Raychel Ferguson

Consolidated Management and Governance Report by Advisors 21 August, 2013

This short report describes the main management and governance areas that impacted on Raychel's care during her hospital admission in June 2001 that the advisors believe require further examination by the Inquiry during the forthcoming Oral Hearings

In addition to all the relevant clinical, nursing & administrative records, the following statements & reports were used in the generation of this document:

1. Protocol & briefs for experts
2. Witness Statements & responses to questions; Mr RR Makar, Senior House Officer, Surgery, Altnagelvin Area Hospital
3. Witness Statements & responses to questions; Dr VK Gund, Senior House Officer, Anaesthesia, Altnagelvin Area Hospital
4. Witness Statements & responses to questions; Dr C Jamison; Senior House Officer, Anaesthesia, Altnagelvin Area Hospital
5. Witness Statements & responses to questions; Mr HM Zafar, Senior House Officer, General Surgery, Altnagelvin Area Hospital
6. Witness Statements & responses to questions; Dr M Butler, Senior House Officer, Paediatric Medicine, Altnagelvin Area Hospital
7. Witness Statements & responses to questions; Dr J Devlin, House Officer, Surgery, Altnagelvin Area Hospital
8. Witness Statements & responses to questions; Dr M Curran, Junior House Officer, Surgery, Altnagelvin Area Hospital
9. Witness Statements & responses to questions; Dr J Johnson, Senior House Officer, Paediatrics, Altnagelvin Area Hospital
10. Witness Statements & responses to questions; Dr B Trainor, Senior House Officer, Paediatrics, Altnagelvin Area Hospital
11. Witness Statements & responses to questions; Dr A Date, Specialist Registrar, Anaesthetics, Altnagelvin Area Hospital
12. Witness Statements & responses to questions; Dr B McCord, Consultant Paediatrician, Altnagelvin Area Hospital
13. Witness Statements & responses to questions; Dr G Allen, Senior House Officer, Anaesthesia, Altnagelvin Area Hospital
14. Witness Statements & responses to questions; Dr Mr Bhalla, Specialist Registrar, General Surgery, Altnagelvin Area Hospital
15. Witness Statements & responses to questions; Dr G Nesbitt, Consultant Anaesthetist & Clinical Director in Anaesthesia & Critical Care, Altnagelvin Area Hospital
16. Witness Statements & responses to questions; Dr Crean, Consultant Paediatric Anaesthetist, Belfast Royal Hospital for Sick Children
17. Witness Statements & responses to questions; Dr D Hanrahan, Consultant Paediatric Neurologist, Royal Belfast Hospital for Sick Children
18. Witness Statements & responses to questions; Dr D O'Donoghue, Clinical Fellow in Paediatric Intensive Care, Royal Belfast Hospital for Sick Children
19. Witness Statements & responses to questions; Dr B Herron, Consultant Neuropathologist, Royal Victoria Hospital, Belfast
20. Witness Statements & responses to questions; Dr R Fulton, Medical Director, Altnagelvin Hospitals Health & Social Services Trust
21. Witness Statements & responses to questions; Mr R Gilliland, Consultant Colorectal and General Surgeon, Altnagelvin Area Hospitals
22. Witness Statements & responses to questions; Mrs S Burnside, Chief Executive, Altnagelvin Area Hospitals
23. Witness Statements & responses to questions; Dr B McConnell, Director of Public Health Medicine, Western Health & Social Services Board
24. Witness Statements & responses to questions; D Patterson, Staff Nurse (D Grade), Pediatrics, Altnagelvin Area Hospitals
25. Witness Statements & responses to questions; A Noble, Staff Nurse (E Grade), Ward 6, Altnagelvin Area Hospitals
26. Witness Statements & responses to questions; M McGrath, Staff Nurse, Theatres, Altnagelvin Area Hospitals

