Witness Statement Ref. No. 335/1

NAME OF CHILD: Raychel Ferguson

Name: Denis Martin

Title: Dr.

Present position and institution:

Retired 31/3/06

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

Clinical Director 1996-2002
Consultant Obstetrician and Gynaecologist 1975-2006

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

Regional committee member of the Confidential Enquiry of Stillbirths and Deaths in Infancy 1993-2006
Member of the AHSST Response team for the Human Organs Inquiry
Member of the DHSS Implementation Steering Group for the Human Organs Inquiry

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

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);

MB FRCOG. I am retired and do not keep a CV.

(b) Describe your career history;

Consultant Obstetrician & Gynaecologist, Altnagelvin Hospital 1975 – 2006

(c) Please describe your work commitments at the AHHSST from the date of your appointment as Clinical Director of the Women & Children's Care Directorate;

I had 5 fixed sessions split between Antenatal clinics (2), Gynae Clinic (1), and Gynae Surgery (2). I also provided Labour ward cover. I participated in an on call rota for Obstetrics and Gynaeclogy on a 1:5 basis. I also carried out ad hoc additional main theatre sessions and additional Gynae out patient clinics to help reduce waiting times. These were not part of my fixed job plan and I did not seek or receive remuneration for them. On top of these I also carried out the general workload of a consultant obstetrician and gynaecologist including carrying out ward rounds, teaching and carrying out the ongoing clinical care of patients. I did not drop any clinical sessions when I took on the role of Clinical Director for Women and Children's care. As Clinical Director I would have attended various meetings with Trust Management, in particular the Hospital Management team. I would have had regular meetings with the Clinical Services Manager for the Directorate. I also arranged and chaired regular Directorate meetings with the Consultants from each specialty within the Directorate and the Clinical Services Manager. I was also tasked by the Hospital Management Team to co-ordinate the planning required for certain specific projects within the Directorate, such as the strategy for the new Maternity Unit and the Ambulatory Care department for Paediatrics.

(d) What was the role of the Clinical Director 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 role was not reduced to writing as far as I am aware. I never had a specific job description or contract. I now understand there was a generic job description in place for Clinical Directors within the Trust from March 2001 but I have only witnessed same recently and do not recall having been provided with a copy whilst I was Clinical Director. I was responsible to the Chief Executive according to the organisational framework. The functions and responsibilities of the role of Clinical Director were not

formalised for me as far as I am aware. They evolved and varied throughout my tenure as Clinical Director. I understand that the present Clinical Director of Women and Children's Care has a formal job description which does not include Paediatrics.

(e) What was the role of the Clinical Services Manager in the provision of Paediatric Services in 2001?

According to the organisational framework the Clinical Services Manager was responsible to the Chief Executive in relation to Paediatrics. Her job description confirms that she reported to me.

(2) Did you have overall responsibility for the provision of Paediatric care in Ward 6 at Altnagelvin Area Hospital in 2001?

I have no qualifications or experience in Paediatrics. I had no involvement in Paediatric clinical care as Clinical Director. I would only have been in the Paediatric ward occasionally (a few times per year). At one stage the Paediatric ward moved from level 10 to level 6 and I was involved in the overall planning of that move. I was also involved in the development of the Paediatric Ambulatory Care facility. I did not as far as I am aware have overall responsibility for the provision of Paediatric care in Ward 6.

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

I presume this was the Chief Executive but I am not aware of any document or guidance that set this out so I am subject to correction.

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

There were none in NI. I attended an annual symposium for clinical directors in Obstetrics and Gynaecology organised Royal College of Obstetrics and Gynaecology.

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

(a) Clinical governance;

(b) Social care governance;

(c) Health and Safety;

(d) Adverse Clinical Incident Investigation;

(e) Complaints procedure;

(f) Performance assessment;

(g) Continuing medical education and professional development;

(h) Clinical record keeping;

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

(j) Communication with next of kin?

I have been retired from the Trust for 7 years and cannot as a consequence answer this question. Presumably someone who is currently at the Trust will be in a position to assist.

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;

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

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

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

(v) How implementation and compliance was enforced;

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

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

See (5)

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

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

(c) What were the standards/criteria set;

(d) What was the outcome of this process?

