Witness Statement Ref. No. 331/1

NAME OF CHILD: Raychel Ferguson

Name: Ian Carson

Title: Dr.

Present position and institution:

Retired (April 2006)

Non-Executive Chairman, Regulation and Quality Improvement Authority (RQIA)

Previous position and institution:
[As at the time of the child's death]
Medical Director/ Deputy Chief Executive - Royal Group Hospital Trust ("RGHT").

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between November 1995-present]

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

WS 077/1
WS 077/3
WS 306/1
WS 306/2

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 such a number then please provide a copy of the document.

(1) In relation to the statement made to the PSNI on 14th March 2006 by Dr. Nesbitt (former Clinical Director in Anaesthesia & Critical Care- Altnagelvin HHSST) in respect of a conversation in June 2001 when he *"spoke to Dr. Chisakuta, a Consultant in Paediatric Anaesthesia and Intensive Care in the RBHSC about their [the RBHSC's] use of No.18 solution in post-operative surgical children and he informed me that they had been using precisely the same regime as Altnagelvin Hospital but had changed from No.18 solution six months previously because of concerns about the possibility of low sodium levels. This was also the position in Tyrone County Hospital"* (Ref: 095-010-040) please state:

(a) Whether the RBHSC had *"changed from No.18 Solution six months previously"*;
I am unable to confirm the accuracy of this statement. The matter should be confirmed with the clinicians directly involved and /or the management in the Paediatric Directorate (RBHSC) and/or the Belfast HSC Trust.

(b) Whether the RBHSC had made any change in its use of Solution 18 in the year preceding 10th June 2001;
I am unable to confirm the accuracy of this statement. The matter should be confirmed with the clinicians directly involved and /or the management in the Paediatric Directorate (RBHSC) and/or the Belfast HSC Trust.

(c) Whether and what hospital documentation would record any change in the practice of prescription and use of Solution 18 in the RBHSC in the year preceding 10th June 2001;
The matter should be confirmed with the clinicians directly involved and /or the management in the Paediatric Directorate (RBHSC) and /or the Belfast HSC Trust.

(d) If such change occurred:

- **What was the change;**
  The matter should be confirmed with the clinicians directly involved and /or the management in the Paediatric Directorate (RBHSC) and/or the Belfast HSC Trust.
- **When did it occur;**
  As above.
- **Did such change occur prior to the death of Raychel Ferguson;**
  As above.
- **What were the reasons for the change;**
  As above.
- **Who was responsible for the change;**
  As above.
- **Were you informed of the change;**
  Not that I can recall.
- **If such a change occurred how was it implemented and by whom;**
  The matter should be confirmed with the clinicians directly involved and /or the management in the Paediatric Directorate (RBHSC) and/or the Belfast HSC Trust.
- **Were you aware of a change;**

Not that I recall.

- **Was the change communicated to any other hospital committees, advisory groups, sub-committees or working parties, either then or subsequently;**
  Changes in clinical practice were usually communicated through professional channels rather than through 'management channels', it could have been discussed at audit meetings or in the context of teaching and training. However, the matter should be confirmed with the clinicians directly involved and /or the management in the Paediatric Directorate (RBHSC) and/or the Belfast HSC Trust.
- **Whether any steps were taken to disseminate this information to the wider medical community (if so please detail to whom such information was disseminated, and if not please indicate why not);**
  Changes in clinical practice were usually communicated through professional channels rather than through 'management channels', in addition to discussion at audit meetings, it could have been discussed at specialty advisory committees at the EHSSB or the DHSSPS. However, the matter should be confirmed with the clinicians directly involved and /or the management in the Paediatric Directorate (RBHSC) and/or the Belfast HSC Trust.

- **Whether any steps were taken to disseminate this information to the Altnagelvin Hospital (if so please detail to whom such information was disseminated, and if not please indicate why not);**
  Changes in clinical practice were usually communicated through professional channels rather than through 'management channels'. However, the matter should be confirmed with the clinicians directly involved and /or the management in the Paediatric Directorate (RBHSC) and/or the Belfast HSC Trust.
- **Whether any steps were taken to disseminate this information to the Tyrone County Hospital (if so please detail to whom such information was disseminated, and if not please indicate why not);**
  As above
- **Whether any steps were taken to disseminate this information to Craigavon Area Hospital (if so please detail to whom such information was disseminated, and if not please indicate why not)?**
  As above.