27. Witness Statements & responses to questions; M McAuley (née Rice), Staff Nurse (D Grade), Ward 6, Altnagelvin Area Hospitals
28. Witness Statements & responses to questions; A Roulston, Staff Nurse, Ward 6, Altnagelvin Area Hospitals
29. Witness Statements & responses to questions; S Gilchrist, Staff Nurse, Paediatrics, Altnagelvin Area Hospitals
30. Witness Statements & responses to questions; F Bryce, Staff Nurse (D Grade), Paediatrics, Altnagelvin Area Hospitals
31. Witness Statements & responses to questions; E Lynch, Auxillary Nurse (NVQ 2), Paediatrics, Altnagelvin Area Hospitals
32. Witness Statements & responses to questions; E Millar, Sister, Ward 6, Altnagelvin Area Hospitals
33. Witness Statements & responses to questions; Dr JG Jenkins, Senior Lecturer in Child Health & Consultant Paediatrician, Antrim Hospital
34. Witness Statements & responses to questions; Mr J Leckey, HM Coroner, Greater Belfast
35. Witness Statements & responses to questions; Mr S Millar, Chief Officer, Western Health & Social Services Council
36. Witness Statements & responses to questions; Dr B Kelly, Senior House Officer, A&E, Altnagelvin Area Hospitals
37. Witness Statement ; Dr Zawislak, Locum Staff Grade, Surgery
38. Witness Statements and evidence from Mr and Mrs Ferguson
39. Witness statement from Mrs Margaret Doherty (Clinical Services Manager, Altnagelvin Hospital.
40. Witness statement; Mrs Teresa Brown (Risk Management Co-ordinator/ Director, Altnagelvin Hospital.
41. Witness statement; Miss Ann Irene Duddy (Director of Nursing, Altnagelvin Hospital.
42. Witness statement; Mrs K Doherty (Cook, St Patrick's Primary School)
43. Witness statement; Dr Elma Ashenhurst (GP)
44. Witness statement; Dr Declan Warde, (Consultant Paediatric Anaesthtist, Dublin)
45. Witness statement; Mr AP Walby (Associate Medical Director, RGHT)
46. Witness statement; Dr John DG O'Hare (Director of Pharmaceutical Services, RGHT)
47. Witness statement; Mrs Mary McKenna (Senior Staff Nurse, Ward 6, Altnagelvin)
48. Witness statement; Kathryn Little (Paediatric Nursing Sister, Ward 6, Altnagelvin)
49. Witness statement; Dr M Parker (Clinical Audit Co-ordinator, Altnagelvin Hospital.
50. Witness statement; Mrs Ann Doherty (Patient Advocate, Altnagelvin Hospital)
51. Witness statement; Mrs J Hutchinson (Clinical Services Manager, Altnagelvin Hospital)
52. Witness statement; Dr Phillip Gardiner (Consultant Physician & Post-Graduate Tutor, Altnagelvin Hospital)
53. Witness statement; Mrs Anne Witherow (Clinical Effectiveness Co-ordinator)
54. Witness statement; Mr Thomas Melaugh (Director, Clinical Support Services, Altnagelvin Hospital)
55. Witness statement; Dr Elaine Hicks (Clinical DSirector, Paediatrics, RBHSC)
56. Depositions to Coroner's Inquest
57. PSNI witness statements/interviews
58. RHBSC case notes
59. Altnagelvin Area Hospital case notes
60. Inquiry Generated Documents
61. Medico-legal report by Mr John D Orr (Paediatric Surgeon)
62. Expert reports and evidence from Dr Simon Haynes (Paediatric Anaesthetics)
63. Expert reports and evidence from Mrs Sally Ramsay (Paediatric Nursing)
64. Expert reports and evidence from Dr Robert Scott-Jupp (Paediatrician)
65. Expert reports and evidence from George Foster (Paediatric Surgeon)
66. Expert report by Charles Swainson (Governance expert)
67. Report and evidence from Professor Mary Hanratty

1. Summary

The list below summarises the matters for further consideration which form the bulk of this report. Those items marked *Key issue* are considered as potentially significant.

1.1 The adequacy of the action taken by the RBHSC Trust following Raychel's death

- Why the Trust did not register Raychel's death as a serious untoward incident? *Key issue*

- Whether the RBHSC Trust undertook any review of the death of Raychel, and whether this involved any collaboration or communication with Altnagelvin Hospital. *Key issue*

- What lessons were learned following Raychel's death and whether these were conveyed to other hospitals in Northern Ireland?

- Whether The Trust undertook mortality and morbidity reviews and clinical audit in line with guidance from the Paediatric Intensive Care Society (UK)[1].

1.2 The adequacy of the investigation and action taken by Altnagelvin Area Hospitals Trust following Raychel's death

- Whether Altnagelvin Area Hospital Trust took sufficient action to comply with the recommendations of the Report of a Working Group into Paediatric Surgical Services in Northern Ireland (1999). Although the report concluded that the hospital could meet the requirements, the Inquiry should determine whether it had taken adequate steps to do so by 2001, given that: *Key issue*

  a) Post-operative fluid management on the children's ward seemed to be determined by 'custom and practice' rather than evidence.

  b) There was lack of clarity between members of the anaesthetic, surgical and paediatric staff regarding who was responsible for prescribing fluids and the nature and quantity of these.

  c) It is questionable whether the nurses were sufficiently knowledgeable in the care and management of post-operative children to recognise complications and raise these with the appropriate doctor?

  d) Specific to Raychel, when Dr Zafar's prediction that she would progress to oral feeding during the day proved wrong, the nurses sought attention only from the most junior members of the medical staff. The surgical and anaesthetic experts advising the Inquiry expressed concerns about the responsibility placed on the JHO's. However, Swainson considers their education and training provided adequate basic knowledge to guide the prescribing of fluids in children. (226-002-012)

- Whether Altnagelvin Area Hospital Trust adhered to guidance provided by NCEPOD. Specifically did the Trust/Children's Directorate have a policy relating to the timing of surgery and who should undertake surgery on children at night? Also, whether all key surgical staff were aware of the NCEPOD guidance? *Key issue*

[1] Paediatric Intensive Care Society (2001) *Standards Document 2001,* PICS, UK

- Whether Raychel's death was formally recorded as a clinical incident and was reported to NCEPOD.

- Whether the Trust Board was sufficiently informed about Raychel's case and whether the actions taken by its officers were discussed and agreed. Key issue

- Whether the investigation dealt adequately with the responsibility for: *Key issue*

  a) The management of postoperative care for children requiring surgery on the wards in 2001 as between anaesthetic, surgical and paediatric teams

  b) Record keeping by all professionals, including the use of electronic care planning and the maintenance of complete and contemporaneous records

  c) Education and training of medical and nursing staff on Ward 6 regarding fluid management and hyponatraemia in children in 2001

- Whether information and communication with the Ferguson family should have formed part of the clinical Incident review. *Key issue*

1.3 The adequacy of the action taken by the Western Area Health & Social Care Board (WHSSB).

- The involvement of WHSSB in the recommendations and action following the Report of a Working Group into Paediatric Surgical Services in Northern Ireland (1999) on the configuration of children's surgery in Northern Ireland. *Key issue*

- Whether the WHSSB monitored the implementation of national guidance such as the National Confidential Enquiry into Patient Outcome and Death (Executive summary of 1997 and 2003 reports) on 'out of hours' children's surgery.