(7) 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;

(b) Who served on the Clinical Audit Committee;

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

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

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

(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?

There was a Clinical Audit Committee as far as I can recall. Presumably the Trust will have details of its remit and membership. I understand the Clinical Audit Committee set an agenda for audit within the hospital. I was not a member of the Clinical Audit Committee.

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

I do not know.

(a) What was the function of the Committee;

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

(c) Who formed the membership of this Committee;

(d) Whether its deliberations were minuted;

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

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

(a) Clinical policy setting;

(b) Clinical policy monitoring;

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

The Obstetrics unit and Gynaecology unit had ward policy folders which were regularly updated. Policies could be introduced via the Royal College, the Department of Health, the Board or individual Consultants. There may have been similar folders in the Neonatology and Paediatrics units. In Obstetrics and Gynaecology each trainee coming to the department was given a departmental handbook that was prepared by the Consultants. The implementation of policies could be monitored by audit.

(10) Please describe the steps taken to disseminate, implement/enforce compliance with the recommendations deriving from external sources including the following:

(a) The Royal Colleges;

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

(c) Department of Health;

(d) Audit Commission;

(e) General Medical Council;

(f) DHSSPSNI;

(g) HPSS;

(h) Management Executive;

(i) Paediatric Intensive Care Society.

Policies would have been included in the ward policy folders, put on notice boards and incorporated into departmental and hospital handbooks.

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

There were weekly perinatal meetings between the Obstetric and Neonatal staff relating to Obstetrics and Neonatal care. This also provided a forum for discussion about the introduction of new policies. Audits were presented at these meetings. In 2001 I set up a strategy for Risk Management within the Women and Children's care Directorate. When this was set up a named Consultant became responsible for risk management in each of the four units, namely Obstetrics and Gynaecology, Neonatology and Paediatrics.

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

The Royal College of Obstetrics and Gynaecology carried out 5 yearly hospital assessments of the Obstetrics and Gynaecology wards.

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

(a) Raychel Ferguson;

I cannot say exactly but believe I would have heard on the 11th or 12th June 2001.

(b) Lucy Crawford?

Much later, perhaps years later.

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

Raychel's death was on 10th June 2001 in RBHSC. I was not on call during that weekend. I was on annual leave from 13th to 19th June 2001 (inclusive). I did not take action on learning of the death of Raychel Ferguson.

(15) With respect to the Critical incident Review meeting held on 12th June 2001 please explain;

(a) Why did you not attend the meeting or meet with Mr. and Mrs. Ferguson;

(b) Who was responsible for compiling a list of the relevant clinicians involved for the purposes of Review, and how was this done;

(c) Who was invited to attend the Review and whether any record exists to identify those who attended the Review;

(d) Was any attempt made to trace the Paediatric rotas for 7th - 9th June inclusive;

(e) Which members of staff were interviewed, when and by whom, and whether this process was recorded or noted;

(f) What further investigations were carried out by the Review team after the meeting;

(g) Whether or not you received a report in writing into the case of Raychel Ferguson? If so please provide the same;

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

I was not informed or invited to this meeting. Neither was I invited to the meeting with Mr and Mrs Ferguson. I did not receive a copy of any report, nor was I directed to ensure that any recommendations were implemented.

(16) In respect of the *"Update for Chief Executive Re: Critical Incident Meeting"* (Ref: 022-097-307) please state what steps were taken to review the *"further action required"* and to ensure it was achieved. Please also state what steps were taken to address the concerns of nursing staff with respect to surgical inability to commit to children on Ward 6?

I was not provided with a copy of this document.

