Witness Statement Ref. No. 327/1

NAME OF CHILD: Raychel Ferguson

Name: J. Hutchinson

Title: Mrs

Present position and institution:

Retired CSM 30th June 2002

Previous position and institution:
[As at the time of the child's death]
Clinical Services Manager- Altnagelvin Hospital Health & Social Services Trust ("AHHSST")

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 2001 - present]

Health & Safety Committee Jan 2001 – June 2002

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

None

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 to your statement.

(1) Please provide the following information:

(a) Your qualifications as of 2001 (please also provide a copy of your CV);

RSCN RGN RM DipHSSM

(b) Describe your career history;

Clinical Services Manager	**1st April 94**	**-**	**30th June 2002**
Senior Nurse Manager	**1st Feb. 1994**	**-**	**30th March 1991**
Nurse Manager	**1st Jan 1981**	**-**	**January 1991**
Ward Sister (Gynae Ward)	**1974**	**-**	**January 1981**
Part Time Staff Nurse	**1969**	**-**	**1974**
Sister Orthopaedic & Fracture Clinic	**1967**	**-**	**Dec 1968**
Staff Midwife	**1965**	**-**	**1967**
Student Midwife	**1964**	**-**	**1965**
Staff Nurse (ENT)	**1963**	**-**	**1964**
Student Nurse General Training	**1961**	**-**	**1963**
Student Nurse Children's Training	**1958**	**-**	**1961**

(c) Please describe your work commitments at the AHHSST from the date of your appointment as Clinical Services Manager;

My initial appointment as CSM was covering Specialities i.e.

Orthopaedics and Trauma wards, Fracture Clinics ENT, Audiology, Facio-Maxillary and ophthalmology.

1995 General Surgery Urology and Breast Service plus the Critical Care Directorate comprising Intensive Care Theatres and Recovery were added to my remit

(d) What was the role of the Clinical Services Manager and what were its functions, accountabilities and responsibilities, and was this reduced to writing by 2001? If so please provide a copy of the same;

The Trust has been unable to locate my Job Description for me and I no longer hold a copy.

(e) Who was your line manager in 2001?

The Chief Executive Mrs S. Burnside

(2) Who bore ultimate responsibility for the quality of care delivered by AHHSST in 2001?

Each registered nurse is professionally responsible and accountable for practice and should act in such a manner as to promote and safeguard the interests and well-being of patients and clients. (UKCC) Ultimately the Chief Executive would hold responsibility.

(3) In respect of your work with the AHHSST Health & Safety Steering Committee please advise:

(a) Whether you engaged with clinical safety issues;

No Refer. Health & Safety Terms of reference

(b) Whether you engaged with critical incident reviews;

No

(c) Whether you issued any guidance or protocols relevant to the handling of complaints, litigation, communication with next-of-kin, preparation for Inquests and provision of information in respect of adverse outcomes?

No

(4) Please detail those opportunities available in 2000-2001 to Clinical Services Managers (or equivalents) from across Northern Ireland to meet and exchange information of professional relevance by way of managed network or otherwise?

I was not a member of any professional managed networks

(5) In 2001 did the AHHSST have in place any policies, guidance or procedures governing the following:

(a) Clinical governance;

Yes Strategy, provided to the Inquiry date 22nd March 2013 Ref:AD-0529-13.

(b) Social care governance;

No.

(c) Health and Safety;

Yes

(d) Adverse Clinical Incident Investigation;

Risk Management policy

(e) Complaints procedure;

Yes Complaints procedure

(f) Performance assessment;

Staff Development and Performance Review. Also Perceptorship for newly qualified staff nurses

(g) Continuing medical education and professional development;

The Clinical Education Centre was used by medical staff to provide courses, seminars and updates.

All Staff had opportunities to apply to attend courses for further training and development and were released by completing an SL1 Form which would have been approved initially by their line manager.

(h) Clinical record keeping;

Yes noted in policy manual. Guidance also provided by Nursing Bodies

(i) Preparation for Inquests and the gathering of statements therefore;

None

(j) Communication with next of kin?

Yes Bereavement policy Some patient information leaflets also contained information for relatives

If the AHHSST did have any such policies, guidance or procedures in place, then identify the same, provide a copy and state in respect of each:

(i) Whether it was modelled on or informed by any published guidance, and if so please identify this guidance;

Example Management of peripheral IV lines. Please find attached with Statement.

(ii) How the guidance, policy or procedure was distributed;

Distributed to each ward or relevant department

(iii) What training or assistance was given in respect of same;

This would depend on the policy. On the job training, In-service training and More formalised training e.g. specific courses

(iv) How the AHHSST satisfied itself that the guidance, policy or procedure was being implemented and complied with;

Direct supervision, Review of accidents untoward incidents or clinical incidents, On occasions audit and Standards meetings

(v) How implementation and compliance was enforced;

Ward/Sister Managers are responsible and accountable. Compliance would be reinforced to

managers at CSM/Sisters meetings within my directorate. Audit e.g. Medicine Kardex audit carried out by Senior Nurse in conjunction with Pharmacist.