(2) In relation to your email to the Chief Medical Officer, dated 30th July 2001, and your introductory comment *"Please find attached document on the above subject drawn up by Dr. Bob Taylor and his colleagues. It reflects current 'opinion' among experts in the management of these children, however it does not yet command full support amongst Paediatricians"* (Ref: 026-016-031) please:

(a) Identify the document attached;

I indicated in the email that the document was "drawn up by Dr Bob Taylor and his colleagues". I have not retained a copy, and I would suggest that the same should be sought from the paediatric anaesthetists, the Belfast HSC Trust or the DHSSPS.

(b) Explain why it had not yet commanded the full support of Paediatricians?

The content of the email would have been provided to me by Dr Taylor and /or his colleagues, and I understood that it reflected their views at that time. I cannot recall whether the comment regarding "full support of paediatricians" referred to paediatricians in general, or paediatricians

in Northern Ireland, or specifically paediatricians in the RBHSC.

(3) **In relation to the same email and your assertion that *"the problem today of 'dilutional hyponatraemia' is well recognised (see reference to BMJ Editorial). The anaesthetists in RBHSC would have approx. 1 referral from within the Hospital per month. There was also a previous death approx. 6 yrs ago in a child from the Mid-Ulster. Bob Taylor thinks that there have been 5-6 deaths over a 10 year period of children with seizures"* please state:**

The content of the email, and the views expressed, would have been provided to me by Dr Taylor and /or his colleagues, and I understood that it reflected their views at that time.

(a) Whether these figures appear plausible to you;

I am not an expert in this area, and would be unable to comment.

(b) Whether you know anything about the child from the Mid-Ulster and if so what;

I cannot verify the accuracy of the statement in the email, the comment and views expressed, would have been provided to me by Dr Taylor and /or his colleagues, and I was simply relaying information provided to me.

(c) Whether you investigated this information any further?

I did not verify the accuracy of the statement in the email or the attached document; nor did I feel that it was necessary to carry out any investigation.

(4) **Was Raychel Ferguson's case reported as an Adverse Incident within the RBHSC in accordance with the Policy TP9/00?**

The matter should be confirmed with the clinicians directly involved and /or the management in the Paediatric Directorate (RBHSC) and/or the Belfast HSC Trust.

(5) **Was the case of Raychel Ferguson presented at an Audit or Mortality meeting? If so when and by whom? If possible please provide a minute thereof.**

The matter should be confirmed with the clinicians directly involved and /or the management in the Paediatric Directorate (RBHSC) and /or the Belfast HSC Trust.

(6) **Was there any discussion of, or reference to Raychel's case at any other meeting, whether Committee, Grand Round or Training? If so, please provide any record thereof.**
If this question refers to further discussion within the Royal Group of Hospitals & Dental HSS Trust, the matter should be confirmed with the clinicians directly involved and /or the management in the Paediatric Directorate (RBHSC) and /or the Belfast HSC Trust.

If the question refers to further discussion out with the Royal Group of Hospitals & Dental Hospital HSS Trust, see (14) below.

(7) **Was Raychel's death reported to NCEPOD by the RBHSC?**

The National Confidential Enquiry into Perioperative Deaths (NCEPOD) was established in 1988, and its first report was published in 1990. My recollection was that this was a joint venture that reviewed surgical and anaesthetic practice over a period of one year. It was a confidential and anonymous study, initially of 'perioperative deaths', but later its remit was extended to

review outcomes other than death, and it began to look at specific themes, such as endoscopy, emergency surgery, team working etc., and currently it covers all specialities.

NCEPOD was a voluntary system; clinicians were 'encouraged' to participate by their professional bodies. Activity in individual hospitals was co-ordinated by a 'Local Reporter'; often this person was a pathologist, who on the basis of awareness of cases coming for autopsy would encourage surgeons and anaesthetists to fill in a report form and then submit it to NCEPOD. The responsibility to report was not a function of the RBHSC or of the Royal Hospitals & Dental Hospital HSS Trust management. To answer the question specifically, it would be necessary to refer this to the clinicians directly involved.