1.4 The adequacy of the communication within and between clinical teams and between the Trusts and Mr and Mrs Ferguson following Raychel's death.

- Whether doctors adhered to professional guidance regarding recording communications with parents, including concerns and information given and how this was conveyed.

- Whether the information given to Raychel's family during her stay in hospital enabled them to fully understand Raychel's progress. *Key issue*

- Whether competent consultant practice in NI (and the UK generally) at the time mandated personal involvement in the management of patients admitted under their care, in particular conducting a post-take ward round or its clear delegation to a senior trainee; attendance and communication with families at the time of major clinical deterioration; communicating with the bereaved after the death of a patient; attendance at meetings called in response to a death or other serious adverse incident.

- Whether Trust policies were in operation regarding senior involvement in post-take rounds, the degree of supervision required for JHO's and the role of responsible consultants when a patient died under their care. *Key issue*

- The adequacy of the Trust's response to the family in explaining the reasons why Raychel had died, as known at the time. *Key issue*

- Whether guidance or training was provided to clinical teams regarding bereavement and meetings with families, following the death of a child. If so, whether this training enabled staff to recognise when parents may not understand the information given.

- The adequacy of the patient's advocacy system.

- The extent to which the need for confidentiality within a legal claim, hinders the identification of lessons to be learned and subsequent actions to prevent harm to patients. *Key issue*

1.5 The structure, education and management of children's nursing in the Altnagelvin Hospital in 2001

- Why had family-centred care not been used within the children's ward prior to 2001? What prompted the introduction of family-centred care at Altnagelvin? What training and development was given to nurses in this respect, especially for those nurses who are not children's trained or had trained under the old curricula?

- Whether partnership in assessment and care planning was undertaken in practice on Ward 6 in 2001? *Key issue*

- What impact has the introduction of family-centred care had on communication with and involvement of families since it was introduced? What training were nurses given to recognise anxious parents and listen to their concerns?

- How did nurse managers, including the Director of Nursing, assure themselves that nurses on Ward 6 worked within professional guidance and that adult trained nurses had sufficient knowledge and skill to manage the care of children and the ward, including: *Key issue*

    a) The differences between adults and children in particular in relation to fluid and electrolyte balance?

    b) The role of the family in the child's care

    c) Paediatric resuscitation

    d) Recognition of the child whose condition is deteriorating

- How did nurses, especially those on permanent nights, and their managers ensure that they were able to complete their personal development plan and statutory and mandatory training requirements? Did they have access to educational opportunities to support knowledge and skill development? *Key issue*

- How did the Trust ensure that the concerns of children's nurses were addressed at senior management level? What action was taken to address the concerns raised by Staff Nurse McKenna regarding staffing levels? *Key issue*

- The Ward Sister and Director of Nursing should be asked how nurse staffing levels on the children's ward were calculated and agreed. Did they use the RCN[2] or other guidance on staffing children's wards and how was this demonstrated?

- Did the Trust provide guidance to clinical staff regarding roles and responsibilities in clinical practice? Did clinical staff consider professional guidance when making decisions about issues such as prescribing and changes in treatment? *Key issue*

1.6 The standard of record keeping

- What training was provided to the junior HOs in the correct procedures for making a record after an interaction with a patient? Who was responsible for that training and who was responsible for its supervision and audit?

- What training, supervision and audit occurred for all clinical staff in relation to:

    a. Prescriptions for intravenous fluids
    b. Recording assessment and treatment given to patients
    c. Recording treatment plans agreed during the ward round
    d. Recording accurate intake and output charts
    e. Recording parental concerns regarding their child's condition
    f. Recording contemporaneous nursing records

- Did the Trust monitor in any way whether medical notes conformed to the guidance in the GMC document 'Good Medical Practice' and its own publication on casenote standards? What training was provided to house officers in the requirement for making a record after a patient interaction and who was responsible for such training? Did individual clinical departments or individual consultants (surgeons, paediatricians, anaesthetists) audit record keeping or monitor it in any other way? *Key issue*

- How did the Trust monitor adherence to professional nursing guidance on record keeping in 2001? What was the role of the nursing care plan and who was responsible for monitoring the use of this? Who monitored the standard of record keeping in relation to care planning and fluid balance charts? *Key issue*

1.7 The Training and supervision of junior medical staff

- Who was responsible for training JHO's in postoperative fluid management and how was that training carried out?

- Whether there were Trust policies in operation for supervision of JHO's care of patients and what role was played by the consultant surgeon with named responsibility for a patient's care in supervising postoperative management. *Key issue*

- Whether there were Trust policies defining lines of responsibility between nursing staff and surgical trainees.

- Whether there were systems in place within the Trust to ensure that consultants were delegating work appropriately to their trainees.

[2] RCN (1999) *Skillmix and Staffing in Children's Wards and Departments*, London: RCN

2. Detailed discussion

2.1 The adequacy of the action taken by the RBHSC Trust following Raychel's death

The Trust's Clinical Governance Framework (April 1999) identified the need to develop systems to maintain the quality of clinical services. The Trust developed a single incident reporting system dated March 2000 (WS-061-2 from page 207). A Critical Incident Review Group was set up about March 2000. However there appears to be no evidence that the RBHSC Trust undertook a critical incident review of Raychel's death. Dr Ian Carson, Medical Director, believed that the clinicians should have reported at least three of the four children's deaths (within the Inquiry) to him (Transcript 26 June 2013 page 67). Dr Peter Crean, Consultant Paediatric Anaesthetist (WS-038/2) and Dr Donncha Hanrahan, Consultant Paediatric Neurologist (WS-039-1) both recognised that Raychel had suffered from hyponatraemia.

