

1 Tuesday, 27 August 2013
2 (10.00 am)
3 THE CHAIRMAN: Good morning, ladies and gentlemen. Those of
4 you who are familiar with the history of the inquiry
5 know that what happens as each segment starts is that
6 a detailed written submission is prepared and circulated
7 a week in advance of the opening. That was done last
8 Tuesday. There have been some amendments to it, which
9 I think were circulated yesterday.
10 What will happen today is that Ms Anyadike-Danes
11 will highlight some of the more important issues which
12 are set out in that opening, and after she has done that
13 we will go on to start hearing the evidence, and we will
14 do that through Mrs Noble. There are bits and pieces of
15 housekeeping to be done, but what I want to do this
16 morning is to allow Ms Anyadike-Danes to deliver the
17 oral highlights of the written opening. We will then
18 take a break and do the housekeeping and hear from
19 Mrs Noble, and then from tomorrow onwards we'll go
20 through the witnesses in the order which is set out
21 in the witness schedule. Mr Stitt?
22 MR STITT: Mr Chairman, arising out of your observations, we
23 have indicated that we would wish to make some brief
24 responses to the opening. We have done so through some
25 e-mails, and I note the alacrity with which the response

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1 was received from the inquiry team.
2 I wish to seek your permission to make a short
3 address. I have not provided anything in writing in
4 advance, and the reason for that, sir, is that until
5 sometime late -- more than halfway through Saturday,
6 I was out of the jurisdiction on vacation. I have spent
7 Sunday and Monday looking at the most comprehensive
8 opening which has been prepared and there are some
9 points which I would wish to make. They'll not be
10 lengthy but I do believe they're important, and I will
11 undertake to reduce them to writing in exactly the same
12 form as I would give them orally.
13 I would say that there was no secretarial back-up on
14 Sunday and the Bar Library was closed on Monday where
15 the secretarial back-up is. That's the logistical
16 reason why the normal protocol of submitting a written
17 suggested opening was not followed on this occasion.
18 I will be brief, but I would ask, sir, that you
19 seriously consider my application. My clients do think
20 it's important, there are net issues, all it will be is
21 to highlight those issues, it will be reduced to writing
22 and with absolute clarity.
23 THE CHAIRMAN: I'm envious that you were still on holiday
24 until the weekend. Beyond that, I'm not sure it will be
25 necessary for you to reduce it to writing if we're going

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1 to have it on the transcript, but it's a matter for you.
2 MR STITT: I thought it would be helpful. That having been
3 said, sir, in my own defence I have spent a considerable
4 amount of August working on this case.
5 THE CHAIRMAN: Okay. It's not perfect, but I am content if,
6 on your assurance, that these are net issues which
7 you're going to address, rather than anything more
8 fundamental.
9 MR STITT: This is not a general trawl through the evidence.
10 This is not the time or the place for that.
11 THE CHAIRMAN: No. I'm content for that to be done.
12 Mr Quinn?
13 MR QUINN: On reflection, I think we would like a copy of
14 Mr Stitt's response. Even though it's in the
15 transcript, it's just useful to have his response to
16 compare against the opening that's going to be presented
17 by learned counsel for the inquiry.
18 THE CHAIRMAN: In that event, if you deliver it after
19 Ms Anyadike-Danes today, Mr Stitt, hopefully we can have
20 that by the close of business on Friday.
21 MR STITT: Yes.
22 THE CHAIRMAN: Thank you.
23 MR QUINN: Thank you, sir.
24 THE CHAIRMAN: Ms Anyadike-Danes?
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1 Opening by MS ANYADIKE-DANES
2 MS ANYADIKE-DANES: Thank you very much. Good morning.
3 Mr Chairman, the investigation into --
4 THE CHAIRMAN: Sorry, Ms Anyadike-Danes, to interrupt you.
5 I should have asked, are you appearing for both
6 trusts in this segment? Is this opening on behalf of
7 both the old Altnagelvin, now Western, and the old
8 Royal, now Belfast?
9 MR STITT: No, I'm Altnagelvin.
10 THE CHAIRMAN: Right. And you're for Belfast, Mr McAlinden.
11 Do you intend to open or not?
12 MR McALINDEN: No.
13 MS ANYADIKE-DANES: The investigation into the governance
14 issues in Raychel's case, and the process and results of
15 which are described in the written opening, Mr Chairman,
16 that you have mentioned, that has all been informed by
17 the investigations not just into Raychel's case but into
18 the cases of Adam, Claire and Lucy, because that has
19 involved the Royal Group of Hospitals trusts in the
20 mid-1990s as well as the 2000, mid-2000s, and also the
21 Sperrin Lakeland Trust from 2000 to the mid-2000s. This
22 has allowed us to look at systems, procedures and
23 approaches there and compare them and contrast them.
24 An aid to that, Mr Chairman, has been the
25 consolidated chronology that I think I probably first

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1 introduced in relation to Lucy but, as its name
2 suggests, we are building on it as each successive case
3 comes. If I may pull up the relevant bit where we pick
4 up Raychel's governance, that's at 325-004-038.

5 You can see from the top of the page that Lucy's
6 pre-dates that, and before that would be Claire, and
7 before that Adam. Then there's a section even before
8 Adam to lay out the state of play as it was known.

9 So this now starts Raychel's. I'm not proposing to
10 go through this, but simply to let you know that it's
11 there.

12 The way it works is that all those matters that
13 directly relate to Raychel are in the main column on the
14 left-hand side, and then the other developments concern
15 primarily the hyponatraemia guidelines but also matters
16 in relation to other children, and also other important
17 publications and developments. The reason for this is
18 so that you can begin to see what else was going on
19 at the time that matters were moving forward in
20 Raychel's case.

21 So if I just give you an example from the next page,
22 039. You see there on 30 June, that's the department's
23 publication "Organisation with a memory". You can see
24 where that falls in the context of what was happening
25 with Raychel.

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1 Then if I just give you one more so you see, if we
2 pull up --

3 THE CHAIRMAN: Just before you do, that references to the
4 department and chaired by the CMO, that's in London
5 rather than Belfast, isn't it?

6 MS ANYADIKE-DANES: Yes. Then if we look at 047, you can
7 see along the left-hand main column that
8 Clodagh Loughrey, for example, is providing her report
9 to Dr Herron, which forms part of the post-mortem
10 investigation, but then you can see at the same time,
11 though, what's going on in the other developments
12 column, and you can see the departmental board adopting
13 the risk management, you can see that the CMO special
14 advisory committee is meeting -- that was a meeting for
15 paediatrics -- and then you can see Dr Jenkins being
16 instructed in relation to his report for Lucy.

17 So I just wanted to bring that to your attention
18 in the hope that it will assist you as we go through and
19 you can see where the chronology falls in relation to
20 other events.

21 We have also produced, as we have for all the cases,
22 a list of persons. I'm not going to pull that up, but
23 the reference for it is 328-001-001. You will already
24 have had a list of persons in Raychel's case as it
25 relates to clinical matters, and this list of persons

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1 now includes those who are directly involved in the
2 governance issues as distinct from the clinicians and
3 nurses.

4 Mr Chairman, let's start with the organisational
5 structure for delivering the service that's provided to
6 Raychel, and indeed to her family, and the lines of
7 responsibility for assuring that it was appropriate.

8 The Altnagelvin Hospitals Health and Social Services
9 Trust was established by an order of Parliament on
10 1 April 1996 and it was fully accountable to the
11 Northern Ireland Department of Health and Personal
12 Social Services. The trust's main commissioner of
13 services was the Western Health and Social Services
14 Board, and the relationship between the two of them was
15 governed by a service agreement. Although the trust
16 operated independently from the board, it did maintain
17 close links with the board to ensure that the services
18 it provided met the needs of the resident population.

19 The review and oversight of the trust was provided
20 by the Western Health and Social Services Council, which
21 is a body that you will have heard of before in relation
22 to Lucy. That was established in 1996 specifically to
23 keep under review the operation of Health and Personal
24 Social Services in its area and to make recommendations
25 for the improvement of those services.

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1 Now, the trust's board of directors bore
2 responsibility for setting and delivering the overall
3 policy and strategy and maintaining the financial
4 viability of the trust. We can pull up the
5 organisational chart that sets out those lines of
6 responsibility, and one sees it at 312-014-001.

7 There you are. You can see the chairman of the
8 board and the board of directors, and on the right-hand
9 side, shaded in blue, they're the executive directors.
10 Then below that are the clinical directors, and below
11 that are the committees and sub-committees. So you see,
12 for example, that Mrs Burnside, she was the
13 chief executive and she reported to a senior officer
14 within the Permanent Secretary's department on issues
15 within the trust. She was accountable also to the
16 general manager of the board for the leadership and
17 management of the hospital organisation and the
18 maintenance of efficient services and effective
19 financial management. She was also responsible directly
20 to the chairman of the trust board, as you can see from
21 there.

22 You can also see, for the purposes of Raychel's
23 case, some of the important executive directors. They
24 include Ms Duddy, she's director of nursing, you see her
25 there, and Dr Fulton, he was the medical director.

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1 The responsibility for overseeing the day-to-day
2 operational management of the trust rested with the
3 hospital management team, and that team includes
4 a number of the clinical directorates, and they're each
5 managed by a clinical director and also a clinical
6 services manager. You can see how that operates below
7 there.

8 Mrs Burnside would have had the responsibility for
9 the implementation and monitoring of these corporate
10 structures and ensuring the development of a management
11 system that secured accountability.

12 If we go to the two directorates with greatest
13 relevance to Raychel's case, that's the surgery and
14 critical care and the women and children's care
15 directorates. You see the directors were Mr Bateson,
16 he's since deceased, and Dr Martin, he was a consultant
17 obstetrician and gynaecologist.

18 The surgery and clinical care directorate had
19 overall responsibility for the provision of Raychel's
20 surgical procedure, and anaesthesia and critical care
21 appears to have been a sub-division within that, and
22 Dr Nesbitt, who was consulting anaesthetist, was
23 a clinical director.

24 The extent to which the women and children's care
25 directorate was also responsible for the provision of

1 care and treatment to Raychel as a paediatric patient on
2 Ward 6 is not entirely clear to us. We hope it will be
3 clearer after the hearing.

4 The paediatric department appears to have been
5 a sub-division of that women and children's care
6 directorate, and it was under the supervision of
7 Mrs Doherty, who was clinical services manager. But
8 Dr Martin has informed the inquiry that he had no
9 involvement in paediatric clinical care as clinical
10 director, and he says:

11 "I did not, as far as I'm aware, have overall
12 responsibility for the provision of paediatric care in
13 Ward 6."

14 So that's clearly going to be an issue.

15 In fact, the overlapping of those two directorates,
16 surgery and the children's directorate, when it comes to
17 paediatric surgical patients, that was also an issue
18 when we dealt with Adam in the Royal. In fact one pulls
19 up 303-043-510, that was the position in relation to the
20 Royal Trust, and you can see there, on the blue boxes
21 following down from Dr Carson as medical director, that
22 potentially the services that could have been delivering
23 for Adam were split amongst a number. You see there's
24 a paediatric service, there's anaesthetics, theatre and
25 intensive care. I think there was also surgery right

1 down at the bottom.

2 You may recall, Mr Chairman, that that was an issue
3 about which Dr Gaston acknowledged some concerns that
4 Dr Taylor, who was the consultant paediatric
5 anaesthetist, was in a different directorate from others
6 who were also involved in Adam's care. So the efficacy
7 of these sorts of structures, Mr Chairman, is going to
8 be something to be explored.

9 The role of clinical director was primarily
10 a leadership role within the department, and issues
11 relating to standards of care or poor performance would
12 be directed to the clinical director in the first
13 instance, but it was the medical director who was
14 responsible to the trust for monitoring the quality of
15 medical care at Altnagelvin. As I've said, at the time
16 of Raychel's admission that person was Dr Fulton.

17 He was a consultant dermatologist and his principal
18 responsibilities are set out in his job description.

19 Some of those that had a direct -- they're all
20 relevant, but the ones most acutely relevant is to
21 secure the wide input to medical policy and strategy
22 through the chairmanship of clinical directors' forum
23 and also with the director of nursing to promote the
24 development of clinical audit within the trust as
25 a means of examining the outcomes of care provided by

1 the trust, and also to ensure that professional
2 standards are maintained in the provision of medical
3 services within the general guidance that's issued by
4 the department and within the terms of the contracts
5 with the purchasers.

6 Dr Fulton also in his role led the team
7 investigating any serious clinical incidents, and he
8 advised the trust board on medical issues, on
9 complaints, clinical incidents, disciplinary action and
10 so forth, and he provided medical advice on litigation.
11 So in that capacity, he took charge of the investigation
12 into Raychel's care at Altnagelvin once they had been
13 informed that she had died at the Children's Hospital.

14 Ms Duddy was director of nursing and she had
15 responsibility for the department of nursing and risk
16 management to reflect an evolved clinical governance
17 agenda, and she held meetings with the clinical services
18 managers on a monthly basis and together with the --

19 THE CHAIRMAN: Ms Anyadike-Danes, would you pause? Could we
20 take down the Royal organisational structure and put
21 back up the Altnagelvin one.

22 MS ANYADIKE-DANES: 312-014-001.

23 THE CHAIRMAN: Thank you.

24 MS ANYADIKE-DANES: So you see how that lies. Together with
25 the medical director, she was accountable to the board

1 for clinical audit, quality of care and overall risk
2 management, although it was the risk management
3 coordinator, who is Mrs Brown, and she was charged with
4 management responsibility for trust-wide risk management
5 culture with coordination of risk identification,
6 analysis, control and audit activity.

7 Then just to make up the team who were dealing with
8 those sorts of matters, you have Mrs Anne Witherow, and
9 she served as a clinical effectiveness coordinator
10 responsible for leading on standards and guidelines and
11 managing the audit team. So that was the team who were
12 there to ensure that so far as it could be done the risk
13 to, for example, Raychel in her care at Altnagelvin was
14 minimised.

15 On 10 April 2001, Mrs Burnside, with some
16 prescience, suggested that as it was now six years since
17 the directorate structure was created, it would be
18 worthwhile to review it and assess if the structure was
19 appropriate for its purposes and if it aids delivery of
20 trust objectives. She advised that she would like views
21 from the hospital management team in relation to
22 relationships, structures, performance, educational
23 department standards and accountability.

24 Detailed responses to that request were to be
25 received by 27 April 2001. Whether the structures were

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1 assessed as adequate for purpose and whether changes
2 could and should have been made in the months before
3 Raychel's admission, they're all going to be matters to
4 be explored further, as indeed exactly what responses
5 she received to that request.