(17) In the aftermath of the death of Raychel Ferguson did you have reason to consider any of the following matters arising (and if so please include details):

(a) Performing a detailed audit of all aspects of the case;

(b) The record of communication with Raychel's parents;

(c) The quality, consistency and timeliness of information given the Ferguson family;

(d) The overall leadership of the clinicians treating Raychel;

(e) The absence of the consultant responsible for Raychel's care, from Raychel's care;

(f) Interviewing, receiving input from or involving the Ferguson family in the Review;

(g) Obtaining the expert views of an internal/external specialist;

(h) The skill and suitability of junior surgical staff to oversee fluid management;

(i) Difficulties experienced by surgical doctors in attending upon Paediatric patients;

(j) The conduct and responsibility for post-take ward rounds;

(k) The responsibility for intravenous fluid prescription/administration as and between Anaesthetic, Surgical and Paediatric teams;

(l) The extent, type and duration of the vomiting suffered by Raychel on 8th June 2001;

(m) The failure to replace abnormal electrolyte losses caused by vomiting;

(n) Possible shortcomings in the nursing care provided to Raychel Ferguson;

(o) Inter-clinician-communication (ICC);

(p) Whether or not intravenous fluids had been administered at a greater rate than recommended;

(q) Whether or not there had been any shortcoming in the frequency of assessment of Raychel's electrolytes;

(r) Whether or not there had been any shortcoming in the assessment and recording of urinary output and vomit;

(s) The records relating to the post operative care of Raychel;

(t) The competence and training needs of those who cared for Raychel;

(u) The content and update of nursing care plans;

(v) The efficacy of the bleeper summonsing system;

(w) The balance of responsibility between medical and nursing staff in respect of monitoring patients;

(x) The failure to include Post Operative Nausea and Vomiting in the Episodic Care Plan;

(y) The clinical protocols available to nurses in Ward 6 on 8th June 2001;

(z) A review of ward practices and conventions to determine whether they were appropriate, and whether they might better be reduced to writing as clinical protocols;

(aa) Whether there were any broader systemic failings in the provision of the care given Raychel?

I knew there was a Critical Incident Review team investigating the circumstances of Raychel Ferguson's death. My understanding was if any of the matters set out from (a) to (aa) required consideration, that they would be actioned by the Critical Incident Review team.

(18) 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.

There was a presentation by the Medical Director to the Hospital Management Team on 9th October 2001. I have a copy of the minutes of this meeting and if the Inquiry requires a copy I can make it available.

(19) Please state when you first became aware of the content of the following:

(a) The Autopsy report provided by Dr. Herron (Ref: 014-005-006);

(b) The report of Dr. Sumner to the Coroner (Ref: 012-001-001);

(c) The report of Dr. Loughrey (Ref: 014-005-014);

(d) The reports of Dr. Jenkins (Ref: 317-009-002 and 317-009-004);

(e) The report of Dr. Warde (Ref: 317-009-006)?

(a) – (e) When asked to provide this statement.

Was any consideration given to sharing the content of these reports with the Ferguson family? And if not why not? N/A

(20) ***"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;**

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

(c) Why was it permitted to continue;

(d) Was it reviewed?

I was not aware of this problem in this regard. It was never reported to me.

(21) In relation to the Memorandum of 2nd May 2003 (Ref: 021-044-091) and the ***"uncertainty regarding the management of surgical paediatric patients"*** **please state:**

(a) What this uncertainty was and how it manifested itself;

(b) Whether there was any difference of approach between the surgical and paediatric specialty teams?

I was not aware of any such uncertainty. It was never reported to me.

(22) In respect of the letter by Dr. Nesbitt dated 3rd July 2001 (Ref: 021-057-037) and the assertion that ***"some clinicians evidently feel that no. 18 solution is the fluid they wish to prescribe, and have disagreed with the regime suggested… I am concerned that my attempt to put in place a safe policy has met with resistance so quickly. Perhaps you could discuss this urgently within the Surgical Directorate so that a regime can be agreed"*** **please state:**

(a) Whether members of the Surgical specialty team disagreed with the discontinuance of the use of No. 18 Solution;

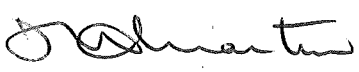
(b) If so why?

None of this was reported to me. I was not aware of any of this.

(23) 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 been retired now for seven years and am now aged 70. I have done the best I can to respond to the detailed and complex questions asked by the Inquiry. My memory does not permit a detailed response to every question but I hope that the Trust can add to the detail of some answers from their records. During my years as Clinical Director, I was not involved in clinical care on the Paediatric ward. The document at 077-004-005 exemplifies the position in the sense that my successor as Clinical Director for Women and Children's care was not apparently required to sign this document.

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

Signed:  **Dated:** 10th July 2013