The only evidence we have found of any learning which came out of her death was the referral of her case to the Working Group on the Prevention of Hyponatraemia dated 26th September 2001; (Dr Robert Taylor WS-330/1). Dr Crean states he believes Rachel's case led to this group being formed (WS 38/3/15a).

Whilst RBHSC was recognised as a regional centre of excellence and teaching (Dr Carson WS 331/1), Dr Crean states that RBHSC had no formal role in the dissemination of learning and good practice (WS 038/3/(2)). However, Professor Swainson (226-002-010) suggests that RBHSC had a duty to share '*significant changes in practice*', as Northern Ireland's only specialist children's service.

Dr Crean met Mr and Mrs Ferguson at their request to discuss the post-mortem results but there is little evidence of communication with Altnagelvin Hospital (WS 038/2) after Raychel's death.

Matters for further consideration

- *Why the Trust did not register Raychel's death as a serious untoward incident?* *Key issue*
- *Whether the RBHSC Trust undertook any review of the death of Raychel, and whether this involved any collaboration or communication with Altnagelvin Hospital.* *Key issue*
- *What lessons were learned following Raychel's death and whether these were conveyed to other hospitals in Northern Ireland?*
- *Whether the Trust undertook mortality and morbidity reviews and clinical audit in line with guidance from the Paediatric Intensive Care Society (UK)*[3].

2.2. The adequacy of the investigation and action taken by Altnagelvin Area Hospitals Trust following Raychel's death

The Altnagelvin Trust recognised that Raychel's death was a serious incident and the resulting action by senior staff, which was guided by developing Trust processes, was prompt. Stella Burnside accepted that, as Chief Executive, she had ultimate responsibility for the overall quality of the services provided by the Trust, although the statutory duty did not come into place until 2003. (WS 046/2 page 8)

[3] Paediatric Intensive Care Society (2001) *Standards Document 2001,* PICS, UK

The investigation which followed the death was set up as a Clinical Incident Review on 12th June 2001. The actions from this tended to concentrate on technical issues around fluid management rather than issues of patient observation and communication with relatives. Nursing staff did raise concerns regarding the accessibility of surgical staff during the day (WS 049/4 p9, 14c, WS 056/3 p16, 16c). There is evidence that some of the investigation's findings were put into practice.

There are some significant discrepancies between the nursing statements and oral evidence, and that given by the Ferguson family. Swainson highlights the difference in perception between nurses and the experts regarding the severity of the vomiting (226-002-022).

The Trust took immediate action to learn from what had happened to Raychel. The Clinical Effectiveness Manager met with Ward 6 staff to discuss fluid balance charts and record keeping (WS 329/1 p12/13). There is evidence that senior clinicians and executive managers pursued the wider remit to ensure that clinical errors involved in Raychel's death would be communicated to benefit the wider NHS community in Northern Ireland. In particular, Dr Nesbitt, Clinical Director of anaesthetics undertook to research the literature referring to No 18 solution and following the Clinical Incident Review meeting on 12th June 2001, he promptly contacted some of his anaesthetic colleagues in NI to alert them. The Trust, through Dr Fulton (Medical Director), also ensured that the Department of Health & Social Services was made aware of the issue and of the need for good guidance on fluid management across a wider community, (WS-043/1 Pg10). Dr Nesbitt (as does Dr Crean) believes that Raychel's case was instrumental in setting up the Chief Medical Officer's Working Group to consider the use of fluids in children (WS35/2/(31j).

However, the Trust investigation appeared not to examine broader issues associated with Raychel's death. These included:

- The impact of the Report of a Working Group into Paediatric Surgical Services in Northern Ireland (1999) on the configuration of children's surgery in Northern Ireland [4]. This report made recommendations about the number of cases and training required by surgeons and anaesthetists involved in children's surgery. The report provided timescales for the introduction of its recommendations.

- The impact of the National Confidential Enquiry into Patient Outcome and Death (Executive summary of the 1997 and 2003 reports) on 'out of hours' children's surgery. NCEPOD has provided guidance on emergency surgery for over 20 years[5], highlighting the potential and real problems with undertaking surgery out of normal working hours by junior surgeons and anaesthetists.

There is a question regarding the completion of a clinical incident form following Raychel's death, which might have ultimately elevated the issue to the *Trust Board*. Margaret Doherty reported that the incident form should have been sent to the Risk Management Department, but Mrs Brown states that a form was not completed as the incident was reported verbally to the CEO by Dr Nesbitt (WS 322/1/(17e).

The Altnagelvin Trust, *Hospital Management Team* received a presentation from Dr Nesbitt on Fluid Balance on 9 October 2001. (316-006j-004)

[4] Paediatric Surgical Services in Northern Ireland, Report of a Working Party, 1999
[5] National Confidential Enquiry into Patient Outcome and Death. Executive summary of 1997 report and 2003 report.