6 So, then, if I move on to the clinical governance
7 context of June 2001, so that's as it was for Raychel.
8 The trust had announced in its annual report for 1998 to
9 1999 that from 1 April 2000, chief executives will be
10 responsible for not only the financial performance of
11 the trust but will have clear accountability for quality
12 in the clinical setting. In preparing to meet these
13 responsibilities, a clinical governance strategy has
14 been developed at Altnagelvin, which details the
15 structures and processes required to ensure that
16 patients will receive the highest quality of care with
17 the best clinical outcomes.

18 That was what they had intended to do. The annual
19 report for the following year, 1999 to 2000, reported:

20 "A clinical governance committee has been
21 established and will provide assurance to the trust
22 board that procedures relating to clinical effectiveness
23 and quality, risk management, education and training are
24 in place within the trust and are functioning
25 effectively."

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1 So, so far as the trust was concerned, the
2 foundations of clinical governance were there in
3 June 2001 when Raychel was admitted.

4 So an issue is going to be the extent to which any
5 failings in Raychel's care and its aftermath that you
6 may determine, Mr Chairman, were contributed to by
7 deficiencies in the systems established by the trust to
8 exercise governance over its services and/or by the way
9 those systems were operated.

10 So if I move then to education and training.

11 The service agreement between the board and the
12 trust that I've mentioned recognised that staff training
13 and development programmes were to be one of
14 Altnagelvin's key activities. If I concentrate on the
15 medical education, in 2001 Altnagelvin was a teaching
16 hospital. In that role, one might have thought that it
17 would have been imperative that the knowledge and skills
18 of its clinical and nursing staff were kept up to date.

19 Mr Gardiner was the educational supervisor,
20 postgraduate tutor for doctors in 2001 and he was
21 charged with overseeing the medical education and
22 training provided at Altnagelvin, but he didn't have any
23 clear list of responsibilities, as we understand it.

24 Mr Fulton had principal responsibility because
25 he was medical director to coordinate and promote high

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1 standards at all stages of medical education, and he
2 describes the continuing medical education and
3 professional development of doctors as the
4 responsibility of the Northern Ireland postgraduate dean
5 and delegated to the postgraduate tutor at Altnagelvin.

6 This is a structure which we may well revisit later
7 on when we deal with the departmental section, but
8 suffice it to say, Mr Gilliland, who was, of course,
9 Raychel's consultant, was the undergraduate surgical
10 tutor and the postgraduate surgical tutor and the
11 college tutor at the time when Raychel was admitted. He
12 had responsibility for the training and education of
13 doctors, so it's noteworthy that he's recorded as having
14 told the coroner that he only became aware of
15 hyponatraemia after Raychel's death. He has sought to
16 correct that, Mr Chairman, by saying that he was
17 referring by that statement to dilutional hyponatraemia,
18 and that, of course, will be a matter for you,
19 Mr Chairman.

20 He's also informed the inquiry that he was unaware
21 of the 1989 NCEPOD recommendations that junior doctors
22 operating on children should not do so without senior
23 advice or of the danger of infusing hypotonic fluid in
24 children who had prolonged vomiting. Mr Foster has been
25 unable to believe that that could be possible because he

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1 said it was well-known that hypotonic fluids may cause
2 dilution, and you may recall, Mr Chairman, that in the
3 inaugural meeting of the Western Anaesthetic Society,
4 which includes the area of Altnagelvin, that was held on
5 30 September 1998, and Dr Chisakuta gave a talk on
6 recent advances in paediatric anaesthesia dealing with
7 the issues raised in Professor Arieff's 1998 paper,
8 which is titled "Post-operative hyponatraemia
9 encephalopathy following elective surgery in children",
10 his evidence -- that's Dr Chisakuta's evidence -- was
11 that the senior anaesthetists in the area, therefore
12 Altnagelvin, would have attended that meeting.

13 The training of junior doctors was determined by the
14 Northern Ireland Medical and Dental Training Agency in
15 conjunction with Dr Gardiner. He was jointly
16 accountable to both the trust and to the deanery for the
17 provision of postgraduate medical education, and the
18 postgraduate dean and the chief executive shared
19 ultimate responsibility for postgraduate education.

20 The education that's come under greatest scrutiny
21 in the investigation is that of the pre-reg house
22 officers, the PRHOs. Their place was primarily
23 a training and apprenticeship year under the control of
24 Queen's University, Belfast, and each PRHO was assigned
25 a supervising consultant responsible for the assessment

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1 of their training with the assistance of the overall
2 educational supervisor. Attendance at their course, the
3 induction course, was mandatory, and attendance at the
4 forum, an organised programme of weekly talks was
5 specifically encouraged.

6 The inquiry has already considered, in the course of
7 Adam's case, those links between the university, the
8 postgraduate deanery and the trust in relation to
9 education training of doctors. We have revisited it in
10 Raychel's case, these six years later, in the context of
11 particular clinicians, though not in any overall way,
12 those particular clinicians who are concerned with her
13 care and treatment.

14 The inquiry's experts dealing with surgical and
15 anaesthetic practice, Mr Foster and Dr Haynes, have
16 indicated some concerns about the education, as
17 demonstrated by the clinicians. Mr Foster, when he was
18 asked whether doctors Curran and Devlin should have --
19 both of whom were PRHOs -- recognised the possibility
20 that Raychel was suffering from hyponatraemia says:

21 "It is to be regretted that these very junior
22 doctors apparently did not recognise or consider the
23 possibility. However, they would have had little
24 training in surgical physiology and post-operative care
25 and this I believe to be a serious governance issue."

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1 Dr Haynes is of the opinion that there was ignorance
2 at all levels about the management of fluids and
3 electrolytes amongst all staff at Altnagelvin in 2001,
4 and he states:

5 "Before Raychel's death, the nursing staff had no
6 training on fluid and electrolyte management and the
7 junior house officers did not have the necessary
8 knowledge. Intravenous fluid therapy is one of the
9 commonest interventions in a wide range of hospital
10 patients, especially around the time of surgery."

11 We will consider some of those issues during the
12 hearing, Mr Chairman, but as I say, it may be that
13 we will look at other aspects of that during the
14 departmental segment.

15 If I go specifically to education as to fluids.
16 Dr Gardiner has confirmed that he set up an educational
17 teaching programme for the PRHOs, which included
18 instruction on fluid balance and sessions on electrolyte
19 disturbances. You will have heard the experts' own view
20 of the standard of knowledge on fluid management.

21 Dr Haynes is of the opinion that there was ignorance
22 at all levels, as I said, and furthermore he talks about
23 the lack of understanding amongst the nursing staff.

24 Mr Foster has also made his comments about the
25 junior doctors.

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1 So how such a state of affairs existed, and
2 apparently undetected, is something to be considered
3 during the hearing, as is what role did the Children's
4 Hospital, the regional paediatric centre, play in
5 disseminating lessons learned and so contributing to the
6 training of the clinicians in other hospitals in the
7 region.

8 You have heard evidence from Dr Taylor at the
9 Children's Hospital. He said that occasionally the
10 paediatric anaesthetists facilitated requests from
11 consultant anaesthetists in other hospitals to visit
12 theatres and update their clinical skills.

13 Dr Crean, who was also an anaesthetist at the
14 Children's Hospital, said that whilst he wasn't aware of
15 any formal role that the Children's Hospital had in
16 disseminating learning and good practice, they did
17 foster informal links with consultant anaesthetists
18 in the area hospitals, and he's always made it clear
19 that any consultant anaesthetist was welcome to spend
20 time in the Children's Hospital for a refresher.

21 In addition to that, Dr Taylor founded the Sick
22 Child Liaison Group in or about early 2000, which he
23 says met two to three times a year, and its main purpose
24 was to improve the quality of care to critically ill
25 infants and children being transferred to paediatric

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1 ICU, but it did provide a forum where fluid management
2 issues might be discussed, and within a fortnight of
3 Raychel's death, Dr Taylor at such a meeting was
4 presenting several papers, indicating the problems with
5 the use of hypotonic fluids in children.

6 Dr Crean also set up a group, he set up
7 the paediatric anaesthetic group in 1999 to provide
8 a forum for discussion. Whether that forum would have
9 been an effective one for the purposes of disseminating
10 information on Solution No. 18 is not clear, and whether
11 the Children's Hospital could have instituted more
12 formal arrangements for the dissemination of learning,
13 that is a matter to be considered further, and indeed,
14 in due course, what it does currently about that.

15 If I pass now to nursing education. There wasn't
16 a similar educational structure within nursing as
17 existed for the medical staff, and there was not one
18 individual in charge of nursing education.

19 The ward managers, so that would be somebody like
20 Sister Millar, the departmental managers and directorate
21 managers, somebody like Margaret Doherty, identified the
22 nursing staff within their areas who were required to
23 attend courses that were being offered, and that's
24 essentially how that training progressed.

25 Each directorate was required to undertake training

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1 needs analysis in respect of its nursing staff and
2 submit that to the director of nursing on an annual
3 basis, and then that was forwarded on to the department,
4 who would advise as to whether or not training places
5 would be made available to accommodate those requests.
6 So that was the system.

7 The DLS has informed the inquiry that nurses have
8 been educated on the management of IV fluids in children
9 since 2001, and that the training given in respect of
10 children on fluids has been in progress since 2002. All
11 that having been said, Sister Millar, the ward sister
12 who was responsible for the paediatric ward in 2001 on
13 which Raychel was admitted, had received no prior
14 training in respect of fluid management in children, the
15 use of hypotonic fluids, the management of
16 post-operative vomiting and nausea, or the risk of
17 hyponatraemia or observations and record keeping, and
18 she says:

19 "As at that time I was not aware of the factors that
20 can cause electrolyte imbalance in a paediatric patient
21 following surgery. I recognise that vomiting can be one
22 of those factors though."

23 It was, however, ward Sister Millar, who was
24 expected through staff appraisal to identify the needs
25 of staff on the ward, and it was she who would meet with

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1 staff in Educare, the in-service education consortium,
2 to determine training and educational requirements. So,
3 Mr Chairman, if she herself was not aware of some of the
4 critical issues in relation to Raychel's care, then it
5 calls into question how she could, even doing her best,
6 have identified deficiencies in other nurses' training.

7 You may recall, Mr Chairman, that
8 Professor Hanratty, who provided a detailed background
9 paper of nurses' education starting from 1975 right up
10 to date -- not to be pulled up but the reference for
11 it is 308-004-006 -- she gave evidence to you on
12 20 March on nurses' education, and what that should have
13 meant in terms of them understanding Raychel's symptoms
14 and deteriorating condition, and some of those issues
15 in relation to the nurses' knowledge about fluids we're
16 going to consider further. But she did express her
17 concerns.

18 We'll also consider some of the nurses' training
19 issues in relation to Conor's case and those which arise
20 after the guidelines in 2002. His case was in 2003. So
21 we'll be looking at nurses' education from that
22 perspective, particularly in that case.

23 Just briefly about consultant appraisal, because
24 they also were to have their education assessed to
25 a degree. The department introduced compulsory

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1 appraisal for all consultants from 1 April 2001, but
2 that system wasn't fully operational by the time that
3 Raychel was admitted, and even if it had been, it's not
4 clear that it would have been in time to have detected
5 any deficiencies to have had much bearing on her care.

6 I want now to turn to nursing and the nursing issues
7 because they form such an important part of our
8 investigation into Raychel's care.

9 Mr Foster, who was the expert to the inquiry,
10 concludes that:

11 "The care of the surgical patients on Ward 6 was to
12 all intents and purposes left to nursing staff on the
13 ward. The doctors simply complied with requests from
14 the nursing staff and as very junior trainees could not
15 have been expected to make clinical decisions on
16 post-operative children."

17 Dr Haynes observes:

18 "The post-operative care given to Raychel was
19 deficient insofar as fluid prescription in the
20 paediatric ward appears to have been dictated by the
21 nursing staff. They could recite to junior medical
22 staff what was routinely prescribed to post-operative
23 patients, according to long-standing custom and practice
24 but the nurses were very unlikely to have a proper
25 understanding of fluid and electrolyte balance or

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1 understand how abnormalities could arise."
2 Ms Ramsay, who was the nursing expert for the
3 inquiry, has concluded that there just simply was no
4 clear system in place.
5 Raychel was allocated to Staff Nurse Patterson --
6 that was her named nurse under that system -- but Staff
7 Nurse Patterson did not provide continuous care for
8 Raychel. Sister Millar has described how on days staff
9 were allocated to designated areas in the ward, and on
10 nights the staff worked as a team for all patients. So
11 that led Margaret Doherty to advise that the named nurse
12 allocation was not totally compliant because of turnover
13 of patients and so forth.
14 In fact, there was an audit report done on that,
15 which showed that only 83 per cent of patients appeared
16 to have an allocated named nurse on admission, and
17 84 per cent of those patients had almost no contact with
18 their named nurse during their hospital stay.
19 Professor Swainson, who's the governance expert for
20 the inquiry, has observed that the concept of a named
21 nurse for a whole episode of care may have resulted in
22 better communication with the parents:
23 "Even on a single shift, a nurse with responsibility
24 for a child could have resulted in better recognition of
25 the child's deteriorating clinical state."

