose/function of the Clinical Incident Report form?
The Clinical Incident Form was used as notification to Senior Medical/Nursing team (Directorate Team) to enable discussion of issues and agree an action plan to improve care.

(b) When (approximately) was this form introduced?
I am unable to indicate when this form was introduced as I have been retired for 6 + years and do not remember.

(c) At April 2000, in what circumstances were nursing staff or clinicians (working within Women and Children's Services) expected to make a clinical incident report?
Any clinical professional could initiate an incident report notification to the Directorate Team.

(d) Was clinical incident reporting the subject of any written policy, procedure or protocol, whether formal or informal, as of April 2000? If so, please make arrangements for the Inquiry to be provided with a copy of any relevant document.
I am unable to elaborate on this as I am retired 6+ years and do not remember.

(e) Were any categories of staff trained in relation to clinical incident reporting? If so, please outline the nature of the training provided, and the staff who would have received such training?
I am unable to elaborate on this as I am retired 6+ years and do not remember.

(f) Which sections of the form starting at Ref: 036a-045-096 were completed by you, and which were completed by the reporting Ward Sister?
All of the form was completed by myself (as evidenced by the handwriting) with information given to me by Sister Etain Traynor, Ward Sister who was the only Ward Sister on the Ward.

(g) Identify by name the Ward Sister who made the report to you and explain why the name of the Ward Sister does not appear on the report.
All of the form was completed by myself (as evidenced by the handwriting) with information given to me by Sister Etain Traynor, Ward Sister who was the only Ward Sister on the Ward.

(h) The Critical Incident Report form records, "*Concern expressed about fluids prescribed/administered.*" Without simply repeating what is set out in the form, fully outline the concern about fluids that were reported to you.
As the details on the form are 12 + years ago and I am retired 6+ years I cannot reply to this as I do not remember.

(i) Under any policy, procedure or practice which was applicable at the time, what action should you have taken in response to the concern which had been reported to you.
I reported the content of the incident Form directly to Dr Trevor Anderson, Clinical Director, and to Mr Eugene Fee, Director of Nursing. As the child's family were related to me Mr Fee advised me that he would lead with Dr Anderson on the investigation of the incident.

(j) Having received this report from the Ward Sister, specify in chronological order each of the steps that you took in relation to the concerns that had been reported to you.

For the avoidance of doubt describe all of the reports, inquiries and investigations that you made, identify the persons that you spoke to and what you said to them, and if you created any documents in relation to this issue, please refer to those documents and explain your purpose in creating them.
I reported the content of the incident Form directly to Dr Trevor Anderson, Clinical Director, and to Mr Eugene Fee, Director of Nursing. As the child's family are related to me Mr Fee advised me that he would lead with Dr Anderson on the investigation of the incident. Therefore I was not involved in the investigation.

(k) Under any policy, procedure or practice which was applicable at the time, what action should have been taken by others in response to the concern which had been reported to you.
I reported the content of the incident Form directly to Dr Trevor Anderson, Clinical Director, and to Mr Eugene Fee, Director of Nursing. As the child's family are related to me Mr Fee advised me that he would lead with Dr Anderson on the investigation of the incident.

(l) Insofar as you are aware, outline any action which was taken by others in response to the concerns that were reported to you.
I reported the content of the incident Form directly to Dr Trevor Anderson, Clinical Director, and to Mr Eugene Fee, Director of Nursing. As the child's family are related to me Mr Fee advised me that he would lead with Dr Anderson on the investigation of the incident.

(3) Provide any further points and comments that you wish to make, together with any documents, in relation to:

As Mr Fee and Dr Anderson lead the investigation I have no documents and therefore I cannot respond to these questions. (3 a- e reply)

(a) The cause of Lucy's death;

(b) The role performed by you, the Sperrin Lakeland Trust or others in terms of the steps that were taken to reach conclusions in relation to the cause of Lucy's death;

(c) The procedures which were followed in order to review or investigate issues relating to the cause of Lucy's death;

(d) Lessons learned from Lucy's death and how that affected your practice at the Erne Hospital or elsewhere;

(e) Any other relevant matter.

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

Signed: E. Rather Millar.

Dated: 14 March 2013