Mrs Stella Burnside states that she briefed the *Trust Board* following Raychel's death, (WS-046/2 Pg 34). Mrs Brown's evidence (WS322/1-p127) suggests that the first recorded *Trust Board* discussion on Raychel was not until 7th November 2002. The Altnagelvin Hospitals Annual reports 2001 to 2004 do not refer to individual clinical incidents and a section on Clinical Governance and Quality Improvement in the 2001/2002 annual report does not appear in subsequent years. (321-004). Swainson further states that there is no mention of Raychel's case in the first published report of the new *Altnagelvin Trust Health and Social Care Governance Committee* in 2003. (226-002-004)

Matters for further consideration

- *Whether Altnagelvin Area Hospital Trust took sufficient action to comply with the recommendations of the Report of the Working Group into Paediatric Surgical Services in Northern Ireland (1999). Although the report concluded that the hospital could meet the requirements, the inquiry should determine whether it had taken adequate steps to do so, given that:* *Key issue*

  a) Post-operative fluid management on the children's ward seemed to be determined by 'custom and practice' rather than evidence.

  b) There was lack of clarity between members of the anaesthetic, surgical and paediatric staff regarding who was responsible for prescribing fluids and the nature and quantity of these.

  c) It is questionable whether the nurses were sufficiently knowledgeable in the care and management of post-operative children to recognise complications and raise these with the appropriate doctor?

  d) Specific to Raychel, when Dr Zafar's prediction that she would progress to oral feeding during the day proved wrong, the nurses sought attention only from the most junior members of the medical staff. The surgical and anaesthetic experts advising the Inquiry expressed concerns about the responsibility placed on the JHO's. However, Swainson considers their education and training provided adequate basic knowledge to guide the prescribing of fluids in children. (226-002-012)

- *Whether Altnagelvin Area Hospital Trust adhered to guidance provided by NCEPOD. Specifically did the Trust/Children's Directorate have a policy relating to the timing of surgery and who should undertake surgery on children at night? Also, whether all key surgical staff were aware of the NCEPOD guidance?* *Key issue*

- *Whether Raychel's death was formally recorded as a clinical incident and was reported to NCEPOD.*

- *Whether the Trust Board was sufficiently informed about Raychel's case and whether the actions taken by its officers were discussed and agreed.* *Key issue*

- *Whether the investigation dealt adequately with the responsibility for:* *Key issue*

  a) The management of postoperative care for children requiring surgery on the wards in 2001 as between anaesthetic, surgical and paediatric teams

b) Record keeping by all professionals, including the use of electronic care planning and the maintenance of complete and contemporaneous records

c) Education and training of medical and nursing staff on Ward 6 regarding fluid management and hyponatraemia in children in 2001

- *Whether information and communication with the Ferguson family should have formed part of the clinical incident review.* *Key issue*

2.3. The adequacy of the action taken by the Western Area Health & Social Care Board (WHSSB).

Dr William McConnell, the Director of Public Health Medicine at WHSSB was informed by Dr Fulton in mid-June of the circumstances around Raychel's death, in particular the use of intravenous solution 18 (WS 047/1). Dr McConnell raised the issue at the regular Chief Medical Officer/Directors of Public Health meeting on 2nd July 2001 at which the need for regional guidance was agreed.

Matters for further consideration

- *The involvement of WHSSB in the recommendations and action following the Report of a Working Group into Paediatric Surgical Services in Northern Ireland (1999) on the configuration of children's surgery in NI.* *Key issue*

- *Whether the WHSSB monitored the implementation of national guidance such as the National Confidential Enquiry into Patient Outcome and Death (Executive summary of 1997 and 2003 reports) on 'out of hours' children's surgery.*

2.4. The adequacy of the communication within and between clinical teams and between the Trusts and Mr and Mrs Ferguson following Raychel's death.

Ramsay and Swainson raise concerns about communication with the family during Raychel's care in hospital. Swainson refers to the GMC's *Good Medical Practice* guidance of 2000 as the framework for doctors to work within.(226-002-002, 226-002-022) There are significant differences in the perceptions of the nursing staff and the family about Raychel's condition following surgery. Sally Ramsay notes that '*none of Mrs Ferguson's observations were recorded in the care plan'* (0224-004-029). Staff Nurse Noble reported that the guidance regarding recording communication with parents was '*to record that parents were kept up to date with the care plan*' (WS 049/4 p5). Ramsay concluded that the '*concerns and observations expressed by Raychel's parents and friends were unnoticed*' (224-004-031). Swainson feels communication between nurses and the family was not strong, calling this '*a central feature of this case*' (226-002-022).

Mr Foster believes that the consultant surgeon should have come in to talk to Mr and Mrs Ferguson following Raychel's collapse and transfer to ICU due to the severity of the situation (223-002-026). Swainson disagrees, although he suggests that the responsible consultant should have met the family prior to Raychel leaving Altnagelvin Hospital. (226-002-022) Mr Gilliland gave evidence that he considered it common practice in the NHS that a patient might receive in-patient care without the responsible consultant seeing them. He could not recall any specific system for alerting him to the presence of a newly admitted patient. He did not accept the view of Mr Orr and Mr Foster on the need for consultant (or other senior surgical) presence when

things go badly wrong postoperatively for a reason other than a surgical complication (transcript 14th March 2013, p200 to 201).

Swainson refers to the limited communication between the Trusts. He raises concerns that RBHSC did not formally discuss concerns around fluids nor send a more detailed discharge summary as a method of informing medical staff at Altnagelvin and the GP of what had happened (226-002-010). He describes communication overall as '*casual and mostly verbal',* with insufficient communication between doctors and nurses and incomplete clinical notes and observations (226-002-011).