25

1 And we'll go on to see that that pattern of a number
2 of people looking at Raychel, particularly over 8 June
3 when she deteriorated, that was a pattern not just of
4 the nurses but also of the junior doctors.
5 There are criticisms made also of the computerised
6 nursing care planning system. That's dealt with in some
7 detail in the written opening, so I don't propose to go
8 into that now.
9 I would like to focus on something that did cause
10 some concern, which is communication between the nursing
11 and medical staff. In fact, communication generally was
12 a matter of concern, so I'm going to look at that in
13 a number of respects. The first, though, is this
14 between the nurses and medical staff.
15 Dr Jenkins was instructed by the trust in relation
16 to Raychel's case. He gave an interview to that UTV
17 Insight programme on 7 June, When Hospitals Kill.
18 He was asked in the course of that interview what he
19 thought were the great lessons to be learned from Lucy
20 and Raychel's death.
21 He said:
22 "Communication is at the heart of so many problems
23 where a doctor makes a judgment as to the treatment of
24 a child and passes that information on, but perhaps
25 doesn't write it down or someone mishears what they say,

26

1 and I think the communication and the record keeping,
2 which gives a written record of what a doctor prescribes
3 or the treatment that a doctor wants a child to have,
4 that to me is at the core of this. That is a thing that
5 can best protect our children".
6 As we have listened to the evidence in the clinical
7 section, one will be able to see just the areas in which
8 that communication was perhaps not as effective as it
9 might have been, and in some cases was totally absent.
10 In her report to the inquiry -- so if we look now at
11 the governance aspect of that -- Sally Ramsay observed
12 that there were no communication protocols available
13 at the time, and that was shared by Mr Foster, who found
14 evidence of poor, as he termed it, vertical
15 communication between members of the surgical teams.
16 Sister Millar highlights a situation whereby
17 attempts were made by the nurses to contact the surgical
18 SHO initially, and then the SHO to come and give Raychel
19 some IV anti-emetic for her vomiting. However, they
20 didn't answer their bleeps immediately. And she says
21 that there was difficulty in contacting the surgical
22 doctors as they were in theatre and didn't answer their
23 bleeps, which is a situation that Mr Foster regarded as
24 being very unsatisfactory.
25 The fact that the doctor responsible for Raychel's

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1 care was not known to the nurses had the result that she
2 was seen by several junior doctors during the day.
3 Well, that might not have been the only reason why she
4 was seen by several junior doctors. As we'll come on to
5 see that seems to have been the system.
6 Mr Gilliland didn't know the details of his patients
7 who were admitted on the 7th, at least that seems to be
8 the case, and that is also a matter of concern for
9 Mr Foster, and he says suggestive of serious vertical
10 communication problems in the Altnagelvin Hospital.
11 Dr Makar himself described the confusion as to the
12 identity of the on-call consultant surgeon. Mr Foster
13 says, as he develops his concern about communication:
14 "There was obviously confused communication between
15 the doctors and nurses, and a mindset that did not seem
16 to accept that a serious problem was occurring."
17 He says further:
18 "These were very junior doctors and they did not
19 inform their senior colleagues. As I have mentioned on
20 more than one occasion in my report, the paediatric SHOs
21 must have been present on the ward virtually constantly
22 and I cannot understand why the nursing staff did not
23 speak to them."
24 Well, we know that they spoke to at least one, which
25 was Dr Butler, who changed Raychel's IV bag at about

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1 midday.
2 Professor Swainson agrees that there was
3 insufficient communication between the nurses and the
4 surgical staff and that systems for the clear lines of
5 communication when plans do not go as expected are
6 notable by their absence and are below the standard
7 expected in 2001.

8 Mr Chairman, it's going to be a matter for you to
9 determine whether in this most fundamental aspect of
10 clinical effectiveness there were functioning system,
11 and if there were shortcomings, how they arose and how
12 they might best have been avoided.

13 One formal means of communication is medical records
14 and record keeping. The trust had a patient case note
15 standards, they produced that in 1996, and case note
16 documentation audit was performed in Altnagelvin in
17 1999/2000.

18 In fact, that audit is rather interesting as to what
19 it shows. It records that only 57 per cent of patients
20 had a daily entry in their medical records, and this
21 indicated, according to the report, large gaps in some
22 patient's notes, which may be reflective in the clinical
23 activity of the area, but it prompted a query as to
24 whether it was acceptable for patients occupying acute
25 admissions beds not to be seen daily by a medical

1 officer. Those results were discussed at a clinical
2 audit committee meeting in November 2000.

3 Mr Parker indicated that every individual
4 directorate had received a copy of their own results,
5 that is the results of that audit, and were informed
6 that re-audit would take place in one year's time.

7 Mrs Witherow said that she had attended the ward
8 sisters' meetings to discuss the action required
9 in relation to nursing and she added that the clinical
10 directors would be required to action the medical
11 aspects of this.

12 It is unclear to date which clinical director had
13 the responsibility for driving the response to that
14 audit within Ward 6 for the benefit of paediatric
15 surgical patients, and we hope to find that out in the
16 course of the hearing.

17 If I may just summarise them, though, the issues for
18 our purposes, or some of them, that have arisen
19 in relation to medical notes and records in Raychel's
20 case.

21 First off, the fluid balance chart. It didn't
22 record all the vomiting that took place on 8 June.
23 Dr Sumner describes the fluid balance chart as not
24 recording a note of any urine output or oral fluid
25 intake. That's the fluid balance chart.

1 Then there's a written observation sheet. They were
2 inadequately maintained for 8 June. The general chart
3 contains only one reference to vomiting.

4 Mr Foster was absolutely unequivocal in his view.
5 He said that the notes made at 1300 and 1800 do not
6 mention vomiting at all. Any critical reader of the
7 file can only conclude that the true severity of the
8 vomiting suffered by this child was seriously
9 underestimated by the nursing staff on Ward 6.

10 He points out:

11 "More detailed records throughout the 8th would have
12 assisted the nursing staff to detect an ongoing
13 deterioration throughout the afternoon and the evening
14 of the 8th. In reality, there was so little written
15 down that it would only have been by verbal
16 communication that the nurses would have realised the
17 reality of the clinical situation. It is my belief that
18 this communication was lacking."

19 Ms Ramsay makes her own comments about the actual
20 style of the observation chart making it difficult to
21 assess the trends and changes.

22 There's only one reference to vomiting in the
23 nurses' episodic care plan. Changes in Raychel's
24 condition were not properly recorded so as to prompt
25 assessment by a doctor and, for example, the Zofran

1 administered by Dr Devlin was not recorded or Raychel's
2 response to it on that plan.

3 There are other comments in similar vein that the
4 experts have made.

5 If I just list finally the clinical notes, so moving
6 from the nursing notes, the clinical notes for 8 June
7 contain only one record, an untimed, three-line entry
8 made by Mr Zafar in relation to his ward round.
9 Although it directs continued observations, it doesn't
10 state what those continued observations are supposed to
11 be.

12 It did become clear, it seemed to me, Mr Chairman,
13 during the hearing from Mr Makar and Sister Millar, that
14 they had different views, actually, on what was
15 expected, and the lack of clinical notes is despite the
16 fact that Mr Makar, Dr Butler, Dr Devlin, Dr Curran, all
17 attended on 8 June. The significance of this is that
18 Dr Curran did not appreciate when he attended at about
19 2200 hours and prescribed the anti-emetic cyclizine that
20 Dr Devlin had already attended at 1800 hours and
21 prescribed an anti-emetic and that that anti-emetic had
22 not been able to prevent further vomiting. Well, he
23 didn't know that because none of that was written down.

24 It's a matter for you, Mr Chairman, to determine and
25 consider the extent to which Altnagelvin allowed the

1 doctors and nurses to regulate the standard of their own
2 record keeping and whether there was any proper system
3 of scrutiny over the practices that they developed.

4 Then to move to clinical protocols.

5 The responsibility for incorporating clinical
6 guidelines into the work of Altnagelvin was written into
7 the written terms of clinicians' employment.

8 Examination of the clinical issues arising from
9 Raychel's case has drawn attention to the absence in
10 2001 of written clinical guidelines or protocols in
11 a number of these respects, Mr Chairman, which you might
12 consider to be quite important in relation to Raychel's
13 case.

14 Relaying information to on-call consultants in
15 respect of a patient admitted under their care: no
16 protocol about that or guidance.

17 Clarifying medical responsibility for surgical cases
18 on paediatric wards.

19 Decision to operate on children at night.

20 Performance of out-of-hours surgery by junior
21 doctors acting without consultant knowledge.

22 Supervision and management of post-operative
23 children.

24 Prescription of intravenous fluids in post-operative
25 children.

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1 Managing intravenous fluids.
2 Post-operative measurement of serum electrolytes.
3 Effective patient handovers.
4 Post-take ward rounds.
5 Management of post-operative nausea and vomiting.
6 Discharge of children from hospital or the transfer
7 of patients between hospitals.
8 And the making of records and/or record keeping for
9 staff above JHO level.

10 Evidence, we hope, will be given in the absence of
11 written protocols and what the guidance was that was
12 provided on those matters, and how junior doctors and
13 those requiring that guidance were to know in any
14 consistent fashion what it should be.

15 If we go to recommendations of NCEPOD, the National
16 Confidential Inquiry Into Post-operative Deaths.

17 If we take just one external source of guidelines,
18 because that was one they could have used, the
19 1999 NCEPOD report, Extremes of Age, recommends that
20 anaesthetic and surgical trainees need to know the
21 circumstances in which they should inform their
22 consultants before undertaking an operation on a child.
23 Pretty clear. Neither the consultant anaesthetists nor
24 the consultant surgeon who were on call were informed of
25 Raychel's admission or were involved in the decision to

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1 operate.

2 The NCEPOD advice was important, not least because
3 the previous NCEPOD report observed that children
4 operated on at night are more likely to have
5 complications, and Mr Orr described the 1989 NCEPOD
6 recommendations -- Mr Orr was an expert brought by the
7 trust -- as a wake-up call to the surgical and
8 anaesthetic professions in regard to the management of
9 children. And he says they received significant
10 publicity and circulation within the professions, but
11 those recommendations were not applied in Altnagelvin in
12 2001 both surprised and worried him because there had
13 been 11 years to implement a report which made such
14 a major impact on the provisions.

15 Doctors Makar, Zawislak, Gund and Jamison gave
16 evidence that they were unaware of the 1989
17 recommendation that no trainee should undertake any
18 anaesthetic or surgical operation on a child of any age
19 without consultation with their consultant. In fact,
20 Dr Jamison accepted that Altnagelvin had no guidelines
21 on it and that if she had known about the NCEPOD report:

22 "... certainly it would have influenced me at that
23 time and I would have contacted the third on-call
24 consultant had I known about that".

25 Mr Gilliland has acknowledged that the NCEPOD

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1 recommendations were not applied in Raychel's care, were
2 not adopted as policy in Altnagelvin, and he was unaware
3 of the NCEPOD "who operates when" report.
4 Professor Swainson says that the trust should have had
5 clear systems for ensuring compliance with relevant
6 national UK professional guidance. Clinical audit was
7 established firmly by 2001 and doctors would be expected
8 to review their practice and service organisation
9 against NCEPOD reports and guidance. And the trust's
10 medical director should have ensured that the report was
11 considered and acted upon, and in many trusts this would
12 have been reported to the board or at least the clinical
13 governor or risk committee in 2001. And reasons for not
14 implementing a NCEPOD recommendation would need to be
15 agreed by the medical director and signed off by the
16 board, according to Professor Swainson.

17 It's difficult to understand why there should have
18 been a failure to adopt NCEPOD recommendations because
19 they were available to the staff. But more particularly
20 Mr Bateson, the clinical director for the directorate
21 most at issue, and Dr Hamilton, who was a consultant
22 anaesthetist at Altnagelvin, they actually acted as
23 contributors to the work of NCEPOD, and Mr Panasar,
24 a consultant surgeon at Altnagelvin, was on the working
25 group that produced a 1999 report on paediatric surgical

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1 services in Northern Ireland, which made the
2 recommendations that there should be adherence to the
3 NCEPOD recommendations concerning the supervision of
4 junior anaesthetic and surgical staff.
5 THE CHAIRMAN: It might be different, mightn't it, if there
6 was any evidence that consideration had been given
7 within Altnagelvin to implementing NCEPOD reports and
8 they decided "we can do A, B and C, but D and E is a bit
9 beyond us at the moment"?
10 MS ANYADIKE-DANES: That might be the case. In which case,
11 you'd expect to see that recorded somewhere, that they
12 made a conscious decision that: we are not following
13 this recommendation because we have this alternative
14 practice which will deliver the same objectives, or we
15 don't accept those are viable optatives. Something.
16 THE CHAIRMAN: Yes.
17 MS ANYADIKE-DANES: Notwithstanding all of that, immediately
18 following Raychel's inquest Altnagelvin's communications
19 department produced a document entitled "Potential media
20 questions and some suggested answers arising from
21 Raychel Ferguson inquest and our statement".
22 That document included this as a potential question
23 that Altnagelvin might have to deal with:
24 "How can the public be sure that there are no other
25 procedures and practices in Altnagelvin that might lead

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1 to this kind of tragedy happening again?"
2 The suggested answer was:
3 "The public should be reassured that Altnagelvin
4 practises in accordance with the highest professional
5 standards as required by the various Royal Colleges
6 in the United Kingdom. We constantly audit our work
7 against these standards and ensure we keep up to date
8 with the new developments and new treatment options."
9 Mr Chairman, whether that claim was warranted
10 ultimately will be a matter for you after the evidence.
11 Moving to audit, the service agreement for the
12 provision of hospital services between the trust and the
13 board provided that:
14 "Each specialty will be required to participate in
15 clinical audit on a multidisciplinary basis as
16 appropriate and individual professions will also be
17 required to initiate audit projects in relevant
18 circumstances. Audit projects should be designed to
19 develop suitable guidelines and treatment protocols from
20 which outcomes can be measured."
21 Dr Parker was the clinical audit coordinator for the
22 hospitals, and the clinical director of surgery and
23 critical care also bore some responsibility for that.
24 But Dr Parker has advised that he can find no record
25 of any audits initiated following the identification of

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1 clinical risks in Raychel's case:
2 "I did not receive any correspondence following the
3 critical incident review requesting an audit be
4 undertaken by the audit department. I did not sit on
5 a critical incident review panel."
6 But he does say, though:
7 "An individual critical incident review doesn't
8 usually trigger an audit. If there was a suggestion
9 that several cases were similar an audit would have
10 a role to establish the facts."
11 So it will be a matter for evidence whether the
12 features of Raychel's case, particularly in relation to
13 the responsibility for paediatric surgical cases and
14 also for the provision of fluid management therapy,
15 whether any of those fell within the sort of subject
16 that should have given rise to a critical incident
17 review.
18 Apart from the critical incident review meeting that
19 actually took place, there's no indication that
20 Raychel's case was examined in the context of
21 a multidisciplinary audit, whether in 2001 or at all for
22 that matter, nor is there any indication that any
23 individual aspect of her care or treatment was subject
24 to audit, and only a limited number of clinical audit
25 committee meeting minutes have been provided to the

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1 inquiry. So they might have happened, but we haven't
2 seen evidence of it yet.
3 Altnagelvin did perform an audit of fluid balance
4 charts in February 2003. That audit did not extend to
5 Ward 6 because it was said to use different
6 intake/output charts to other wards. So we don't know,
7 but we hope to find out, whether those charts
8 in relation to the children on Ward 6 have been the
9 subject of audit, and if they have, what has been the
10 result.
11 On 25 March 2002, the then CMO,
12 Dr Henrietta Campbell, wrote to the trust to announce
13 the department's guidelines on prevention of
14 hyponatraemia in children.
15 She stated:
16 "It will be important to audit compliance with the
17 guidance and locally develop protocols and to learn from
18 clinical experience."
19 So we will see the extent to which that requirement
20 was met.
21 I turn now to medical responsibility for patients.
22 Raychel was admitted under the care of Mr Gilliland, she
23 was an emergency admission for those purposes, but it
24 was his responsibility to oversee her care and be
25 available for consultation and delivery of care as

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1 required.

