

Witness Statement Ref. No. 345/1

NAME OF CHILD: Raychel Ferguson

Name: Kathryn Little

Title: Miss

Present position and institution:

Safeguarding Children Nurse Specialist

Previous position and institution:

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

F Grade Paediatrics Nursing Sister, Ward 6, Altnagelvin Hospital

Membership of Advisory Panels and Committees:

[Identify by date and title all of those between January 2000 - present]

I have not been a member of any advisory panel or committee

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:

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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);

Registered General Nurse (RGN), Registered Sick Children's Nurse (RSCN)

(b) Describe your career history;

Safeguarding Children Nurse Specialist, WHSCT August 2009 - current position

Health Visitor, WHSCT, Sept 2003 - August 2009

Student Health Visitor, WHSCT, Sept 2002 - Sept 2003

F-Grade Paediatric Nursing Sister, Children's Ward, Altnagelvin Hospital, June 1987 - September 2002.

Staff Nurse, Children's Ward, Altnagelvin Hospital, December 1986 - June 1987

Post Reg. Student Nurse, Royal Belfast Hospital for Sick Children, October 1985 - December 1986

Staff Nurse, Geriatric Ward, Coleraine Hospital, April 1985 - October 1985

Staff Nurse, Paediatric Ward, Coleraine Hospital, December 1983 - April 1985

Student Nurse, Belfast City Hospital, October 1980 - October 1983

(c) Please describe your work commitments in 2001;

F Grade Paediatric Nursing Sister, Altnagelvin Hospital. In the absence of G Grade Sister my responsibilities were taking charge and managing Paediatric Unit, delegation of duties to staff as appropriate, also I was designated child protection representative and supported staff in the child protection process, communicating with other disciplines.

(d) What was your role, what were the functions, accountabilities and responsibilities of your post, and were these reduced to writing by 2001? If so please provide a copy of the same;

In the absence of G Grade Sister, my responsibilities were taking charge and managing Paediatric Unit, delegation of duties to staff as appropriate, also I was designated child protection representative and supported staff in the child protection process, communicating with other disciplines. I was accountable to my Line Managers, Sr Elizabeth Millar and Mrs Margaret Doherty.

I was not on duty during the time Raychel Ferguson was on the ward. I have never had contact with Raychel Ferguson or her parents.

(e) Who was your line manager in 2001?

Sister Elizabeth Millar and Mrs Margaret Doherty.

(2) With reference to the five pages of handwritten notes (Ref:316-085) please state:

(a) Whether you took these notes;

I confirm that these notes are in my handwriting.

(b) Who asked you to take these notes, and when;

I recall being asked and I strongly believe that the request came from my line manager Mrs Margaret Doherty in the absence of Sister Millar to provide her with a resume of events which she required urgently for a meeting. I cannot recall the exact date when Mrs Margaret Doherty asked me to take these notes however I believe it may have been the 10th or 11th June 2001 as Sister Millar was off duty and I was in charge in her absence, this was the only time I was involved in the case.

(c) What was the purpose of taking these notes and what did you use the notes for;

I believe that Mrs Margaret Doherty asked me to take these notes as she needed them for a meeting which I believe was to take place on Monday 11th June 2001 at 2pm.

(d) Whether you took any further note or record;

No further notes or records were taken by myself.

(e) Whether you retained any further notes or documentation and if so please provide;

No further notes or documentation were retained by myself.

(f) Who was present at the interviews and where were they carried out;

I did not undertake interviews with members of staff, however, I did have telephone contact with staff nurse Ann Nobel and information shared by staff nurse Ann Nobel was recorded by me in these notes. Staff Nurse Ann Nobel was informed that I was recording this information in notes for Mrs Margaret Doherty.

(g) Who asked you to interview the nurses, and when;

I was not asked to interview any nurses. I was simply asked in the absence of Sister Millar to provide a resume of events for a meeting and to inform the staff who were on duty on Friday night 8th June 2001 that they were required to attend this meeting. I believe this request was made by Mrs Margaret Doherty my line manager

(h) Why were you asked to carry this out;

Mrs Margaret Doherty had arranged a meeting with staff involved and required a resume of

events.

(i) Whether you had any experience or training in such matters;

No.