Raychel died on 10th June 2001 and the Trust met with the family to inform them of the cause of death on 3rd September, 2001. Dr Haynes notes that Mr Gilliland did not attend the meeting with Raychel's family on 3rd September. Foster and Haynes state that Mr Gilliland should have attended this meeting in view of the fact that 'he (Mr Gilliland) was responsible for the totality of her care'. Gilliland stated that he did not attend as he would have had nothing to add (WS 044/2 page 36), but Foster raises the question regarding whether the surgery should have been undertaken at all, which Gilliland was the best person to address.

There are different recollections between the family and the Trust on the discussions at the September 3rd meeting. In her statement, (WS-01 Para 46) Marie Ferguson said "I left the meeting totally confused believing it to be pointless". She did not believe that the meeting had addressed the cause of Raychel's death and felt the Trust was "aggressive and defensive" and that the meeting "was the beginning of a cover up". The Trust Chief Executive in her witness statement (WS 046) felt that a full apology was given with a commitment to be open about what happened. There appeared to be no pre-meeting with staff from the Trust (WS-046/2 Pg 27). Dr Nesbitt states his belief that everyone at the meeting was open and honest and tried their best to answer the questions put to them. (WS 35/2/31e) However, Swainson (226-002-008) suggests that there was no attempt on the part of Trust staff to be open, encourage resolution of concerns or to apologise because the meeting was based on questions from the family. Whilst Dr Nesbitt felt he had provided a full explanation to the family, the family had not understood this at the time.

Anne Doherty, Patient Advocate at Altnagelvin Trust identified the role of the Patient Advocate in part 'to support patients/relatives in voicing concerns'. However she had not met the Ferguson's prior to the meeting on 3rd September, at which she was asked by Stella Burnside to make notes. (WS-325/1 Pg 2). Telephone contact with the Western Health and Social Services Council had been made by Kay Doherty (Mrs Ferguson's sister) on 23rd August 2001. Mr Stanley Millar, Chief Officer's advice included "to go to a solicitor with a request to follow up an allegation of negligence" which "would however have negated the formal NHS Complaints Procedure". In addition Mr Millar pledged continuing support and advice from the Council. (WS-093/1)

Once legal action commenced, communication between the Fergusons and the Trust appeared to have ceased. Swainson suggests that it is not common practice to share information with the family once litigation had been started. (226-002-009)

Matters for further consideration*:*

- *Whether doctors adhered to professional guidance regarding recording communications with parents, including concerns and information given and how this was conveyed.*

- *Whether the information given to Raychel's family during her stay in hospital enabled them to fully understand Raychel's progress.* *Key issue*

- *Whether competent consultant practice in NI (and the UK generally) at the time mandated personal involvement in the management of patients admitted under their care, in particular conducting a post-take ward round or its clear delegation to a senior trainee; attendance and communication with families at the time of major clinical deterioration; communicating with the bereaved after the death of a patient; attendance at meetings called in response to a death or other serious adverse incident.*

- *Whether Trust policies were in operation regarding senior involvement in post-take rounds, the degree of supervision required for JHO's and the role of responsible consultants when a patient died under their care.*

- *The adequacy of the Trust's response to the family in explaining the reasons why Raychel had died, as known at the time.* *Key issue*

- *Whether guidance or training was provided to clinical teams regarding bereavement and meetings with families, following the death of a child. If so, whether this training enabled staff to recognise when parents may not understand the information given.*

- *The adequacy of the patient's advocacy system.*

- *The extent to which the need for confidentiality within a legal claim, hinders the identification of lessons to be learned and subsequent actions to prevent harm to patients.* *Key issue*

2.5. The structure, education and management of children's nursing in the Altnagelvin Hospital in 2001

Prof. Hanratty states that the structure of nurse education in Northern Ireland included family-centred care and the principles and practice of fluid and electrolyte balance (transcript of evidence). Ramsay refers to the concept of 'family-centred care' as recognising parents as experts in their own child and necessitates nurses communicating effectively with families to understand how children are responding to treatment. Sister Millar stated that this concept had become 'more emphasised' from the middle of the 1980s in nurse training (WS 056/3 p3). Miss Duddy reported that family-centred care was taught as part of paediatric nurse training and education, but was not introduced into the trust until 2001. However, she stated that nurses were encouraged to work in partnership with parents *'in all aspects of the care of children including Assessment and Care Planning'* (WS 323/1 p5).

Swainson (226-002-012) suggests that the nurses did not consider possible reasons why Raychel was vomiting, either because they considered her to be having a normal post-operative course or because they lacked experience and failed to act. Ramsay concludes that a lack of knowledge of hyponatraemia resulted in '*inadequate attention*' being paid to Raychel's symptoms (224-004-030). Whilst it is clear from the '*Table of Nurses' Training & Experience*' (312-007) that few nurses had knowledge of hyponatraemia, it is not clear whether they had received training in recognising sick children or in basic or advanced paediatric resuscitation.

Staff Nurse Noble had worked since 1985 as a registered general nurse in a children's ward. During that time she had been unable to undertake children's nursing as she worked nights and

had family commitments (transcript 27th February 2013, p100). She was left in charge supervising other nurses on the ward (transcript 27th February 2013, p140). It is not clear how she was able to assure her manager that she met the professional requirements outlined by the UKCC[6],[7].

In 2001 Sister Millar was the most senior nurse in the children's service (transcript 28th February 2013, p14). She stated that she was directly responsible to Miss Duddy for the standards of care on the children's ward. The *line management and professional accountability flow charts* suggest that Sister Millar was the most senior children's nurse within the trust, with all posts above her within the Women's & Children's Directorate being held by midwives (WS 323/1 p35/36). It is not clear where Sister Millar sought professional guidance or could share practice developments relating specifically to children's nursing or how she could ensure issues were addressed at directorate level. Margaret Doherty (CSM) reported a good network for midwifery CSMs, but was not aware of anything similar for paediatrics, although she discussed issues with RBHSC on the rare occasions this was required (WS 336/1 p5).