2 He was expected, as the on-call consultant, to
3 oversee the totality of the patient's care. And, as he
4 explained:

5 "The consultant surgeon therefore takes
6 responsibility for the management of his clinical
7 service. The delivery of care will frequently be
8 delegated to other members of the surgical team who are
9 deemed by the consultant to be competent to deliver the
10 care. Patient care is, therefore, consultant-led rather
11 than consultant-delivered."

12 But the process by which Mr Gilliland deemed his
13 surgical team, the members of it that were taking care
14 of Raychel, competent is as yet unclear.

15 In Mr Gilliland's opinion the consultant overall was
16 responsible for ensuring that there was a system that
17 would deliver care to that patient. So the process by
18 which he deemed the system adequate to deliver care to
19 Raychel, that's not presently clear either.

20 The GMC good medical practice guidance sets out
21 Mr Gilliland's duty as a leader of a specialty surgical
22 team charged with Raychel's care was to ensure that her
23 care was properly coordinated and managed and that
24 arrangements were put in place to provide cover at all
25 times. However, Mr Gilliland didn't see Raychel at all,

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1 and there's no clear evidence that he even knew that
2 Raychel was his patient until after her death.

3 According to Mr Gilliland, there was no formal
4 protocol for ensuring that the on-call consultant was
5 informed of all patients under his care at that time,
6 and Mr Foster regards that, if that's true, as a matter
7 of concern.

8 Then, if we get into the slightly more difficult
9 areas of actually the division of responsibility for
10 Raychel's care.

11 We see that she was on Ward 6, and the
12 responsibility for paediatric surgical patients there
13 lay with the surgical team. So, as you know,
14 Mr Chairman, from the clinical evidence, you have
15 surgical patients on an otherwise paediatric ward, and
16 that brings together two disciplines, surgery and
17 paediatrics.

18 Dr Johnson observed that:

19 "Although the surgical patients were on the
20 paediatric ward, that was the only common denominator,
21 they were solely managed by the surgical team, the
22 surgical JHO, SHO, registrar, consultant, and we
23 paediatricians had no involvement with them whatsoever."

24 Mr Gilliland described an informal practice on
25 Ward 6 whereby paediatricians would respond to the needs

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1 of surgical patients if surgical staff were unavailable.
2 And the attendance of surgeons on their patients at
3 Ward 6 was an issue that has been mentioned, he said,
4 from time to time and it seemed to flare and then
5 quieten, improve for a while, and then it would come to
6 the surface again, but it did seem to be an issue for
7 the nursing staff.

8 And Dr McCord, who was is a paediatric consultant,
9 believes that encouragement was given by the
10 paediatricians that Sister Millar should speak to the
11 senior consultant surgeons to make her concerns known.
12 And she gave evidence about her concerns in the overall
13 management of those surgical patients by the surgical
14 team.

15 The system at that time in Altnagelvin was that it
16 was the pre-reg, the PRHOs, who were the first on-call
17 clinicians for post-operative children. But as I've
18 already said, they had not yet completed their basic
19 medical education.

20 And Mr Foster believes that to place them in
21 a position of being first on call for post-operative
22 children was unsatisfactory, and he expressed surprise
23 that that situation escaped the scrutiny of the
24 Postgraduate Deanery responsible for the continued
25 education of these pre-registration doctors.

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1 Given their inexperience, the PRHOs sometimes
2 required consultant guidance, and that was recognised by
3 Mr Gilliland, and sometimes required guidance from the
4 nursing staff.

5 But he felt that:

6 "If people knew that problems were developing and
7 they required my input, then I would expect to be told."

8 But, Mr Chairman, that, of course, depends upon
9 those people having sufficient knowledge or experience
10 to realise that they do actually require senior input.

11 And Mr Gilliland conceded in evidence that the
12 problem was that no one at that stage realised what was
13 exactly happening to Raychel and how rapidly she was
14 deteriorating. Well, part of that problem was those who
15 would be observing it were PRHOs and nursing staff.

16 Mr Foster concludes that the situation they were put
17 into by junior housemen being first on call and the
18 nurses were effectively the safety net -- now, that
19 system has changed, Mr Chairman, because junior house
20 officers, since Raychel's passing, have not been,
21 apparently, allowed to come on Ward 6, and the only
22 surgical people who have contact with the children are
23 from senior house officers upwards.

24 If I can just pull out very briefly 312-001-001.
25 I do so really just to remind ourselves of the

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1 interactions between the clinical staff and Raychel.
2 Then if I pull up 328-004-001. This is a new table
3 that has been prepared. What you see there is it's
4 really focusing on the surgeons because it's the
5 surgical team.

6 The blocks of colour, they're unidentified
7 clinicians. Those highlighted in yellow, those are the
8 clinicians who actually had direct contact with Raychel.

9 What I'm showing here is simply 8 June so that you
10 can see, Mr Chairman, how little contact there was. If
11 you leave aside Mr Zafar in the early morning, as his
12 ward round, then really you see we're dealing with JHOs
13 who actually had interaction with her, leaving aside the
14 changing of her IV bag at noon. But that demonstrates
15 the lack of seniority of the team who were most
16 interacting with her at the time when perhaps something
17 might have been done to address her deterioration.

18 And also, what we've also shown there is what their
19 on call times were. That may be a chart that we look at
20 for longer with others, but I just put it up so that you
21 can see.

22 There is also, and I'm not going to pull it up, but
23 I'll give you the reference for it, 312-008-001, a table
24 that shows the trainee clinicians' education, training
25 and experience with particular reference to

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1 hyponatraemia and record keeping. So with that, if you
2 cross-refer this to that table, you will see what they
3 described as their experience and education in
4 hyponatraemia and fluid management.

5 None of the five doctors who saw Raychel that day
6 saw her more than once, and they did not communicate
7 with each other about her. No doctor had ongoing
8 knowledge of her condition. No doctor was able to
9 observe changes over time. The nursing staff did not
10 report concerns about change of condition, so it would
11 seem, and Raychel was not seen by anyone more senior
12 than a senior house officer from admission to seizure
13 nor was any senior clinician involved in any
14 post-operative investigation.

15 That, in terms of the surgical team, was the care
16 for which Mr Gilliland was directly responsible.

17 Dr Haynes has condemned the lack of senior
18 involvement in Raychel's care as completely
19 unsatisfactory, and he believes Mr Gilliland should
20 at the very least have seen her at some point during
21 8 June. The extent to which Altnagelvin identified and
22 dealt with these issues as part of lessons learned,
23 that's going to be something to be addressed during the
24 hearing.

25 However, the importance of consultants supervising

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1 patient care doesn't seem to be included in the action
2 plan that was produced by the critical incident review
3 meeting, to which I will turn a little later on, and
4 it's not until almost two years later, 2 May 2003, that
5 there is a memorandum from Dr Nesbitt to Mr Bateson,
6 making it clear that timetabling of duties will be
7 altered to give the on-call consultant surgeon time to
8 review in detail the patients admitted under his care.
9 And Professor Swainson says that the trust should have
10 been aware of these gaps in clinical care, but these
11 were not addressed until after the tragic death of
12 Raychel.

13 So now the clinical responsibility for IV therapy.
14 There was no protocol, as I've indicated, available to
15 guide doctors in the post-operative prescription of IV
16 fluids.

17 Dr Gund, who was a junior anaesthetic, he initially
18 made an appropriate, so the experts have held,
19 prescription for IV fluid administration for Raychel on
20 return to ward. But he didn't, apparently, have the
21 confidence in his own knowledge to ensure that that
22 prescription was followed by the ward staff, and he was
23 unable to say with certainty whether prescription was
24 the responsibility for surgeons or the paediatricians.
25 He decided ultimately to allow Raychel's fluids to

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1 follow what he was told were ward protocols, suggested
2 by nursing staff, on the basis that they would ask
3 paediatricians to prescribe Raychel's fluids. This was,
4 in the view of Dr Haynes, completely inappropriate.

5 The surgical SHOs thought that the intravenous
6 prescription was the responsibility of the
7 paediatricians, but consultant paediatrician Dr McCord
8 states:

9 "Neither I nor my staff were consulted regarding the
10 prescription of IV fluids for Raychel. We wouldn't have
11 expected to be. It was a matter for the surgical team."

12 And that's another matter that Dr Haynes thinks is
13 highly unsatisfactory, and in fact he encapsulates his
14 view about this in a particular part of his report where
15 he says:

16 "The problem was there was no clear structure, no
17 acceptance of responsibility between the senior staff
18 in the three specialties, surgery, anaesthesia and
19 medical paediatrics, regarding this important aspect of
20 patient management. It appears always to have been
21 somebody else's job. The consultant staff in each one
22 of the three departments, by failing to meet to agree
23 lines of responsibility, generated a system in
24 Altnagelvin Hospital where IV fluid prescriptions for
25 post-operative surgical patients were being dictated to

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1 junior medical staff by the nursing staff on the basis
2 of custom and practice rather than by patient
3 observation and informed by individual patient need."

4 In short, Mr Chairman, you might conclude that it
5 was a mess and a potentially unsafe one, and the task of
6 this hearing is to try and discover how it was allowed
7 to occur.

8 Mr Gilliland says that neither he nor his surgical
9 team were aware of the Ward 6 practice of continuing
10 preoperative fluid prescriptions post-operatively,
11 because that's exactly what happened in Raychel. He
12 concedes:

13 "I would have to say, I should have known that.
14 There were clinical director meetings where we might
15 have discussed that issue, yet the frailties of that
16 system were only exposed by Raychel's tragic death."

17 And Professor Swainson is of the view that:

18 "The consultant surgeons should have been clear with
19 the nurses and the junior doctors on who was responsible
20 for prescribing fluids to post-operative children and
21 what fluids to prescribe."

22 Another question, therefore, that arises,
23 Mr Chairman, is: why did the clinical directors'
24 meetings fail to disclose and address that practice?
25 And did that amount to a failure in clinical leadership

1 and/or clinical governance? And what, if anything, has
2 changed?

3 If I move now to the transfer of Raychel to the
4 Royal, the Children's Hospital. Mrs Ferguson has told
5 the inquiry that:

6 "We believe the cover-up began on the morning
7 Raychel was being transferred to the Royal. We now know
8 the situation was hopeless, Altnagelvin just sent her to
9 Belfast so that it would be recorded that Raychel died
10 there. There was no hope for her."

11 Dr Nesbitt rejects that, claiming the diagnosis was
12 not clear.

13 The neurosurgeons in Belfast had accepted:

14 "Re transfer Raychel to their care, the ICU in
15 Altnagelvin does not provide services for children and
16 such cases are always transferred to the regional
17 paediatric units. And it's never too late, especially
18 in children, and I can confirm that I have personally
19 seen recovery from positions I thought to be
20 irretrievable."

21 The accuracy and basis of the information given to
22 the Ferguson family was addressed during the hearing on
23 clinical issues, and a principal issue in relation to
24 governance and this hearing relates to whether, as the
25 family believe, they were given false hope by the

1 mention of surgery and the transfer to Belfast.

2 Dr Nesbitt says it has underlined for him the
3 importance of effective communication with distraught
4 family members.

5 If it took a situation like that, Mr Chairman, for
6 an experienced consultant like Dr Nesbitt to see that,
7 maybe the skill and care required in communicating
8 effectively with distraught family members is something
9 that should have been the subject of some training
10 before Raychel's death. It will be a matter for you in
11 terms of the facts of the matter, Mr Chairman, to
12 determine why Raychel was transferred to Belfast and
13 whether imperfect communication, an eagerness to believe
14 a cover up gave rise to her family's false hope.

15 That leads straight into the question of
16 communication with parents, which is another of the
17 important communication issues that we have been
18 investigating.

19 The department had a charter for patients and
20 clients, March 1992. That charter accords:

21 "... a right to be kept informed about your
22 progress. Your relatives and friends are also entitled
23 to be informed."

24 That's particularly important in the case of
25 paediatric patients who are too young or too ill to be

1 informed directly about their own progress and where the
2 communication really becomes a matter for communication
3 with their family.

4 The nurses' episodic care plan for Raychel
5 incorporates a requirement to keep her parents informed,
6 and Mrs Ramsay comments that it's important for nurses
7 to listen to parents, note their concern and give
8 appropriate information as necessary to allay any
9 anxieties.

10 The entries in the care plan for 1700 hours on
11 8 June indicate that Raychel's parents were happy with
12 her care. However, none of Mrs Ferguson's observations
13 were recorded in the care plan. Mr and Mrs Ferguson
14 have expressed upset that when they voiced concerns
15 about Raychel's condition and vomiting, they were
16 neither accepted nor acted upon and in fact in some
17 cases it wasn't even recorded.

18 And Dr Sumner has observed:

19 "In my opinion, it is always very unwise to dismiss
20 the opinions of the parents, after all it is they who
21 know their child best, and in this case there does seem
22 to have been a failure of communication. Children's
23 nursing is based on the principle that parents have
24 greater knowledge of their child than the nurse caring
25 for them. Listening to the parents is vital."

1 In fact, that became the basis of family-centred
2 care:

3 "Where information from parents is inadequately
4 recorded the records will not portray a true picture of
5 the clinical condition and as a result important
6 problems may be missed."

7 On the clinical side of the communications with
8 parents, whilst Mr Makar spoke briefly to Mr Ferguson
9 first thing in the morning on 8 June, Mrs Ferguson
10 recalls that between 9 am on the 8th and 12.40 am on the
11 9th, "no member of the medical staff approached me".

12 This failure of the medical staff and the surgical
13 team in particular to communicate with Raychel's family
14 during the day of her deterioration is compounded by
15 a failure to communicate adequately with them after
16 Raychel's collapse. And Professor Swainson has observed
17 that the differing accounts of Raychel's condition
18 during 8 June suggests that communication was not strong
19 and that the parents' concerns about Raychel's progress
20 during the afternoon and evening of 8 June were not
21 listened to or were dismissed, and this is a central
22 feature in the case.

23 But, Mr Chairman, as you will have seen from the
24 opening, there just were no protocols in place, nor
25 training given to guide clinicians in the task of

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1 giving, receiving and recording information to parents.
2 The difficulty for Raychel's parents -- well, of the
3 many difficulties that they experienced -- this was one
4 that having travelled in hope from Altnagelvin, they
5 were immediately met with the very bleak prognosis
6 at the Children's Hospital of Raychel is critically ill
7 and the outcome is very poor.

8 They have no criticism of the way they were treated
9 by the clinicians at the Children's Hospital and
10 appreciated the candour. And, in Mr Foster's view,
11 Mr and Mrs Ferguson were treated with all possible care
12 and sensitivity at the Children's Hospital. That's not
13 the aspect of the communication.