(8) Was there any reference to Raychel's case at any hospital committee meeting or in any other healthcare context? If so, please provide any record thereof.
See response to (14) below.

(9) Was there any use made of learning derived from Raychel's case in any training or educational context? If so please provide detail.
The matter should be confirmed with the clinicians directly involved with the care of Raychel in Altnagelvin or in the RBHSC; other information may be available from the Northern Ireland Medical & Dental Training Agency.

(10) Whether you had any communication with anyone in the AHHSST/ Altnagelvin Hospital in respect of the death of Raychel Ferguson (and if so please specify)?
Please see WS 077/1 - I am unable to recall any notification to myself as Trust Medical Director, at or around the time of Raychel Ferguson's death; and in that context and capacity, I do not recall any communication with Altnagelvin Hospital.
See response to (14) below.

(11) In respect of the RBHSC role as a Regional Centre of Excellence/ Teaching Hospital do you consider it to have held any particular responsibility for the dissemination of learning and good practice to Area Hospitals in Northern Ireland 1995-2005?

The Royal Group of Hospitals & Dental Hospital HSS Trust, which includes the RBHSC, was an undergraduate teaching and postgraduate training hospital, a regional referral centre and widely recognised for its contribution to research and development in healthcare. Local and regional teaching and training seminars, and conferences were frequently held in the Trust. Senior clinicians frequently contributed to other seminars held in hospitals throughout Northern Ireland, and also at a national & international level. Changes in clinical practice were therefore usually communicated through professional channels, rather than management channels.

(12) Please describe any links which may have existed between the RBHSC/RGHT, the Altnagelvin Hospital and the wider medical community with respect to:

- **(a) Information sharing;**
  For clinical matters, this would have been conducted on a 'clinician to clinician' basis. In regard to other matters this would have been conducted through the Chief Executive's Office
- **(b) Coordination of education, training and medical updates;**
  This may have been conducted on a 'clinician to clinician' basis, but would more likely to have been conducted through a 'network' of clinical tutors or Regional Education Advisers, and would have been coordinated by the Northern Ireland Council for

Postgraduate Medical & Dental Education, or by Queen's University of Belfast.

(c) **Issues of referral;**
This would normally have been conducted on a 'clinician to clinician' basis, but may have involved the Area Health & Social Service Boards for such things as 'extra-contractual referrals'.

(d) **Correlation of clinical guidelines;**
It is possible that there was some 'clinician to clinician' correlation of 'pathways and guidelines', however more significant work would have been conducted regionally under the auspices of CREST (Clinical Resource Efficiency Support Team) which was a small team of health care professionals established under the auspices of the Central Medical Advisory Committee (DHSSPS) in 1988.

(e) **Issues of communication.**
For clinical matters, this would have been conducted on a 'clinician to clinician' basis. In regard to other matters this would have been conducted through the Chief Executive's Office

(13) Please advise as to the structures in place in 2001 for regular meetings between Medical Directors, Directors of Public Health, representatives of DHSSPSNI and the CMO and whether the same were minuted.
Please refer to my Witness Statement 077/1

(14) In relation to your meeting with Medical Directors please state:

Please refer to my Witness Statement 077/1. In 2001, I was Medical Director in the Royal Group of Hospitals & Dental Hospital HSS Trust. I attended the DHSSPS on one day a week on secondment as a 'special adviser in clinical governance' to the CMO. The Permanent Secretary would have met with Trust Chief Executives on a regular basis; similarly, the Chief Nursing Officer met on a regular basis with Directors of Nursing in HSS Trusts, and while there was a system of advisory committees that met with the CMO, there were no formal meetings of Trust Medical Directors with the CMO. I facilitated the commencement of these particular meetings. The meetings were chaired by the CMO. During my tenure as Deputy CMO (from August 2002 to April 2006), there would have been occasions when I would have deputised for the CMO in the chair.

(a) How often such meetings were held;

Approximately 2 or 3 meetings per year

(b) Whether you made or kept any note or record thereof?

As a participant, I may have made hand written notes at the time, but these have not been retained. To the best of my recall, the early meetings were not minuted, but later meetings were recorded by Departmental officials.

(15) Did you keep a file or record of your work in relation to the case of Raychel Ferguson and did you retain all documentation relating thereto? If so please provide copies.