In consequence, we are concerned that Sister Millar might have been the only representative from paediatrics among a number of representatives from women's services at the monthly *Sister and Heads of Department meetings*, which could have made it difficult to focus on issues of concern on Ward 6 (WS 056/3 p2).

Information provided from a range of staff including Staff Nurse Noble, Sister Millar, Miss Duffy and Margaret Doherty suggested that staffing levels on Ward 6 were no different from normal whilst Raychel was on the ward, with the exception of 8th June, when two nurses were off sick (WS 336/1 p6). Sister Millar stayed on the ward, which was covered by three very senior nurses (28/02/2013 p11). A benchmarking exercise between 2000 and 2003 showed a steady increase in both qualified and unqualified staff in Children's Services over this period (WS 323/1 p54). In November 2000 the benchmarking showed that Altnagelvin had the lowest percentage of qualified to unqualified staff across the hospitals included (although within RCN guidance). However, Altnagelvin had the second highest ratio of whole time equivalent nurses to beds (WS 323/1 p67). Margaret Doherty reported difficulties recruiting to the paediatric unit during this period (WS 336/1 p6). Between June 2000 and June 2001 Staff Nurse McKenna wrote to Margaret Doherty three times with concerns regarding staffing levels on Ward 6 (321-051-002 to 006). In February 2001, Nurse McKenna requested that Mrs Doherty raise her concerns with Miss Duddy and Mrs Burnside. This letter was also signed by Sister Millar. The third letter was accompanied by an audit of dependency and staffing levels on Ward 6 (321-051-007 to 018). The audit did not include those children requiring a high level of care or being transferred to another hospital. It identified the lack of a suitable dependency tool and no time for a wide range of activities including staff education and clinical supervision, attendance at meetings and the development of standards, audit and care pathways. It is not clear whether these matters were escalated to Mrs Burnside and what action was considered whilst the Trust experienced difficulties recruiting to vacant nursing posts.

There seems to be a discrepancy in the perception regarding frequency of appraisal of nursing staff. Miss Duddy and Margaret Doherty believed this to be undertaken annually, whilst Sister Millar said that all staff were appraised every 1-2 years. However, Nurse Noble stated that

[6] UKCC (1992) *The Scope of Professional Practice*, United Kingdom Central Council for Nursing, Midwifery & Health Visiting.
[7] UKCC (1992) *Code of Professional Conduct,* United Kingdom Central Council for Nursing, Midwifery & Health Visiting.

appraisal was undertaken 2-3 yearly. Similarly, clinical supervision had not been established formally in 2001 (WS 056/3 p5). It is not clear how staff were facilitated to discuss their development needs and issues relating to practice.

There appears to be a discrepancy between nursing reports regarding their responsibility for initiating changes in patient management and reporting these to the surgical/paediatric teams. Staff Nurse Noble was able to influence fluid prescribing but Sister Millar suggested that nurses had little responsibility for changing treatment/care plans. Nurse Rice called a doctor several times, but did not attempt to call a more senior member of the team when she received no response.

Matters for further consideration

- *Why had family-centred care not been used within the children's ward prior to 2001? What prompted the introduction of family-centred care at Altnagelvin? What training and development was given to nurses in this respect, especially for those nurses who are not children's trained or had trained under the old curricula?*

- *Whether partnership in assessment and care planning was undertaken in practice on Ward 6 in 2001.* Key issue

- *What impact has the introduction of family-centred care had on communication with and involvement of families since it was introduced? What training were nurses given to recognise anxious parents and listen to their concerns?*

- *How did nurse managers, including the Director of Nursing, assure themselves that nurses on Ward 6 worked within professional guidance and that adult trained nurses had sufficient knowledge and skill to manage the care of children and the ward, including:* Key issue

  a. *The differences between adults and children in particular in relation to fluid and electrolyte balance?*

  b. *The role of the family in the child's care?*

  c. *Paediatric resuscitation?*

  d. *Recognition of the deteriorating child?*

- *How did nurses, especially those on permanent nights, and their managers ensure that they were able to complete their personal development plan and statutory and mandatory training requirements? Did they have access to educational opportunities to support knowledge and skill development?* Key issue

- *How did the Trust ensure that the concerns of children's nurses were addressed at senior management level? What action was taken to address the concerns raised by Staff Nurse McKenna regarding staffing levels?* Key issue

- *The Ward Sister and Director of Nursing should be asked how nurse staffing levels on the children's ward were calculated and agreed. Did they use the RCN[8] or other guidance on staffing children's wards and how was this demonstrated?*

- *Did the Trust provide guidance to clinical staff regarding roles and responsibilities in clinical practice? Did clinical staff consider professional guidance when making decisions about issues such as prescribing and changes in treatment?* *Key issue*

2.6. The standard of record keeping

The experts have raised a number of concerns relating to record keeping, including whether it was complete and accurate (226-002-011/012, 226-002-021, 224-004-031).

Swainson can find no evidence (226-002-020) that the Trust ever audited its policy on Patients' Casenotes Standards (see 323/1 p144).