14 Dr Ashenhurst, the Ferguson family's GP, has
15 confirmed that there is no record of any communication
16 from Altnagelvin Area Hospital about Raychel's transfer
17 to Belfast:

18 "Usually, we would receive a form informing us of
19 the transfer. Nor did any member of Altnagelvin staff
20 speak to myself or a GP colleague about the fact or
21 cause of Raychel's death. We did not receive a copy of
22 the autopsy report."

23 Neither was she briefed as to the outcome of the
24 critical incident review.

25 Mr Chairman, you'll have heard in some of the other

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1 cases how keeping in touch with the GP can perform
2 a very useful exercise because it is sometimes to the GP
3 to whom the parents go when they want to try and
4 understand better what happened to their child. That is
5 a more familiar figure perhaps than the treating
6 clinicians. But this particular GP wouldn't have been
7 able to help them with that because this particular GP
8 apparently wasn't kept in the loop by Altnagelvin.

9 So this issue of who should have spoken to Raychel's
10 family, when and in what terms will be considered from
11 a governance perspective in this hearing, and that leads
12 me to the critical incident review.

13 So notwithstanding all that doctors Nesbitt and
14 McCord may have known about Raychel's collapse, low
15 sodium levels, cerebral oedema, early on the morning of
16 9 June, there is no evidence that a formal report of an
17 adverse critical incident was made at Altnagelvin.

18 Mr Gilliland believes:

19 "There had been discussion between our own medical
20 staff and the doctors in the Children's Hospital about
21 the probable cause of Raychel's death. I believe I was
22 made aware of that discussion some time on 11 June and
23 that some of that discussion had been critical."

24 The substance of these discussions, so far as we're
25 aware, is not recorded. If it is recorded, it has not

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1 been provided to us. But there seems to be a reference
2 to a rumour alleging Altnagelvin's mismanagement of
3 Raychel's fluid therapy, which emerged from the
4 Children's Hospital on Sunday 10 June. That is recorded
5 but no very great detail about it, and no evidence of
6 communication between the Children's Hospital and
7 Altnagelvin about the views that the Children's Hospital
8 was apparently expressing on her treatment in
9 Altnagelvin.

10 But there was an investigation. Mrs Burnside, as
11 chief executive, informed Dr Fulton of Raychel's death
12 on the morning of Monday 11 June and asked him, as
13 medical director, to investigate this very serious event
14 in his role as medical director.

15 He was assisted in that by Mrs Brown, she was risk
16 management coordinator, and a meeting was convened the
17 following day, 12 June. That review was to be governed
18 by the Altnagelvin critical incident protocol of 2000.
19 Let's pull that up. 026-012-016.

20 This is what should have happened. You can see
21 clinical notes to be completed and a clinical incident
22 form should have been completed.

23 If I move on down, you can see that the risk
24 manager, that is Mrs Brown, will arrange a critical
25 incident review meeting ASAP and that these people

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1 should have been involved. Well, you can see the
2 nursing director, clinical effectiveness coordinator.
3 They're all to be involved.

4 Then the critical incident meeting will endeavour to
5 clarify the circumstances. One sees that.

6 And:

7 "Staff may be asked to complete a statement,
8 containing factual information of their involvement, to
9 assist in the investigation."

10 Then you get to the penultimate step:

11 "The risk management coordinator will provide the
12 chief executive with a written report, with conclusions
13 and recommendations within an agreed timescale."

14 Mr Fulton has said what he was trying to do, he was
15 trying to form an accurate account of the events leading
16 to Raychel's death while it was still clear in
17 everyone's memory:

18 "I was also keen to ascertain whether lessons could
19 be learnt so that a recurrence of the tragic event could
20 be avoided."

21 But as we have progressed with the investigation,
22 Mr Chairman, it seems that the review process that was
23 actually carried out may not have been a faithful
24 response to Altnagelvin's own protocol, because that
25 directs that the risk manager will arrange a critical

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1 incident meeting. That happened. But it also directs
2 who should be there and what should happen as a result
3 of it.

4 So, then, if we consider what they actually did do.
5 The starting point is that the critical incident meeting
6 was convened quickly, it was convened within two days of
7 Raychel's death. But unfortunately, Ms Duddy, who was
8 director of nursing and the director of risk management,
9 didn't know about it and, therefore, didn't attend, and
10 she says she didn't actually learn of Raychel's death
11 until Mrs Brown, the risk management coordinator, spoke
12 to her some time after the meeting had taken place, but
13 she was one of the persons, according to the protocol,
14 who should have been there.

15 Dr Fulton assured this inquiry that Mrs Brown
16 contacted the relevant staff, all agreed to attend, and
17 that he recorded the attendees and what they said. But
18 he subsequently acknowledged that not all of the
19 relevant witnesses were contacted, that he made no
20 record of those who did attend, that he did not record
21 what was said and that in terms he has no reliable
22 recollection of the review. So, for example, doctors
23 Devlin and Curran, I have just been taking you through
24 their role, were not contacted, they were the junior
25 doctors, and in fact their experience might have been

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1 very important to have had.

2 Dr Curran says that he had expected either the
3 consultant or the clinical director or somebody from the
4 hierarchy in the hospital to chat to all the staff
5 involved. That's what he thought was going to happen.

6 Also, Raychel's designated paediatric named nurse,
7 Staff Nurse Patterson, was not present at the meeting,
8 and there seems to have been no attempt made to obtain
9 a statement from her.

10 Dr Bhalla, the surgical registrar who attended after
11 Raychel's collapse, he thought he should have been
12 invited because he was the person in the surgical
13 department who was present during Raychel's critical
14 time. In fact, he was the most senior surgical person
15 to attend at that time, but he wasn't invited.

16 The failure to gather evidence in any systematic
17 fashion or to make a record of the review meant that
18 evidence was lost. The surgical rota, for example, is
19 now no longer available so we are not able to fill in
20 some of the gaps that I showed you in the schedule, and
21 memories have faded, it's inevitable.

22 In the year after Raychel's death many of the
23 medical personnel involved relocated to hospitals
24 elsewhere. In fact, the risk management in the NHS
25 manual advises specifically:

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1 "In addition to individual witness statements, it is
2 useful to record the names of all staff on duty at the
3 time of the incidents, perhaps in the form of a staff
4 rota. It can sometimes be several years before, in this
5 case, the concern is a claim, a claim is made, and it is
6 often difficult to track down which staff were
7 involved."

8 Well, precisely, that sort of thing happened with
9 Raychel.

10 The Altnagelvin clinical incident policy of February
11 emphasised that it's extremely important that any
12 clinical incident should be reported on the appropriate
13 documentation, which will be sent to the RMCO, that was
14 Mrs Brown, who will contact all relevant staff and
15 obtain detailed reports. It's not clear that any
16 detailed reports were obtained or, if they were, then
17 I don't believe the inquiry has been advised of them.

18 No minutes were taken at the meeting to encourage
19 openness. Instead, Mr Fulton made some notes and drew
20 up an action sheet. We can see that at 026-011-012. If
21 we can pull up alongside 013.

22 THE CHAIRMAN: Sorry, is it quite fair to say no minutes
23 were taken at the meeting to encourage openness?

24 MS ANYADIKE-DANES: I think that's what Dr Fulton wanted to
25 do. In fact, he was proposing --

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1 THE CHAIRMAN: Sorry, I see what you mean. Sorry,
2 I misunderstood the sense of it, because we know there
3 was some degree of openness at the meeting?
4 MS ANYADIKE-DANES: Yes, in fact I think, Mr Chairman, it
5 was proposed there would be minutes taken of it. Then
6 I think there was some disquiet about that, so to
7 encourage free discussion, if I can put it that way, it
8 was decided not to take them.
9 What one might have thought would happen is that
10 some detailed notes would be made afterwards to get the
11 sense of what the discussion was and so forth. And in
12 fact, so far as we are aware, these two pages, leaving
13 aside another document called the "Action sheet", which
14 I'll come to in a second, these two pages are what
15 exist, so far as Mr Fulton is concerned, from that
16 meeting.
17 In fact, it's not entirely clear when these were
18 taken. That's part of the problem now, and that was
19 part of Dr Fulton's problem when he was trying to help
20 us with whether a particular person was there or that
21 person's name appeared because that was somebody to whom
22 he spoke afterwards and got part of the chronology from.
23 But if one looks at 013, these seem to be his notes.
24 He will be taken through, and you have seen them before,
25 Mr Chairman, and it'll be a matter for later on as to

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1 whether in all the circumstances those could be regarded
2 as adequate.
3 Also an action plan was produced. If we pull down
4 those two sheets and pull up instead 026-011-014. There
5 we are. That's the action sheet.
6 The purpose of that was to describe the deficiencies
7 identified by members of the review team and,
8 presumably, to identify a way forward. Staff Nurse
9 Noble gave evidence at the review, considered and
10 concluded that there had been excess intravenous fluids
11 administered and a failure to monitor electrolytes.
12 And Dr Nesbitt reviewed the infusion rate of
13 Solution No. 18 and he felt it was too high for
14 Raychel's weight. However, it's not clear that the
15 notes that you'd seen previously do record that there
16 was excessive fluid, although the failure to monitor
17 might be inferred from item 2 here where it says, "Daily
18 U&E, all post-ops".
19 Dr Haynes is critical of this, he says that
20 the daily electrolyte essay is required for all children
21 receiving intravenous post-operative fluids and this is
22 merely re-instating something which had clearly, in his
23 view, fallen by the wayside over the years of
24 Altnagelvin:
25 "... and I suggest that this occurred because of the

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1 lack of consultant ownership of the issues."
2 So one perhaps might have wanted to know if there
3 was any discussion as to how something that he regarded
4 as so fundamental needed to be part of an action plan.
5 The deficiencies in record keeping are not directly
6 noted, although one might infer it from item 4, "Monitor
7 urinary output and query vomit", also and 6 "Fluid
8 balance documentation", but it might be noteworthy that
9 only seven months before Raychel's admission, in fact
10 in November 2000, there was a benchmarking exercise of
11 standards of care to examine Altnagelvin's performance
12 against other acute hospitals in Northern Ireland, and
13 the report identified areas that needed to be addressed,
14 some patients who were on intake/output charts had
15 information missing. In fact, seven were incomplete out
16 of 14, and to address these issues, it will be necessary
17 to involve staff and get their suggestions.
18 Mr Chairman, we'll be endeavouring to find out what
19 actually happened in the light of that because that's an
20 indicator that some improvement might be required, and
21 that, as I say, is happening seven months before
22 Raychel.
23 Dr Haynes finds it obvious from reading the
24 documents that had been given to him that documentation
25 of fluid balance in the hospital was not of a high

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1 standard prior to Raychel's death. Why that should have
2 been the case in the light of the benchmarking report is
3 something to be further considered.
4 But if we go to what might have been reflected
5 in the notes of the review meeting from what we have
6 since learnt in the evidence, Sister Millar recalled
7 telling the review meeting:
8 "I had for some time been unhappy with the system
9 within the hospital for caring for surgical children.
10 There was always a difficulty in getting doctors, there
11 weren't enough of them. I said that I thought it was
12 totally unfair that the nurses had such responsibility
13 for the surgical children. I had spoken about this
14 before and I know I had spoken about it at the sisters'
15 meetings".
16 Staff Nurse Noble said:
17 "There should have been more senior doctors
18 responsible for overseeing fluid management of surgical
19 children."
20 And then Sister Millar again acknowledged:
21 "It was recognised at the meeting that there was
22 a failure in the documentation. The main issue that was
23 discussed that day though was fluids".
24 And Staff Nurse Noble conceded -- and this is
25 an important point that she brought out -- that:

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1 "It was recognised that because Raychel had been
2 vomiting all day that the vomiting was severe and
3 prolonged."

4 Mr Chairman, it's not clear that one would
5 necessarily see that from the notes that Mr Fulton has
6 retained, nor did it actually come out in that way until
7 Staff Nurse Noble gave her evidence.

8 Dr Haynes' view was that there was a significant
9 omission from these action points. The consultant body
10 at Altnagelvin had either never been involved or had
11 ceased to be actively involved in the fluid management
12 of routine patients, and there was an opportunity at
13 that meeting for the medical director to insist that all
14 consultant colleagues took a hands-on role in the
15 supervision of intravenous fluid therapy. Consultants
16 ensuring that the trainees knew that they were expected
17 to do the necessary blood tests, get the results and act
18 on them if necessary. And it also seems unclear at that
19 time who was responsible for fluid management in
20 post-operative children.

21 An important outcome, though, of the review was
22 Dr Nesbitt's research into Solution No. 18 and its use
23 in the region. He felt a low sodium solution such as
24 Solution No. 18 could be unsuitable for post-operative
25 children as they were predisposed to hyponatraemia. His

1 grasp of the role -- in fact, in fairness to him, early
2 grasp of the role of Solution No. 18 in Raychel's
3 hyponatraemia was important and it led to item 1 on the
4 action sheet and the notice that came immediately after
5 the review, which was that from now onwards,
6 12 June 2001, all surgical patients are to have IV
7 Hartmann's solution, medical patients to continue on
8 Solution No. 18.

9 The following day, though, the action sheet was
10 amended and partially rewritten to become the document
11 headed "Action agreed following critical incident
12 meeting 12 June 2001", and the first item on the plan
13 was changed so that it now became, "Review evidence for
14 use of routine post-operative low electrolyte
15 intravenous infusion and suggest change if evidence
16 indicates. No change in current use of Solution No. 18
17 until review". That's a matter to be further pursued.

18 Dr Nesbitt also conducted a telephone survey, which,
19 sir, you've heard about, and some of the witnesses from
20 the Royal have been asked about. From that, you will
21 know that he wrote to Dr Fulton and Mrs Brown on
22 14 June, so fairly soon afterwards, to report that:

23 "The Children's Hospital anaesthetists have recently
24 changed their practice and moved away from
25 Solution No. 18 to Hartmann's. This change occurred six

1 months ago and followed several deaths involving
2 Solution No. 18, and as from today we will no longer
3 routinely use this fluid in the management of surgical
4 cases."

5 And you know, Mr Chairman, that he named
6 Dr Chisakuta in Belfast as his telephone informant, but
7 Dr Chisakuta can't actually recall that conversation.

8 In fact, none of the clinicians from the
9 Children's Hospital who gave evidence in relation to
10 Lucy's death the previous year were able to recall or
11 shed any light on the changes in the use of
12 Solution No. 18. But, sir, you have seen information
13 provided by the pharmacy department, which does seem to
14 confirm that there was decline in the use of
15 Solution No. 18 in the months preceding Raychel's death.

