

## LIST OF PERSONS INVOLVED: RAYCHEL GOVERNANCE

## SCHEDULE 1: Persons involved as Inquiry Witnesses

Name	Position in June 2001	Role	Deposition / PSNI Statement	Inquiry WSs	Called as a Witness?
<b>FAMILY &amp; LAY PERSONS</b>					
Mr. Raymond Ferguson	Raychel's father		095-005-015 (PSNI)	021/1	
Mrs. Marie Ferguson	Raychel's mother		012-028-144 (Coroner) 095-001-001 (PSNI) 095-002-005 (PSNI) 095-003-009 (PSNI) 095-004-014 (PSNI)	020/1	
Mrs. Kay Doherty	Mrs. Ferguson's sister	Attended the meeting between the representatives of the AHHSST and the family on 3 <sup>rd</sup> September 2001		326/1	✓
<b>ALTNAGELVIN</b>					
Mr. Robert Gilliland	Consultant Surgeon, Altnagelvin	Named consultant for Raychel's admission for surgery.	012-038-176 (Coroner)	044/1 044/2 044/3 044/4	✓
Dr. Brian McCord	Consultant Paediatrician, Altnagelvin	Was the paediatrician on-call on 9 <sup>th</sup> June 2001.	012-036-170 (Coroner)	032/1 032/2 032/3	✓
Dr. Raymond Fulton	Consultant Dermatologist and Medical Director until Feb 2002, AHHSST	Established a critical incident review on 12 <sup>th</sup> June 2001	012-039-179 (Coroner) 095-011-047 (PSNI)	043/1 043/2 043/3	✓
Dr. Geoff	Consultant Anaesthetist,	Accompanied Raychel for her scan on the morning of 9 <sup>th</sup> June	012-037-173 (Coroner)	035/1	✓

LIST OF PERSONS (CLINICAL)

Name	Position in June 2001	Role	Deposition / PSNI Statement	Inquiry Ws	Called as a Witness?
Nesbitt	Clinical Director, and Medical Director, AHHSST	2001 after her respiratory arrest, liaised with neurosurgeons in the Royal Hospital, arranged for her transfer to RBHSC and travelled with her to the RBHSC. Subsequently took the clinical lead after the critical incident meeting was convened, and developed protocol for fluid management at Altnagelvin. Medical Director from March 2002.	095-010-030 (PSNI)	035/2	
Mrs. Stella Burnside	Chief Executive of AHHSST	Made contact with Chief Medical Officer to advocate a regional review of the issue of electrolyte balance in postoperative children. Convened a meeting of clinicians and nursing staff who met with the Ferguson family on 3 <sup>rd</sup> September 2001		046/1 046/2	✓
Mrs. Therese Brown	Risk Management Co-ordinator, AHHSST	Liaised with the Coroner regarding the collection of witness statements for the Inquest from Altnagelvin staff. Assisted PSNI with their inquiries by providing relevant clinical records etc.	095-018-077 (PSNI)	322/1	✓
Margaret Doherty	Clinical Services Manager, Paediatrics, AHHSST	Clinical Services Manager, Paediatrics		336/1	✓
Dr. M. Parker	Clinical Audit Co-ordinator, AHHSST	Clinical Audit Co-ordinator and member of Medical and Specialist Advisory Committees		324/1	
Mrs. Anne Doherty	Patient Advocate, AHHSST	Responsible for complaints, attended and minuted the meeting between the representatives of the AHHSST and the family on 3 <sup>rd</sup> September 2001		325/1	
Dr. Phillip Gardiner	Post-Graduate Tutor, AHHSST	Responsible for medical education and training provided at Altnagelvin		328/1	
Dr. Thomas Melaugh	Clinical Director, Clinical Support Services, AHHSST	Served on the Drug & Therapeutic and Ethics committees, the Clinical Governance Steering group and a member of the Hospital Executive team		334/1	

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Name	Position in June 2001	Role	Deposition / PSNI Statement	Inquiry WSs	Called as a Witness?
Dr. Denis Martin	Clinical Director, Women & Children's Care Directorate, AHHSST	Clinical Director responsible for the provision of clinical care in this Directorate		335/1	
Mrs. J. Hutchinson	Clinical Services Manager, AHHSST			327/1	
Mrs. Anne Witherow	Clinical Effectiveness Co-ordinator	Responsible for ensuring the clinical effectiveness of care given. Attended Update for Chief Executive Re; Critical Incident Review Meeting		329/1	
Mrs. Marie Dunne	Communications Manager, AHHSST	Responsible for communications across the AHHSST			
<b>NURSING (ALTNAGELVIN)</b>					
Ann Noble	Nurse, Ward 6, AHHSST	On duty on the Ward when Raychel was admitted on 7 <sup>th</sup> June 2001. Was responsible for providing care to Raychel including attending to her when her tonic seizures started at 03.00 hours on 9 <sup>th</sup> June. Was present at the Critical Incident Review Meeting on 12 <sup>th</sup> June 2001 and the meeting with the family on 3 <sup>rd</sup> September 2001	012-043-207 (Coroner)	049/1 049/2 049/3 049/4	✓
Elizabeth Millar	Nursing Sister, Ward 6, AHHSST	Overall responsibility for the Paediatric Ward in 2001. Was present at the Critical Incident Review Meeting on 12 <sup>th</sup> June 2001.	012-041-202 (Coroner)	056/1 056/2 056/3	✓
Miss Irene Duddy	Director of Nursing, AHHSST	Professional leadership of nurses		323/1	✓
Margaret Dooher	Staff Nurse, Ward 6, AHHSST	Accompanied Raychel to the RBHSC		344/1	
Miss Katheryn Little	Nursing Sister, Ward 6, AHHSST	Took notes of information provided to her by Nurse Noble for use by Margaret Doherty		345/1	