Matters for further consideration

- *What training was provided to the junior HOs in the correct procedures for making a record after an interaction with a patient? Who was responsible for that training and who was responsible for its supervision and audit?*

- *What training, supervision and audit occurred for all clinical staff in relation to:*

  a. *Prescriptions for intravenous fluids*
  b. *Recording assessment and treatment given to patients*
  c. *Recording treatment plans agreed during the ward round*
  d. *Recording accurate intake and output charts*
  e. *Recording parental concerns regarding their child's condition*
  f. *Recording contemporaneous nursing records*

- *Did the Trust monitor in any way whether medical notes conformed to the guidance in the GMC document 'Good Medical Practice' and its own publication on casenote standards? What training was provided to house officers in the requirement for making a record after a patient interaction and who was responsible for such training? Did individual clinical departments or individual consultants (surgeons, paediatricians, anaesthetists) audit record keeping or monitor it in any other way?*

- *How did the Trust monitor adherence to professional nursing guidance on record keeping in 2001? What was the role of the nursing care plan and who was responsible for monitoring the use of this? Who monitored the standard of record keeping in relation to care planning and fluid balance charts?*

2.7 Supervision and training of surgical trainees

Oral evidence from the surgical trainees and from the nursing staff, put to Mr Gilliland during his evidence, suggests there were differences between what the nurses considered was their role in relation to JHOs and how that was perceived by the JHOs themselves.

[8] RCN (1999) *Skillmix and Staffing in Children's Wards and Departments*, London: RCN

It is clear from witness statements and oral evidence that the anaesthetists and paediatricians at Altnagelvin used very different IV fluid maintenance regimes and that the nurses on Ward 6 followed paediatric practice. The junior medical staff who gave evidence were not always clear about why certain fluids were prescribed or not.

Dr Curran (WS028/2) stated that [at the relevant time] he could not recall any formal training in fluid management or hyponatraemia. Dr Devlin (WS027/2) stated he had no specific postgraduate paediatric training and, at the time, had no specific formal training in postoperative fluid management or record keeping regarding fluid management.

In his report (7.3) and oral evidence, Mr Foster was critical of the degree of responsibility given to JHOs, as was Mr Orr. Dr Haynes, in his report, expressed concern that the junior house officers would have had no formal paediatric experience at postgraduate level.

Dr Gardiner, postgraduate tutor at Altnagelvin states he was not responsible for the training of JHO's, which was a matter for their supervising consultant and the Postgraduate Dean.

Professor Swainson, in his report, states 'the prior training of all the doctors in training was satisfactory' (226-002-011/37) and 'the training experience of junior surgeons…appears to provide an adequate basic knowledge and background to guide the prescription of fluids.' (ibid/41). He also states that the Trust should expect systems to ensure consultants are delegating work appropriately to doctors in training.

Given the evidence from the JHO's concerned in Raychel's care and the opinions given by the other experts, we are not able to determine the basis on which Prof Swainson's opinion of their training is based.

Matters for further consideration

- *Who was responsible for training JHO's in postoperative fluid management and how was that training carried out?*

- *Whether there were Trust policies in operation for supervision of JHO's care of patients and what role was played by the consultant surgeon with named responsibility for a patient's care in supervising postoperative management.* *Key issue*

- *Whether there were Trust policies defining lines of responsibility between nursing staff and surgical trainees.*

- *Whether there were systems in place within the Trust to ensure that consultants were delegating work appropriately to their trainees.*

3. People the Inquiry may wish to question further

Mr Gilliland:

- In relation to his oral evidence about normal practice in the NHS in regard to the direct involvement of consultant surgeons in the care of in-patients; in regard to the consultant's role in dealing with families when a child suffers significant deterioration in their condition; in regard to bereavement.

- The adequacy of the systems in place for the delegation to surgical trainees.

- His role and responsibility for training JHO's and how he could be satisfied as to their knowledge and skills.

Dr Fulton:

- Only in relation to Prof.Swainson's concerns regarding not ensuring that recommendations of the report were followed or gaining formal support from the CEO and Board for alternative arrangements

Mrs Stella Burnside

- To provide further information on the involvement of the Trust Board following the death of Raychel.

- To clarify the arrangements for patient advocacy

- To outline whether Altnagelvin Area Hospital Trust adhered to guidance provided by NCEPOD and how such guidance is disseminated throughout the Trust.

- To clarify what action Altnagelvin Area Hospital Trust took to comply with the recommendations of the Report of a Working Group into Paediatric Surgical Services in Northern Ireland (1999).

Miss Duddy:

- In relation to her response to the concerns of Staff Nurse McKenna regarding staffing level.

- As lead for risk management, to clarify whether she should have overseen the incident review process and should have ensured systems were in place to monitor the standard of patient records.

- As lead for nursing within the Trust, to question whether she should have had systems in place to monitor nursing staff development including appraisal and clinical supervision.

Margaret Doherty:

- Whether she took steps to address the concerns of Staff Nurse McKenna.

Sister Millar:

- To establish whether she monitored the standards of care for the children's service.

- To establish whether she formally assessed Raychel when both her staff and the family had raised concerns about vomiting.

- In relation to delegating responsibility for ward management to a nurse without children's nurse training.

Therese Brown:

- In not keeping clear and contemporaneous notes of the investigation process

Dr Crean/Dr Hanrahan

- In not reporting Raychel's death as clinical incident.

- In not providing detailed written information ('clinical summary') on Raychel's progress to the referring clinician(s) at Altnagelvin

Dr William McConnell

- In relation to any obligation to monitor implementation of the working party report on Paediatric Surgical Services.

- In relation to any obligation to monitor implementation of guidance from NCEPOD.