16 What's more, Dr Nesbitt says he discovered that the
17 fact that the Children's Hospital had stopped using
18 Solution No. 18 was the reason behind Dr Anand
19 discontinuing its use in Tyrone County Hospital. This
20 is what she told me when I contacted the hospital on
21 around 13 June. Unfortunately, Dr Anand and has no
22 recollection of that.

23 So he summarised Altnagelvin's position as having
24 followed a widespread and accepted policy of using
25 Solution No. 18 for post-operative fluids and there was

1 evidence to show that this policy is potentially unsafe
2 in certain children who have undergone a surgical
3 procedure. And he has concluded that had Altnagelvin
4 known of the Children's Hospital's change of practice
5 from the use of Solution No. 18, "this would have been
6 a strong message and one we would have acted on".

7 Focusing on the use of Solution No. 18, which is in
8 fact what happened, apparently, at the review, might
9 have meant that other aspects of Raychel's care weren't
10 taken up and considered with perhaps quite the degree
11 of -- and got perhaps quite the degree of attention that
12 they might have. One is exactly what was discussed
13 about the failure to replace electrolyte losses caused
14 by vomiting and what role that played in Raychel's
15 deterioration.

16 The connection between vomiting and solution
17 depletion was known at that time, but what actually was
18 discussed, what the nurses and clinicians during that
19 review knew about, acknowledged they knew about it, is
20 not clear, and that leads to this issue of prolonged
21 vomiting.

22 Dr Fulton has recounted how the nurses agreed that
23 the vomiting was prolonged, but not unusual after this
24 type of surgery. They did not believe that the vomiting
25 was excessive, though they may not have witnessed all of

1 the vomit that happened.
2 The difficulty, Mr Chairman, is that doesn't sit
3 easily with Staff Nurse Noble's subsequent
4 acknowledgment in her evidence that it was recognised
5 that because Raychel had been vomiting all day that the
6 vomiting was severe and prolonged. As I say, that
7 perhaps illustrates how a more detailed summary of the
8 discussion could have assisted.

9 One thing that does seem to be clear is that no real
10 consideration was given to interviewing, reviewing input
11 from or involving the Ferguson family in the review.
12 It's not clear that any consideration was given to
13 engaging external experts at that stage, or, for that
14 matter, interviewing in detail the two doctors who had
15 been prescribing the anti-emetic medication.

16 Documentation and record keeping could have been
17 scrutinised, several nursing issues explored, staff and
18 workloads could all have been discussed. We know there
19 have been issues from the evidence we've received, but
20 it doesn't appear clear they were discussed at that
21 stage. Dr McCord has said that there was a general
22 acceptance that things could have been done better and
23 conceded that he didn't think consideration was given to
24 communicating that fact to the Ferguson family.

25 After the review meeting, Staff Nurse Noble and

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1 Sister Millar gave statements to Mrs Brown, but neither
2 of them identified the issues that they have
3 subsequently identified as having been discussed at the
4 review meeting. They didn't make any reference to the
5 administration of excess fluid, nor the failure to
6 measure electrolytes, as identified at the review, and
7 that's something to be taken up.

8 The chief executive didn't request a written report,
9 but she received verbal briefings:

10 "When the findings of the review were reported to
11 me, there were no indications of persistent patterns of
12 poor care to cause alarm bells or to trigger an external
13 review. Had there been an indication of a pattern of
14 poor performance on the ward, then I would have had no
15 hesitation in seeking further scrutiny."

16 Whether she was right about that will be a matter
17 for you to determine, Mr Chairman. As to the extent to
18 which a formal report with conclusions on deficiencies
19 and failures in treatment would have highlighted
20 inconsistencies in the accounts of the various doctors
21 and nurses, that's also a matter to be considered.

22 So ultimately, Mr Chairman, it'll be a matter for
23 the rest of the hearing for you to consider how thorough
24 that critical incident review meeting was, and to
25 determine the extent to which Raychel's family were

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1 adequately informed about the role of fluid management
2 and electrolyte testing in her deterioration or whether
3 any deficiencies in that regard were downplayed and
4 portrayed as falling below -- for you to determine
5 whether they should have been portrayed as falling below
6 an acceptable standard of care.

7 But there is one thing, Mr Chairman, that I think
8 it's right to point out, and that is that the extent to
9 which the actions of the Altnagelvin Trust in reporting
10 both Raychel's death from hyponatraemia and the
11 implications of Solution No. 18, reporting those to
12 other clinicians, other trusts, the board and the
13 department, you might say that demonstrates how an open
14 sharing of knowledge can lead to better healthcare and
15 potentially save lives, because it seems that as
16 a direct result of that we had the hyponatraemia
17 guidelines, and there's an obvious comparison to be made
18 between the Children's Hospital in relation to Adam's
19 death and the changes in its use of Solution No. 18 and
20 the response of the Altnagelvin Trust to Raychel's
21 death.

22 So if I just move very quickly to the post-review
23 action.

24 THE CHAIRMAN: I was going to suggest, Ms Anyadike-Danes, as
25 you have fairly said, the actions of Altnagelvin as

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1 they've been highlighted in this opening may have had
2 imperfections, but they did have positive knock-on
3 effects for which Altnagelvin takes the credit for
4 taking the lead on.

5 MS ANYADIKE-DANES: Indeed.

6 THE CHAIRMAN: The next section in the opening about
7 post-review action and so on, those begin to summarise
8 some of the steps that did follow on. What I think it
9 might be helpful for you to do at this stage might be if
10 you perhaps move on to one of the rather more troubling
11 issues, which is the 3 September meeting with the
12 families.

13 MS ANYADIKE-DANES: Yes, I can certainly do that.

14 THE CHAIRMAN: That's not to say that the issues in the
15 opening from 78 to 85 aren't significant, they are, but
16 you have given us a flavour of some of the issues which
17 come from that, and then perhaps I think one of the
18 areas that I am concerned from the clinical hearings
19 about is you might want to highlight a few points about
20 the 3 September meeting.

21 MS ANYADIKE-DANES: Yes, Mr Chairman, I can do that. I did
22 feel it was right to point out the fact that one never
23 knows whether we would ever have got the hyponatraemia
24 guidelines but for Altnagelvin's action, but certainly
25 they did directly notify the CMO and they did so with

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1 some alacrity, and in fact those guidelines were
2 produced less than a year after Raychel's death, they
3 were produced in March 2002.

4 THE CHAIRMAN: Yes.

5 MS ANYADIKE-DANES: And it would appear that much of that
6 happened as a result of the action that Altnagelvin
7 took.

8 THE CHAIRMAN: Yes.

9 MS ANYADIKE-DANES: But if I go to the 3 September meeting.
10 That was a meeting that Mrs Burnside organised.

11 At that time, Mrs Ferguson's evidence has been that
12 as time went on, so time went on from the passing of
13 Raychel, she was getting increasingly annoyed that
14 Raychel had died, was buried, and they didn't know what
15 had happened. Mrs Burnside had earlier tried to
16 organise a meeting, but perhaps understandably it was
17 too early for that to happen, so it took place on
18 3 September.

19 She explained that it was the staff who had been
20 involved in Raychel's care and who wished to meet with
21 the family who attended the meeting, if I can put it
22 this way, from the Altnagelvin side. So she was there,
23 doctors Nesbitt and McCord, Sister Millar and Staff
24 Nurse Noble.

25 In addition to Mrs Ferguson, also present were her

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1 sister, that is Mrs Kay Doherty, her brother, a family
2 friend, the family GP and Mrs Quigley from the Western
3 Health and Social Services Council.

4 The meeting was minuted by the patient advocate, who
5 was Ms Anne Doherty, who has no relation whatsoever to
6 Mrs Ferguson's sister, and her record has been accepted
7 as an accurate account, at least of the substantive
8 content of the meeting. It was not intended to be
9 a verbatim account.

10 The junior doctors' handbook that described the
11 patient advocate as the individual employed to take the
12 comments and complaints of the public and act on their
13 behalf to clarify the situation, and her role was not
14 only to support patients and relatives in voicing their
15 concern, but she also had a role to assist the
16 chief executive in responding to complaints. So quite
17 a wide role and a significant position in terms of
18 communication. She was not an independent advocate, and
19 on that occasion she appeared to act solely on behalf of
20 the chief executive to take minutes. She didn't
21 introduce herself to the Ferguson family or make any
22 contribution to the meeting, so far as we know.

23 Now, exactly how that was compatible with her role
24 of supporting the relatives in voicing their concerns
25 that is a matter to be taken up further, Mr Chairman.

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1 But if I turn to who wasn't there, having said who was
2 there.

3 Mr Gilliland wasn't there. In fact, there wasn't
4 a member of the surgical team present at that meeting.
5 Mr Gilliland has accepted that Raychel's care was his
6 responsibility and he was bound by the GMC good medical
7 practice, paragraph 23 of which says:

8 "If a child under your care has died, you must
9 explain to the best of your knowledge the reasons for
10 and the circumstances of the death to those with
11 parental responsibility."

12 Mr Gilliland made no contact with the Ferguson
13 family after Raychel's death. He was invited to attend
14 the meeting, but he declined because, in his view,
15 he had met neither Mrs Ferguson nor Raychel and he
16 considered effectively that there was nothing that he
17 could usefully contribute. He regarded the problem
18 being in and around fluid management and he didn't think
19 that there was a particular surgical issue, although he
20 has conceded:

21 "I understand now that there were surgical issues
22 and that there were questions that the family wished to
23 have answered. I don't think I could have answered
24 anything any better than the answers that they got."

25 But in fairness to him he says:

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1 "If they feel I let them down at that particular
2 moment in time then I'm very sorry."

3 But why Mr Gilliland did not appreciate that there
4 might be surgical issues is something to be explored.
5 It's also something to be explored, exactly what
6 investigations did he carry out amongst his surgical
7 team as to exactly what happened and why, leaving aside
8 the critical incident, just from the perspective of him
9 leading a surgical team, what investigations he carried
10 out amongst them is something that we will explore
11 further.

12 Mr Foster is critical of Mr Gilliland's absence, and
13 he expressed himself as saying he simply can't believe
14 that Dr Nesbitt and Dr McCord were left to explain
15 matters and that no surgeon was present. He puts it
16 very simply, Raychel had been admitted with abdominal
17 pain, she was operated on, as a result of the surgery
18 she suffered complications and died, she was a surgical
19 patient, she was under the care of their team, the
20 surgeons at senior level should have been at the
21 meeting.

22 Dr Haynes shares the view. He says:

23 "Mr Gilliland claims that he was responsible for the
24 totality of her care. If he was, then in my opinion he
25 should have attended that meeting."

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1 The medical director was also absent, as was the
2 director of nursing. There was no external expert or
3 independent figure of authority who was in attendance.
4 You will recall, Mr Chairman, and maybe some comparisons
5 can be made with the meeting that was organised with the
6 Roberts family in relation to Claire's case as to who
7 was present there and how that was managed.

8 From the trust point of view, they were keen not to
9 overburden the meeting by too many people, so that was
10 their reason, and whether in trying to do that they had
11 selected the right people to be there is something to be
12 considered during the hearing.

13 What does seem to have happened is that although the
14 chief executive wanted there to be an open discussion
15 with the family to help them understand and to offer
16 support, there does seem to have been a serious
17 breakdown in communication.

18 This is one of these other communication areas, and
19 that really can be seen by Mrs Ferguson's evidence, that
20 she left that meeting totally confused, believing that
21 it was pointless. She also was completely and utterly
22 dissatisfied. In fact, it might actually have made
23 things worse in some respects.

24 She was told at the meeting that Raychel had
25 followed a normal course of events following her

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1 operation and that the fluids used are the standard
2 across the country:

3 "It was acknowledged that we may have to change if
4 children are getting too much sodium and there has been
5 a middle ground, but nothing that we were doing was
6 unusual."

7 And that as regards electrolyte tests they might
8 have to review their procedures about that.

9 The reason she was told why they weren't -- or at
10 least it's recorded that she was told why they weren't
11 done routinely is it requires a needle into the vein to
12 take the blood.

13 Now, that's not the sum total of what's recorded
14 in the minutes, but if that's the sense of the
15 explanations that were being given to Mrs Ferguson, then
16 it's a matter of how that is to be reconciled with the
17 evidence that you have heard from the nurses and doctors
18 as to what was actually being discussed at the review
19 meeting. For example, that the infusion rate of
20 Solution No. 18 was too high for Raychel's weight, that
21 post-operative children are predisposed to hyponatraemia
22 and that inappropriate ADH is a significant factor.

23 Dr Ashenurst, who was there, she doesn't recall
24 there were any discussions of deficiencies in Raychel's
25 care being mentioned, and none of those who were present

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1 describe Mrs Ferguson being told in clear terms what
2 Staff Nurse Noble acknowledged was recognised, which is
3 that the Altnagelvin and its staff recognise their own
4 failures as to how they've treated Raychel, and part of
5 that was a failure to ensure that her electrolyte
6 assessment was carried out in or about the evening of
7 8 June.

8 THE CHAIRMAN: Okay. Regrettably, the end result is the
9 meeting did not really explain to Mrs Ferguson's
10 understanding what had happened and it may possibly have
11 made the situation worse.

12 MS ANYADIKE-DANES: It might. One of the things that could
13 have been done -- Dr Nesbitt produced a Powerpoint
14 presentation to explain matters. He did that in
15 January 2002, but in fact his evidence was that he had
16 prepared most of that around September 2001. So
17 arguably, what has been summarised there in relation to
18 Raychel's case could have been made available.

19 I know that time is short and I don't want to go
20 into it in any detail, but I just would like to show up
21 a few points out of it. If we pull up the first page so
22 you see what it encompasses, 021-054-117. I'm not
23 saying that all of this would have been appropriate to
24 share and I'm certainly not saying that Mr Nesbitt had
25 prepared all of this by September 2001, but you can see

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1 there in the middle a case report of hyponatraemia.
2 That's Raychel's case. It starts -- well, the first
3 thing to appreciate is what does seem to have been
4 acknowledged.

5 Let's go to 120. These are the at risk patients,
6 and of course Raychel was one of those. You see the
7 stress and nausea in the middle and just about every
8 surgical patient potentially at risk.

9 If we go to the case report, which is actually her
10 case, 121. There you see the salient features:

11 "IV fluid prescribed, Hartmann's. Changed to
12 Solution No. 18."

13 That was default solution, and they knew that there
14 was an issue about that being the default solution.

15 Then if we go to 124, the history of events.
16 Several episodes of vomiting.

17 Then:

18 "Seen by several doctors. No notes, no U&E
19 requested."

20 Then headache. The headache was something the
21 parents were quite worried about and didn't at that time
22 seem to be considered as an important factor, but here
23 it is being noted here of the many things that you could
24 say about the history of events it's specifically
25 identified there.