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Name	Position in June 2001	Role	Deposition / PSNI Statement	Inquiry WSs	Called as a Witness?
Mr. Gerry McMenamin	Charge Nurse, AHHSST	Spoke with the Ferguson's before Raychel's transfer to the RBSHC		337/1	
Mrs. Mary McKenna	Senior Staff Nurse, AHHSST	Issued letters notifying Margaret Doherty of nursing staffing issues, and initiated audit of the clinical paediatric area		346/1	✓
<b>MEDICAL (RBHSC)</b>					
Dr. Peter Crean	Consultant in Paediatric Anaesthesia and Intensive Care, RBHSC	Had overall responsibility for Raychel's care after she had been admitted into the PICU of the RBHSC on 9 <sup>th</sup> June 2001 and carried out brain stem tests with Dr. Hanrahan in confirmation of Raychel's death.	012-032-159 (Coroner) 095-020-092 (PSNI)	038/1 038/2 038/3	✓
Dr. Ian Carson	Medical Director, RGHT	Medical Director, RGHT		331/1	✓
Dr. Robert Taylor	Consultant Paediatric Anaesthetist, RBHSC	Anaesthetist, RBHSC		330/1	✓
Dr. Elaine Hicks	Clinical Director, Paediatrics, RBHSC	Clinical Director responsible for Paediatrics, RBHSC		340/1	
Mr. A.P. Walby	Associate Medical Director, Litigation Management Office, RBHSC	Raychel Ferguson's Inquest		341/1	
Dr. John O'Hare	Director of Pharmaceutical Services, Pharmacy Directorate, RGHT	Pharmacy, RGHT		343/1	
Dr. Brian Herron	Consultant Neuropathologist, Royal Group of Hospitals	Performed autopsy on 11 <sup>th</sup> June 2001 with Dr. Al-Husaini, and subsequently provided an autopsy report (20 <sup>th</sup> November 2001)	012-031-157 (Coroner) 012-047-219 (Report)	041/1	
<b>OTHERS</b>					
Dr. Elma	Raychel Ferguson's General	Attended the meeting between representatives of the AHHSST		333/1	

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Ashenhurst	Practitioner	and the family on 3 <sup>rd</sup> September 2001			
Dr. Anand	Consultant Anaesthetist, Tyrone County Hospital	Provided information as to the use of Solution 18 at Tyrone County Hospital		347/1	
Mr. Stanley Millar	Chief Officer of Western Health and Social Services Council	Was contacted by the Ferguson family after Raychel's death, and provided advice with regard to the avenues available for redress and complaint. Met with the Chief Executive of Altnagelvin after the Inquest		093/1	
Dr. William McConnell	Director of Public Health of the Western Health and Social Services Board	Advised of the circumstances of Raychel's death by Dr. Fulton, and agreed to discuss it at his next meeting with the Chief Medical Officer and Directors of the other three Boards. He was given the responsibility of writing to the other three Directors on this issue. Dr. McConnell's office had previously been advised (in 2000) of the death of Lucy Crawford following treatment in the Erne Hospital		047/1	
Mr. John Leckey	H.M. Coroner for Greater Belfast	Was Coroner to the Inquest which was held on 5 <sup>th</sup> and 6 <sup>th</sup> February 2003. He delivered his verdict on 10 <sup>th</sup> February 2003		090/1	
Dr. Henrietta Campbell	Chief Medical Officer for Northern Ireland	Arranged for CREST to develop fluid management guidelines in the aftermath of Raychel's death			
Dr. Clodagh Loughrey	Consultant Chemical Pathologist, Belfast City Hospital	Provided report to Dr. Herron on 24 <sup>th</sup> October 2001 commenting on the cause of the cerebral oedema which caused the death of Raychel Ferguson	012-019-124 (Letter of opinion)	045/1	

**SCHEDULE 2: Persons involved as Inquiry Expert Witnesses**

Witness Ref No.	Name	Specialty	Report
226	Professor Charles Swainson	Medical Director	05/08/2013

**SCHEDULE 3: Persons involved as other Experts**

Name	Position/Title <sup>1</sup>	Date of Initial Report	Inquiry Ref:
Dr. Edward Sumner	Consultant in Paediatric Anaesthesia	February 2002	012-001-001 (Report) 012-029-150 (Coroner) WS-057/1 (Inquiry)
Dr. John Jenkins	Senior Lecturer in Child Health, Queen's University Belfast	30 <sup>th</sup> January 2003	022-010a-041 (Report for DLS) 012-023-132 (Report for Coroner) 012-030-153 (Coroner) WS-059/1 (Inquiry)
Dr. Declan Warde	Consultant Paediatric Anaesthetist, Children's University Hospital, Dublin	January 2003	317-009-006
Susan Chapman	Nurse Consultant at Great Ormond St	24 <sup>th</sup> September 2005	095-019-078 (PSNI)
Dr. Clodagh Loughrey	Consultant Chemical Pathologist, Belfast City Hospital	24 <sup>th</sup> October 2001	014-006-014

<sup>1</sup> The position shown is that at the time of the Report