(vi) How such guidance, policy or procedure was applied in the case of Raychel Ferguson?

I do not have information relating to the Paediatric unit as it was outside my jurisdiction.

(6) Did the AHHSST seek or obtain accreditation, whether from Kings' Fund Organisational Audit or otherwise, and if so:

(a) What was the accreditation and from whom was it sought;

I do not have this information

(b) On what date was accreditation applied for and received;

I do not know the answer to this

(c) What were the standards/criteria set;

No knowledge of this

(d) What was the outcome of this process?

I have no knowledge regarding outcome.

(7) Did the AHHSST undergo Patient Charter standards accreditation?

I do not have this information.

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

(a) Was there a Clinical Audit Committee? If so, what was its remit;

Clinical audit was embraced Consultants were allowed one session of clinical time per month in which to carry out and address Clinical audit in their speciality

(b) Who served on the Clinical Audit Committee;

I cannot recall this committee

(c) Who was responsible for ensuring that nursing/medical/clinical audits were carried out;

The Medical Director for each speciality would have initial responsibility for the Medical audit. ? Nursing audits carried out by Senior Nurses and Senior Nurse Quality

(d) To whom were the results of nursing/medical/clinical audits sent;

I am not aware of where Medical audits were sent. Nursing audits would have been sent to the Clinical Effectiveness Co-ordinator.

(e) What action could be taken on foot of the results of nursing/medical/clinical audits;

In case of nursing issues The Director of Nursing would make direct contact with CSM who

would take the necessary action

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

Not to my knowledge

(9) In 2001, had the AHHST established a Medical Records Committee or like body? If so, please address the following:

(a) What was the function of the Committee;

Not aware of Medical Records Committee

(b) Was its remit and operation governed by any policy/procedure;

No knowledge of this

(c) Who formed the membership of this Committee;

Unknown

(d) Did you play a role in relation to this Committee, and if so what;

No

(e) Whether its deliberations were minuted;

Not known

(f) Did such a Committee engage with the audit or review of medical records?

I have no knowledge in respect of this

(10) Please describe the structures in place in 2001, and the lines of accountability and responsibility, for:

(a) Clinical policy setting;

I can not recall being involved in any clinical policy setting and have no information to refresh my memory

(b) Clinical policy monitoring;

I have no information relating to this

(c) The adoption of policy on clinical practice as a result of NCEPOD, NICE, CREST and other relevant bodies.

Any issues that were relevant to nursing practice which were not already in place would be examined and adopted if appropriate.

(11) Please describe the steps taken to disseminate, implement/enforce compliance

with the recommendations deriving from external sources including the following:

(a) The Royal Colleges;

All circulars and relevant information was copied to Wards and Departments

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

Information copied to Wards and Departments. Also important issues raised at Sisters meetings (held every 4 to 6 weeks)

(c) Paediatric Intensive Care Society;

Not applicable to my speciality

(d) Department of Health;

Disseminated to all Clinical areas

(e) Audit Commission;

As above

(f) General Medical Council;

As above

(g) DHSSPSNI;

If relevant, copied to wards

(h) HPSS;

As above

(i) Management Executive.

If relevant, Cascaded to Ward level or raised at Sisters meetings

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

Senior Nurse for Quality held 'Standards' meetings on a regular basis with a representative from each ward or department to address patient care improvements.

Periodic monitoring of nursing care e.g. Pressure sores audit

On occasions an audit using the tool Monitor would be carried out .

(13) Was there any system of independent external scrutiny in place to review clinical performance in the AHHSST, and if so please detail the same?

I am not aware of any.
The National Board N.I. inspected clinical areas within the hospital to approve training and clinical placement for student nurses.

(14) When did you first hear of the death of:

(a) Raychel Ferguson;
I cannot recall exactly

(b) Lucy Crawford?
When I first became aware of the Inquiry.

(15) Did you take any action upon learning of the death of Raychel Ferguson? If you made any records or memoranda thereof please supply.

I had no jurisdiction over the Paediatric Department and was not involved in any circumstances surrounding the case.

(16) Please provide the following information:

(a) When did you first become aware of the death of Raychel Ferguson.

I cannot recall exactly

(b) What action did you take in response thereto?

No involvement

(c) What involvement did you have with, or contribution did you make to, the Critical Incident Review conducted in 2001?

None

(d) Please advise whether you were in attendance at the Critical Incident Review Meeting?

No

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

No involvement

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

I was not required to make a statement

(g) How lessons learned were to be communicated across the AHHSST?

No involvement

(h) How was the admission and death of Raychel Ferguson categorised within the AHHSST statistical data in 2001?

I don't know

(i) Was any consideration given to inviting external specialists to review the case of Raychel Ferguson?

I don't know

(j) 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?

This was not within my area of responsibility

(k) When were you informed of the outcome of the Critical Incident Review, by whom and in what terms; and what steps were expected to be taken by you to ensure that the recommendations arising from this Review were implemented?