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1 Then it goes on, further episode of vomiting, and
2 then the sodium result that you see.
3 Then, finally, if I just pick up 128. The top bit
4 is going through that EMJ published case. That was
5 a case that was published before Raychel's admission,
6 but leaving that aside, there it identifies:
7 "Received excessive maintenance fluids."
8 So it might have -- well, it's a matter to be asked
9 whether any consideration was given to explaining things
10 in that relatively simple way in terms just of the
11 chronology of her case as had been developed there by
12 Dr Nesbitt.
13 Just then going on to the Altnagelvin -- I'll move
14 on from Altnagelvin to dissemination and move into the
15 CMO's working group.
16 THE CHAIRMAN: When would be convenient to break?
17 MS ANYADIKE-DANES: Now, because I was just about to go into
18 something.
19 THE CHAIRMAN: We'll finish Ms Anyadike-Danes' opening after
20 a 15-minute break. And, Mr Stitt, then hopefully we'll
21 deal with yours. So if Ms Noble is waiting to get on,
22 we'll take her evidence after lunch at about 2 o'clock.
23 I take it Ms Noble is here? Just so that she knows that
24 the way things are going, it'll be 2 o'clock, but
25 we will start Ms noble's evidence at 2 o'clock.

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1 (12.03 pm)
2 (A short break)
3 (12.20 pm)
4 THE CHAIRMAN: Ms Anyadike-Danes.
5 MS ANYADIKE-DANES: Thank you.
6 The first point is, how did this issue of
7 Solution No. 18 get into the CMO's working group at all
8 to be part of guidelines?
9 The reality of it is that very shortly, as
10 I indicated, after Raychel died, the CMO was contacted
11 and was told about Raychel's death. In fact, Dr Fulton
12 has described to the coroner that on 18 June there
13 happened to be a meeting of medical directors.
14 Dr Carson was there, and he was the medical adviser to
15 the CMO, and he described at that meeting the
16 circumstances of Raychel's death.
17 There were also a number of other anaesthetists
18 present, and the interesting thing is that some of them
19 said that they had heard of similar situations, although
20 it wasn't clear to Dr Fulton whether they were
21 describing fatalities or near misses or incidents of
22 that sort. But in any event, he suggested that there
23 should be regional guidelines. He told the medical
24 directors that it was his opinion that there was
25 evidence that Solution No. 18 was hazardous in

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1 post-operative children.
2 I'm going to touch on a matter later on as to the
3 extent to which the whole suggestion for guidelines fell
4 on very receptive ears because there were concerns
5 already in the community about the use of it for
6 post-operative paediatric cases. I'll come to that in
7 a minute.
8 In any event, four days after that, Dr Fulton
9 telephoned the CMO personally and informed her of the
10 death, and he suggested that she should publicise the
11 dangers of hyponatraemia when using low saline
12 solutions, and he said there was a need for guidelines.
13 The CMO at that time was thinking that CREST, who was
14 the regional guidelines group, could do that. What he
15 did do, he, in the form of Altnagelvin, took the matter
16 directly to the CMO and that may prove to have been
17 crucial in how quickly things moved.
18 It is a matter for you to consider, Mr Chairman,
19 whether the Children's Hospital could have done
20 something rather similar after Adam had died, but in any
21 event, once communication had been made with the CMO,
22 things did seem to move rather quickly.
23 Dr Fulton raised the matter with Mr Bradley, he was
24 the chief nursing officer for the western area health
25 board. He raised that in mid-June, so that was pretty

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1 quick as well. He also telephoned Dr McConnell, he was
2 the director of public health at the Western Health and
3 Social Services Board, to inform him.
4 Mr McConnell, of course, would have known from the
5 previous year about Lucy's death and he would have known
6 that the rate of fluid replacement at the Erne was
7 identified as a matter of concern in relation to Lucy's
8 death. Mr McConnell raises the issue at the next
9 meeting of directors of public health on 2 July, which
10 is a meeting to which both the CMO and her deputy
11 attend, and they refer to this death at Altnagelvin, who
12 is Raychel, due to hyponatraemia, caused by fluid
13 imbalance. He says that the current evidence shows that
14 certain fluids are used incorrectly post-operatively and
15 it was agreed that there should be guidelines.
16 But interestingly enough, even before then,
17 Dr Taylor had been able to advise the Sick Child Liaison
18 Group on 26 June, so that's very quickly after Raychel's
19 death, that work is to take place on agreed guidelines
20 from the Department of Health. So that's what happened.
21 The CMO set up a regional group to review
22 hyponatraemia and bring forward guidelines. As part of
23 that she sought advice, and Dr Carson responded to that
24 on 30 July.
25 It's worth looking at this. It's an e-mail,

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1 actually, and the reference for it is 021-056-135.
2 There we are. It's quite short, but it includes
3 some quite important information. So, first of all, he
4 attaches a document drawn up by Dr Taylor, and I'll go
5 to that in a minute.
6 But what he says is:
7 "The document reflects current opinion among experts
8 in the management of these children. However, it does
9 not yet command full support amongst paediatricians."
10 So there's a distinction there between, one would
11 assume, the anaesthetists who think this is the way
12 forward, if I can put it that way, and some
13 paediatricians who remain unsure.
14 He gives an explanation for why the paediatricians
15 are unsure, but then he goes on to say:
16 "The problem today of dilutional hyponatraemia is
17 well recognised."
18 And he gives a reference to the BMJ editorial:
19 "... and the anaesthetists in the
20 Children's Hospital would have approximately one
21 referral from within the hospital per month, and there
22 was also a previous death approximately six years ago in
23 a death in Mid-Ulster and Bob Taylor thinks there have
24 been five to six deaths over a ten-year period of
25 children with seizures. There is obviously a need to

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1 get better agreement between anaesthetists, intensivists
2 and paediatricians."
3 So the split between those who see this as the way
4 forward appear to be the anaesthetists and intensivists,
5 with some of the paediatricians perhaps not.
6 What we think was the attached document is
7 a two-page document, we can pull that up pretty quickly
8 too. If we could have them alongside each other.
9 043-101-223 and 224.
10 There is a bit of manuscript notation on this, which
11 can be addressed during the hearing. I'm not concerned
12 with that at the moment.
13 If you can see first:
14 "The dilutional hyponatraemia documented in
15 otherwise healthy children following routine elective
16 surgery."
17 You can see the class of children at risk, often
18 female, post-operatively, and that, of course, was
19 Raychel.
20 Then you can see in the third paragraph:
21 "The sick child."
22 It talks about how the glucose is metabolised and
23 what the significance of that is, and the loss of fluid
24 from the circulation. Then the ADHD causing the
25 response and the kidneys to retain water.

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1 Then you can see that that all ends up as a double
2 whammy, as he describes it.
3 The final sentence before one gets into the
4 recommendations:
5 "Therefore, to prevent hyponatraemia, we must limit
6 the free water component of intravenous fluids and
7 monitor urine output and serum chemistry."
8 This is what is being described as current opinion,
9 in other words what was already known.
10 The question is, how, if that's the case, that
11 didn't translate into or was not reflected in Raychel's
12 care at the time. Incidentally, that reference that he
13 talks about in the BMJ, you can see that there on the
14 second page. So that will be considered further, and
15 Dr Taylor is going to come and give evidence.
16 The result of all of that was that the CMO asked her
17 deputy to assemble a working group to consider
18 hyponatraemia in children, and the group was to make
19 recommendations on the fluid balance in children and it
20 was to be presented to the special advisory committees
21 on surgery, paediatrics and anaesthetics.
22 It held its first meeting on 26 September. It's not
23 known at this stage how the group was actually selected.
24 If I just pull up the first sheet, you can see who
25 attended. If we pull up 007-048-094.

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1 That is who was there, with apologies from
2 Dr Jenkins. He does participate later on, but he just
3 presumably couldn't be there on that particular date.
4 You can see where they're from. In terms of the
5 children's cases, who this inquiry is most concerned
6 with, you can see you have got Dr Taylor from the
7 Children's Hospital, Dr Lowry, from Craigavon, that is
8 Conor, Dr Nesbitt obviously, Mr Marshall, he's a surgeon
9 from the Erne Hospital, that's Lucy, of course, and then
10 you see your way down.
11 But as I say, we don't know how Dr Darragh put
12 together that group. What we do have, though, is an
13 interesting comment from Professor Savage, who was
14 Adam's nephrologist, and he had correctly identified in
15 Adam's case dilutional hyponatraemia, and he writes to
16 Dr Darragh 1 October 2001 expressing concerns, so after
17 the first meeting:
18 "... that someone in my position only hears about
19 such a group on the grapevine."
20 In any event, the group that was there had knowledge
21 of hyponatraemia and of Raychel's case and collectively,
22 not individually but collectively, they had knowledge of
23 all the cases that are being scrutinised by this
24 inquiry.
25 If we pull up something that we prepared to assist

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1 with this, 328-003-001. This was actually just trying
2 to track that very thing for you. So along the top
3 you've got the four children. I haven't put in Conor
4 because his case is being looked at slightly
5 differently, but in any event, his case postdates this
6 meeting of September 2001.

7 You can see each of these clinicians, and it goes
8 over the page as to some of the others, their
9 involvement, the level of their involvement in the
10 children's cases. The red blocks indicate direct
11 involvement with the child's case. The rest of it is
12 how they were informed about it. The footnotes are
13 information that they might have had from others. We
14 don't know if that's the case.

15 I'll give you an example of that. If we pull up
16 002, I have to say we know least about Mr Marshall,
17 Dr Lowry and Ms McElkerney's role, except we note that
18 they come from relevant hospitals. But the sort of
19 thing one has in the notation is that you see
20 in relation to Mr Marshall, footnote 9, his medical
21 director was Dr Kelly, and it was Dr Kelly who notified
22 all consultant paediatricians and staff grades on
23 21 June of the circumstances of Raychel's death due to
24 hyponatraemia and so on.

25 So we don't know what Dr Marshal knew, but the

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1 footnotes are to indicate possible sources of knowledge.
2 Anyway, the minutes from the meeting record Dr Darragh
3 explaining that concerns about arisen about
4 hyponatraemia concerning in children after surgery, and
5 Dr Taylor, this is what the minutes record:

6 "... informed the meeting about the background
7 incidence of cases seen in the Children's Hospital and
8 patients who are particularly at risk of hyponatraemia.
9 This is a problem that has been present for many years."

10 The department published its guidelines in
11 March 2002 and the CMO wrote a general letter on 25
12 March 2002 to accompany the publication, and she advised
13 that the guidance is designed to provide general advice
14 and does not specify particular fluid choices:

15 "Fluid protocols should be developed locally to
16 complement the guidance and provide more specific
17 direction to junior staff, and it will be important to
18 audit compliance with the guidance and locally develop
19 protocols and to learn from clinical experiences."

20 It is the response in terms of fluid protocols and
21 auditing compliance that is something that will be more
22 particularly taken up in Conor's case and in the
23 departmental section.

24 But what I was trying to do with this schedule was
25 to demonstrate the knowledge that was possibly available

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1 to those participating about the other cases --

2 THE CHAIRMAN: Thank you.

3 MS ANYADIKE-DANES: -- and to explore the extent to which
4 they might have been able to reach a conclusion that
5 hyponatraemia guidelines could have been a useful thing
6 to have developed much sooner than when prompted by
7 Raychel's death.

8 So then there's not really much more I want to say
9 by way of opening, Mr Chairman. I want to touch briefly
10 on the Children's Hospital's role to deal with the
11 inquest and then to say something about litigation.

12 In terms of the Children's Hospital's role, as you
13 know, Raychel was admitted there to PICU on 9 June and
14 brainstem tests were carried out there by doctors
15 Hanrahan and Crean, and of course they are doctors who
16 have previously been involved in Lucy's case and, from
17 that, you'll be able to see Dr Crean's involvement in
18 other cases.

19 The relative counselling records record that they
20 spoke to Raychel's parents and her aunt and that
21 Dr O'Donohoe met with Raychel's parents, her
22 grandparents and aunt, and by approximately 10 o'clock
23 the next morning the coroner's office has been
24 contacted. What we don't know, though, Mr Chairman, at
25 least so far as I'm aware, is the basis upon which it

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1 was decided that that was a case that should be reported
2 to him. And you will recall the issues surrounding the
3 reporting of Lucy's case, we can guess what they might
4 have been, but perhaps that's something to be explored
5 with the witnesses.

6 Part of taking a view as to what they might have
7 been comes from some of the evidence we've got to date.
8 Mr Ferguson said in his evidence that he couldn't
9 exactly remember whether it was Dr Crean or Mr Hanrahan,
10 but one of them kept going on about the vomiting, that
11 seemed to be an important matter, what kind of vomiting,
12 how many vomits, what time, was there any blood in the
13 vomit and so forth, and that seemed to him to be
14 important. Then he says he recalls Dr Crean asking him
15 whether -- at least expressing the view, perhaps
16 rhetorically, whether Altnagelvin was trying to pass the
17 buck.

18 Then Mrs Ferguson remembers one of them saying that
19 this should never have happened, and some of that might
20 indicate that the Royal took the view that Raychel's
21 deterioration, terminal deterioration, was avoidable.

22 Sister Millar has also recalled that a nurse in the
23 intensive care in the Children's Hospital said, when
24 Raychel arrived, and there was a handover, that she was
25 on the wrong fluid. Now, the nurse who did accompany

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1 Raychel is Staff Nurse Dooher, and she said that she was
2 the only nurse who accompanied Raychel to Belfast and
3 she didn't have any conversation with a nurse there
4 about fluids, and she didn't say anything about that to
5 Sister Millar, so it's not clear where that comes from.
6 But certainly, Mr Chairman, the reference to Raychel
7 being on the wrong fluids or something of that sort does
8 seem to crop up in some of the documentation that we've
9 received. In fact, Mrs Burnside recalls that she heard
10 a rumour from PICU that the wrong fluids had been used
11 and that that rumour emerged from a nurse.

12 In any event, as you know, Mr Chairman, Dr Nesbitt
13 says he contacted the Children's Hospital and was told
14 about what they had done about fluids and whether or not
15 that feeds into the rumour about wrong fluids is
16 something that we'll explore.

17 If the Children's Hospital did feel that Raychel was
18 on the wrong fluids, it isn't something that appears to
19 have been formally reported to Altnagelvin. But perhaps
20 before I do that, Mr Chairman, if I just go back to --
21 because in fairness, the DLS has tried to explain the
22 position in relation to Dr Nesbitt's evidence about the
23 telephone survey. In fairness to them, perhaps we'll
24 pull it up. It's 321-073-001. It only arrived with us
25 on 23 August 2013.