(j) Whether you made the notes at the time of interview or were they made up subsequently;

Notes recorded during telephone contact with Staff Nurse Ann Nobel.

(k) The time and date that you interviewed the nurses;

Not applicable.

(l) Whether you interviewed anyone other than nurses Noble and Patterson;

No. I only recall having the telephone conversation with Staff Nurse Ann Nobel.

(m) Whether you compiled any further documentation, and if so please detail;

No.

(n) Whether you made any further oral or written report arising from your investigations;

No.

(o) Whether you made any other investigations, and if so please detail;

No.

(p) Whether you took any further steps, and if so please detail;

No.

(q) Whether you made any contribution to the Critical Incident Review;

No.

(r) Whether you made any contribution to any nursing meetings consequent upon Raychel's case;

No.

(s) Whether you made any contribution to changes in practice (if so please detail);

I have no recollection.

(t) Whether you have any additional recollections of the earlier investigation;

No.

(u) Whether Raychel's case was reported as an adverse clinical incident and if so to whom;

I don't know.

(v) Whether you checked your notes of interview against the medical notes for inconsistency;

No. As the child had been transferred out of the ward, I had no access to medical or nursing records.

(w) Whether you subsequently had access to the nurses statements;

No.

(x) Whether you were subsequently asked to make any statement yourself;

No.

(y) Whether you played any role in the preparation for Inquest, and if so please detail;

No.

(z) Were you asked to provide your views in relation to any ongoing litigation, inquiry or audit?

No.

(3) *"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 statement. In the event that you do agree please address the following matters:

(a) How and when did this *"problem in the Children's Ward"* become established;

I don't know.

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

I don't know.

(c) Why was it permitted to continue;

Not applicable.

(d) Was it reviewed?

Not applicable.

(4) Was there any discussion of Raychel's case in nurse meetings, nursing reviews, nursing audits or learning sessions? If so, please provide any record thereof and describe:

(a) The learning derived therefrom;

I cannot recall.

(b) Those steps taken to utilise the learning?

I cannot recall.

(5) Please provide the following information:

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

I cannot recall exact time or by whom.

(b) Please advise whether you were in attendance at the Critical Incident Review Meeting, and if not whether you would have expected to have been?

No, normal practice for Senior Sister to attend this type of meeting.

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

I don't know.

(d) How lessons learned were to be communicated across the children's ward?

I don't recall.

(e) 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?

I have no recollection.

(f) 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 have no recollection.

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

I received no report in writing into the case of Raychel Ferguson.

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

I received no recommendations in relation to this review, however I believe general practice improvements would have been implemented as directed by Sister Millar. I have no further recollection as I left this ward in September 2002.

(i) Was any consideration given to performing a detailed audit of all aspects of the case?

Not known.

(j) Whether the bleeper system was efficient?

Not known.

(k) Whether the fluid balance documentation was adequate?

Not known.

(l) Whether the computerised presentation of blood results was appropriate and adequate?

Not known.

- (6) 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)?
Not applicable.
- (7) 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.
I am not aware.
- (8) With reference to the Update for Chief Executive Re: Critical Incident Meeting (Ref: 022-097-308) please state the following:
- (a) Was the meeting referred to at paragraph 4 minuted? If so please provide; I have no recollection of attending any meeting in relation to this case. All meetings of this nature were attended by Sister Millar
 - (b) Who convened this meeting and was there an agenda; As I was not in attendance at this meeting I cannot comment.
 - (c) Did you share the concern of the nursing staff that surgeons were unable to give a commitment to children on Ward 6 and if so please describe when this became a concern and what steps you took to address it; I am not aware.
 - (d) How the agreement in respect of fluid balance management was implemented, monitored and enforced? I have no recollection however I believe practice improvements would have been implemented as directed by Sister Millar.
- (9) 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, Kathryn Little, was not on duty at the time Raychel Ferguson was an in-patient in the Children's Ward, Altnagelvin Hospital. My only input to this case was to take notes from a telephone conversation I had with Staff Nurse, Ann Nobel, at the request of Mrs Margaret Doherty, my Line Manager at this time.

I left my post as F Grade Paediatric Nursing Sister in September 2002 to further my career as a Health Visitor with Western Health & Social Care Trust.

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

Signed:

Kathryn ER Little

Dated:

15th July 2013