I wasn't informed Not relevant

(l) What information did you seek in relation to the Review, what meetings did you have and what personal fact finding did you undertake/instigate?

None

(m) Please confirm whether or not you received a report in writing into the case of Raychel Ferguson? If so please provide the same?

No

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

I was not involved in the Review and not aware of its findings

(o) Was any consideration given to performing a detailed audit of all aspects of the case, including:

- **Whether the bleeper system was efficient;**

I am not aware of this

- **Whether the fluid balance documentation was adequate;**

I do not have this information

- **Whether the computerised presentation of blood results was appropriate and adequate?**

I do not have this information

(17) In the aftermath of the death of Raychel Ferguson did you have reason to consider if there had been any systemic failings within the services for which you were responsible (and if so please include details)?

I had no responsibility for this clinical area and have nothing further to add

(18) "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 whether you agree with this and if so:**

(a) To the best of your knowledge, how did this *"problem in the Children's Ward"* **become established, and when;**

No knowledge of this

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

No knowledge of this

(c) Why was it permitted to continue;

I don't know the answer to this

(d) Was it reviewed?

I believe so. On preparing this response 14th June 2013 I have acquired a copy of a letter from Dr Nesbitt re fluid management in children then dated 3rd July 2001 in which he asks Sister Miller to change their policy.

(19) Was there any reference to Raychel's case at any hospital committee meetings or in any other healthcare context? If so, please provide any record thereof.

Dr Nesbitt gave a presentation at Hospital Management Team and referred to the incident.

(20) Please provide such additional comment as you think relevant. It would be of very considerable assistance if you could attach such documentation as you may hold which relates to procedures, strategies, policies or other issues of relevance.

I have nothing further to add

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

Signed: Joan Hutchinson **Dated:** 8/7/13

CIRRICULUM VITAE

JOAN HUTCHINSON

17th June 2013

JOAN HUTCHINSON

Academic Qualifications

Diploma in Health and Social Services Management
Certificate in Health Services Management
Registered General Nurse
Registered Midwife
Registered Sick Children's Nurse

Employment History

Altnagelvin Area Hospital - Acute Hospital 450 Inpatient Beds
54 Day Case Beds
Slow Stream Rehabilitation 18 Inpatient Beds
Care of young physically disabled 17 Inpatient Beds

Clinical Services Manager **Surgery and Critical Care Directorate**
1994 - 2002

This Directorate included

General Surgery Directorate
Surgery & Urology
Breast Clinics
Urology Clinics
Short Stay Unit

Critical Care Directorate
Intensive Care Unit
Dependency Unit
Theatres & Recovery

Specialist Surgery Directorate
Orthopaedics & Trauma
Fracture & Orthopaedic Clinics
Ophthalmology

Ear Nose &Throat
Oral & Maxillo-Facial Surgery
Hospital Orthodontic Services High
Audiology
Orthoptics
Low Visual Aid

Role

- Management responsibility for the delivery of service in all the above specialities
- Engaging with Clinical Directors to ensure a high standard of patient care and the smooth running of the service
- Management of all resources Budgets, Manpower and Facilities e.g. Beds Theatres etc.
- Planning for future Developments in Service taking into account both Trusts and DHSS strategy within the next 5 years
- Working to achieve targets to reduce Waiting Lists and Waiting times for patients to meet government guidelines
- Commissioning of new facilities Intensive Care, High Dependency, New Theatre Block and Recovery
- Monitoring of service through statistical data analysis and participating in audit.
- Embrace the ethos of change within the Health Service and engage Clinicians in the Management Process
- Investigating Complaints in line with Hospital Policy
- Delivering timely discharge summaries to General Practitioners and facilitating clinical coding
- Promote Health and Safety at Work Policy to ensuring a safe working environment for all staff
- Provide opportunities for appropriate training and development to all staff in conjunction with performance review
- Facilitate nursing/medical /and PAMS training placements liaising with the Educational representatives as required

Altnagelvin Area Hospital

Senior Nurse Manager (Surgical Division) Feb. 1991-1994
Nursing Officer (Specialist Surgery) March 1981-1991

Both these positions had a very similar remit:

Managing Nursing Services
The position carried full professional and managerial accountability for delivery of Nursing Care within the Surgical and Specialist Surgical Division.

Altnagelvin Hospital

Staff Nurse (part time) 1970-1973
Following the birth of my 1st baby I worked as a staff nurse in Accident & Emergency. This was a difficult time dealing with Civil Disturbances and gunshot injuries during the peak time of the "troubles."

Altnagelvin Hospital
Ward Sister (Orthopaedic & Fracture Clinic) 1967-1969

Altnagelvin Hosopital
Staff Midwife 1965-1967

Jubilee Maternity Hospital
Midwifery Training 1964-1965

Altnagelvin Hosopital
Staff Nurse (ENT & Ophthalmic Ward) 1963-1964

Altnagelvin Hospital
Post Registered Student Nurse 1961-1963

Ulster Hospital for Children and Women
Children's Nurse Training 1958-1961

Solicitors Office
Shorthand Typist July 1957-Dec 1957