No. Please refer to my Witness Statement 077/1

(16) In relation to the Medical Directors Meeting of 18th June 2001 please state:

Please refer to my Witness Statement 077/1

(a) **Whether there was a written agenda for this meeting? If so please provide;**
I do not have a record of this, please refer to the DHSSPS

(b) **Who attended the meeting;**
I do not have a record of this, please refer to the DHSSPS

(c) **Whether you provided the CMO with a report of the meeting? If so please provide;**
Please refer to my Witness Statement 077/1 – my understanding is that I gave verbal feedback to the CMO.

(d) **Whether Dr. Fulton made reference to any change in the RBHSC use of Solution 18;**
I am unable to recall the detail of any discussion at the meeting.

(e) **Whether agreement was reached in respect of the necessity to draft regional guidelines for the prevention of hyponatraemia;**
No.

(f) **Whether the issue of guidelines in respect of hyponatraemia was placed on the agenda for subsequent meetings? If so when and please provide?**
Not that I can recall, as the CMO had established a separate working group to develop the guidelines that subsequently came into being.

(17) Was there any reference to Raychel's case at Trust Board level or at other hospital committee meetings? If so, please provide any record thereof.
Not that I can recall during my tenure as Trust Medical Director in the Royal Group of Hospitals & Dental Hospital HSS Trust.

(18) With respect to the death of Raychel Ferguson please advise:

Please refer to my Witness Statement 077/1, and (10) above.

(a) **When you first received notification of her death and by what means;**

(b) **What communications with the Altnagelvin Hospital were thereby provoked;**

(c) **Whether you discussed the matter with Consultant Intensivists in PICU;**

Not that I recall

(d) **Whether the RBHSC was involved with the Altnagelvin Hospital Critical Incident Review into Raychel's care and treatment? If so please detail;**

The matter should be confirmed with the clinicians directly involved and /or the management in the Paediatric Directorate (RBHSC) and/or the Belfast HSC Trust.

(e) **Whether the details of Raychel Ferguson's case were communicated to the office of Associate Medical Director (Clinical Performance) in the RGHT?**

I do not have this information, please refer to the Belfast HSC Trust

(19) In relation to the letter from Mr. George Brangam to Mr. Peter Walby dated 16th January 2003 (Ref: 064-022-063) and the statement ***"Dr. Crean has indicated to me that the facts surrounding an earlier matter (Adam Strain deceased) were not on all fours with the present case but, I believe, it would be prudent for you to speak directly with Dr. Ian Carson in relation to this matter, particularly, given it would appear that the Department has some knowledge of the***

circumstances surrounding this particular incident" **please state:**

(a) Whether you have any note or recollection of Mr. Walby speaking to you in relation to this matter, and if so please detail;

It is correct that Mr Walby did speak to me by telephone to inform me of the forthcoming inquest into the death of Raychel Ferguson. I do not recall any detail of the conversation and I do not have a note by way of record.

(b) Did the Department have knowledge of *"the circumstances surrounding this particular incident"* **and if so, what was known and how did it came by this information?**

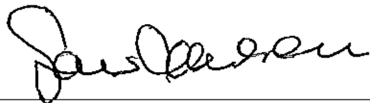
I refer to my previous Witness Statement 077/1 where I record the information made known to myself at or around the meeting of Trust Medical Directors on 18th June 2001. Subsequent to this there was separate communication between Altnagelvin Hospital, and HM Coroner John Leckey, with the Chief Medical Officer, Dr Henrietta Campbell, in regard to the circumstances of the death of Raychel Ferguson.

(20) In respect of the email from Christine Stewart, Press and Public Relations Officer- Royal Hospitals, to Colm Shannon of the Department dated 20th September 2004 (Ref: 023-045-105) please state whether anyone other than Dr. Taylor and the Press Officer was aware that this statement was made on behalf of the Hospital? If so who?

I left the Royal Group of Hospitals & Dental Hospital HSS Trust in July 2002. Please refer to the Belfast HSC Trust.

(21) Please provide such additional comment as you think appropriate. It would be of very considerable assistance if you could also attach any such further document that may be helpful.

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

Signed: 

Dated: 30 May 2013