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1 You'll recall Dr Nesbitt's evidence, and this is
2 what they say. In fact, what they're doing is they're
3 dealing with a part of the opening which deals with
4 Dr Nesbitt's evidence, and what they say is that:
5 "It is stated that Dr Nesbitt conducted a telephone
6 survey."

7 Just as it's recorded there, and goes on to say:
8 "Children's Hospital anaesthetists have recently
9 changed their practice and moved away ..."

10 Then comes their contribution:

11 "We are instructed that the change of practice most
12 likely refers to intraoperative fluids prescribed by
13 anaesthetists and not post-operative fluids because
14 Hartmann's solution was not routinely prescribed
15 post-operatively in the Children's Hospital.
16 Furthermore, I would ask you to note that the only
17 reference to post-operative fluids is made in respect of
18 Craigavon Hospital and the Ulster Hospital."

19 Now, what exactly the Children's Hospital means by
20 that and whether it goes any way to explaining what
21 Dr Nesbitt was told is a matter to be further explored.
22 But what this letter does confirm is that there was
23 a change.

24 What's at issue here is where that change took
25 place, whether it was in relation to intraoperative

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1 fluids or post-operative fluids or when. But a change
2 in the practice did take place and that's what seems to
3 be being confirmed by this letter.

4 In any event --

5 THE CHAIRMAN: Sorry. Is this issue that we were asking
6 about repeatedly between Christmas and Easter?

7 MS ANYADIKE-DANES: That is exactly it, Mr Chairman.

8 THE CHAIRMAN: And this explanation which is now given on
9 23 August was not an explanation given by any witness
10 during that hearing?

11 MS ANYADIKE-DANES: No.

12 THE CHAIRMAN: So it's an explanation which is volunteered
13 on 23 August when they see the draft opening?

14 MS ANYADIKE-DANES: Yes.

15 THE CHAIRMAN: Brilliant. So we hear oral evidence for week
16 after week and this explanation isn't put up, but we now
17 get an explanation or an attempt to clarify on
18 23 August?

19 MS ANYADIKE-DANES: Yes. I am not entirely sure it does
20 clarify, but it certainly is their attempt to clarify,
21 yes.

22 What's significant about it is having acknowledged
23 there was a change in practice what's left entirely
24 unexplained is if they did have a change in practice,
25 they did not communicate that to Altnagelvin, and none

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1 of the clinicians who were consultant anaesthetists, as
2 you've just pointed out, who gave evidence to you, was
3 able to describe this as a change in practice that
4 occurred.

5 THE CHAIRMAN: And there was a follow-up exchange between
6 the inquiry and DLS in which we asked for information
7 about who gave the instructions which are referred to
8 in that paragraph, and the answer was Dr Crean.

9 MS ANYADIKE-DANES: Apparently. And Dr Crean gave evidence.

10 THE CHAIRMAN: Yes. Okay.

11 MS ANYADIKE-DANES: So in terms of -- and this is that
12 recurring theme of communication. In this case, not
13 only did they not communicate that explanation terribly
14 effectively to the inquiry, but if that's what happened
15 there seems to be absolutely no record of them assisting
16 Altnagelvin or anywhere else by saying, "That's what
17 we've done". And even when they had a case before them
18 which seemed apparently to show that there had been
19 inappropriate fluid management, even then there seems to
20 have been no communication to say, "Look, this is the
21 position, this is where you went awry, this is what
22 we've been doing and why we've been doing that".

23 Interestingly enough, Mr Chairman, you may recall
24 that when I was asking Dr Crean about what the
25 Children's Hospital did about trying to disseminate the

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1 experience its clinicians had about fluid management and
2 what did they do when they thought they saw the evidence
3 of inappropriate fluid management, and that was
4 particularly, at that time, in relation to Lucy, where
5 the view was taken that she too had been the subject of
6 inappropriate fluid management regime, and what he said
7 was he would try to contact the clinicians involved and
8 to advise them his views about the fluid management in
9 an effort to assist colleagues and just generally
10 disseminate learning and experience. But there seems to
11 have been no indication of that happening in relation to
12 Raychel's case vis-a-vis Altnagelvin.

13 The other matter is that, leaving aside --

14 THE CHAIRMAN: Sorry, it's more than that. Even if
15 Dr Fulton picked that up, this explanation, or even if
16 Dr Nesbitt picked that up as an explanation, we're now
17 told that he somehow misunderstood the explanation.

18 MS ANYADIKE-DANES: Yes.

19 THE CHAIRMAN: Right.

20 MS ANYADIKE-DANES: Yes.

21 THE CHAIRMAN: Thank you.

22 MS ANYADIKE-DANES: Then Raychel's death at the
23 Children's Hospital -- because that's where she was
24 formally certified as having failed the brainstem death
25 test and, therefore, certified dead -- didn't seem to

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1 prompt a critical incident report or review within the
2 Children's Hospital. Nor does it seem did the
3 Children's Hospital play any part in the Altnagelvin
4 review. And you will recall that similar situation
5 in relation to Lucy where they seemed to be going along
6 their parallel ways to the extent that they were at all.

7 In fact, what Professor Scally observed in relation
8 to Lucy's case on this very same subject was that:

9 "If there was any significant suspicion amongst the
10 staff at the Children's Hospital that Lucy's death was
11 due to inadequate treatment, then the matter should have
12 been reported within the mechanisms available within the
13 Royal Group of Hospitals. In addition, under these
14 circumstances, the Sperrin Lakeland Trust should also
15 have been informed in a formal manner. My view is that
16 this expectation arises out of a general obligation
17 in the case of a death that may have been caused by
18 inadequate treatment and is reinforced by the Children's
19 Hospital's role as a regional centre of excellence."

20 Well, they didn't do it in relation to Lucy and it
21 seems they didn't do it in relation to Raychel, although
22 in relation to Raychel Dr Crean at least seems to have
23 formed the view that there was inappropriate fluid
24 treatment and potential maladministration.

25 Then as to that point, Dr Crean contacted the

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1 coroner on 11 October, and this is now from the
2 coroner's note of that conversation. He was actually
3 phoning because the parents wished to speak to him and
4 it was agreed that he could speak to them but he really
5 ought to confine his comments to the care she'd received
6 in intensive care.

7 Then he notes that Dr Crean told him:

8 "There was mismanagement of this case in the
9 Altnagelvin Hospital. The fluid balance was the key to
10 why her condition deteriorated and that was due to
11 dilutional hyponatraemia."

12 But the important thing there is that he
13 characterised that as mismanagement. And yet, as I say,
14 there's no, apparently, record of him discussing that
15 with Altnagelvin.

16 And even Mr Gilliland's sort of rather elliptical
17 references to "there were discussions", he doesn't say
18 he was being told that the Children's Hospital regarded
19 there as having been mismanagement at Altnagelvin.

20 So if I move then to the inquest. The task of
21 collecting and collating the statements for the inquest,
22 that fell to Mrs Brown. She, of course, had played
23 a very significant part in the critical incident review.
24 She was to play a pivotal role in liaising with the
25 relevant clinical team, the trust solicitors, the

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1 coroner and the board, and she was charged with helping
2 the trust and its personnel through the coronial process
3 as well as assisting the coroner in obtaining evidence
4 for inquest. So her responsibilities extended from the
5 investigation of adverse clinical incidents to the
6 defence of clinical negligence suits and communication
7 with the police even.

8 It's a matter to be investigated whether that very
9 broad role might be considered as having created the
10 potential for conflict. Interestingly, should a doctor
11 have been doing that?

12 The Altnagelvin Junior Doctors' Handbook directs
13 that doctors do not release any report to the police or
14 coroner without showing it to the trust RCMO, and this
15 is particularly important when the family of the
16 deceased have employed a barrister to represent them in
17 court or if he feels an allegation of medical negligence
18 will be made in court.

19 So that really made Mrs Brown the sort of centre of
20 all of the post-death investigation, whether it was to
21 help the coroner or it was to defend the trust's
22 interests.

23 One aspect to highlight is that the assistant
24 Directorate of Legal Services, who was acting on behalf
25 of the trust, wrote to the coroner on 29 March 2002. By

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1 this stage, Mr Chairman, they had seen Dr Sumner's
2 report. She was making it clear that the trust accepted
3 a number of things in that report. It accepted that the
4 cause of death was cerebral oedema due to hyponatraemia,
5 accepted that hyponatraemia occurred as a result of
6 a combination of factors, and that increased secretion
7 of antidiuretic hormone, vomiting, that was
8 a contributory factor in that it could have contributed
9 to some extent to the net sodium loss from the
10 extracellular fluid, and the use of Solution No. 18 in
11 order to provide post-operative maintenance and
12 replacement fluids, that was a contributory factor in
13 bringing about a reduction in the concentration of
14 sodium in the extracellular fluid. So much accepted.

15 What the letter couldn't or wouldn't accept was
16 Dr Sumner's view that the state of hyponatraemia was
17 caused by a combination of inadequate electrolyte
18 replacement "in the face of severe post-operative
19 vomiting," and the water retention always seemed
20 post-operatively from inappropriate secretion of ADH.
21 The important bit there was "in the face of severe
22 post-operative vomiting", because of course that was
23 a matter that was within the observation of the nursing
24 and clinical teams and was theirs, arguably, to address.

25 But notwithstanding what was recorded in the

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1 hospital notes and what Staff Nurse Noble says was
2 acknowledged during the critical review meeting on
3 12 June, the trust did not accept the characterisation
4 of Raychel's vomiting. The nurses' opinion was that the
5 vomiting suffered by Raychel was neither severe nor
6 prolonged. That's what was being communicated to the
7 coroner.

8 As a result of that, the trust did not accept there
9 was any deficiency in their response to Raychel's
10 vomiting and it approached the entire inquest on that
11 basis. What they had done was something that was
12 perfectly standard to have been done. There was nothing
13 to alert them to the fact that the vomiting she was
14 experiencing was severe or prolonged. That was the
15 focus of their approach.

16 Now, whether in the light of the information they
17 already had they were entitled to form that view and
18 pursue it, that's a matter for you, Mr Chairman, to
19 determine. But what we do know is they had some
20 independent expert assistance in how to characterise
21 Raychel's condition.

22 On 1 November 2002, the trust instruct Dr Jenkins.
23 He's a consultant paediatrician and the senior lecturer
24 in child health at Queen's and, of course, he was part
25 of the CMO's working group. You have just seen that

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1 from the meeting note.

2 He gave his opinion on 12 November. He was unable
3 to reach a firm conclusion because he needed specific
4 information to do that, but he found though that while
5 it was possible in retrospect to form the opinion
6 reached by Dr Sumner that Raychel must have suffered
7 severe and prolonged vomiting, this does not seem to
8 have been the assessment of her condition made by the
9 experienced staff at the time. All that he was saying,
10 you could see it in that way but that's now how it was
11 assessed.

12 He made clear:

13 "... the importance of obtaining further details of
14 relevant nursing and medical procedures and management
15 in relation to fluid administration and post-operative
16 monitoring of fluid intake, urine output, and other
17 losses such as vomiting, and in particular [he said]
18 information needs to be obtained regarding the local
19 policy for post-operative fluid administration in
20 children. Was the prescribed regime in this case in
21 keeping with this guidance? If it can be confirmed that
22 the frequency and severity of Raychel's vomiting was not
23 outwith the degree expected by experienced staff in
24 these circumstances and that the staff involved acted in
25 accordance with local policies and guidance, then in my

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1 opinion their actions did not amount to negligence."

2 So there were a lot of caveats for that, and once
3 again, Mr Chairman, you'll be mindful of what Staff
4 Nurse Noble says they had concluded about the incidence
5 of vomiting back on 12 June.

6 That further information was not provided to
7 Dr Jenkins, and he points that out in his letter to the
8 DLS on 27 January 2003. But before he got round to
9 writing his letter on 27 January 2003, the trust had
10 instructed Dr Declan Warde, he's a consultant paediatric
11 anaesthetist at the Children's University Hospital in
12 Dublin. He was briefed on 3 December 2002 to prepare an
13 expert report and attend the inquest, and he was
14 specifically asked to comment on the treatment provided
15 and the issues raised by Dr Sumner.

16 His report is quite interesting. It's dated
17 19 January 2003, and in it he expresses the opinion that
18 Raychel had died as a result of developing cerebral
19 oedema secondary to acute hyponatraemia, which was
20 itself caused by a combination of severe and protracted
21 post-operative vomiting, SIADH and the administration of
22 intravenous fluid with a low sodium content.

23 So he's quite clearly got from documentation that
24 he was provided that there was severe and protracted
25 post-operative vomiting. That report was sent to

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1 Dr Jenkins and he was asked to provide "any further
2 comments which you have, which might assist the trust".

3 The response to that is to be seen in his letter of
4 27 January 2003 that I have just referred to.

5 The effect of that is in many respects he says
6 Dr Warde's report does not differ significantly from
7 previously available information. He makes reference to
8 the significance of the vomiting:

9 "I pointed out in my report of 12 November the
10 importance of seeking further information regarding the
11 frequency and severity of Raychel's vomiting in the
12 opinion of senior staff given the comments in the report
13 by Sister Millar."

14 The following day, the trust solicitor leaves
15 a message for Dr Warde's wife and advises him that he's
16 not required to attend the inquest hearing. Dr Warde
17 received no additional explanation of that and he didn't
18 attend.

19 Dr Jenkins' availability for the inquest was
20 confirmed and he supplied a third report dated
21 30 January 2003, and that's the report that was sent to
22 the coroner. It omits his earlier reference to the
23 rates of fluid administration and the total quantity of
24 fluids calculated as having been given and there is no
25 reference to the possibility that in retrospect it was

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1 possible to form the same opinion as Dr Sumner that
2 Raychel had suffered from severe and prolonged vomiting.

3 He did, however, add the observation that:

4 "It is the combination of excessive loss of sodium
5 for example in vomitus, with water retention with the
6 result of excessive secretion of antidiuretic hormone
7 which leads to a fall in the concentration of sodium in
8 body fluids and increased rise of brain swelling."

9 But the point about the earlier exchanges was that
10 that is due to a severe and prolonged vomiting which
11 should have been detected and the implication is
12 addressed. But when he gave evidence to the coroner,
13 Dr Jenkins agreed with Dr Sumner's view.

14 Well, Mr Chairman, you've heard that it's the duty
15 of a doctor to offer all relevant information to an
16 inquest or inquiry into a patient's death. It's not
17 clear why he was prepared in his evidence to the coroner
18 to concur with the views expressed by Dr Sumner, why he
19 didn't concur with those views in the report he provided
20 to the coroner, but he will give his evidence on that.

21 Dr Warde's report wasn't sent to the coroner. No
22 mention of the report was made at the inquest. The
23 report, of course, was relevant to the issues under
24 consideration, and Professor Swainson believes that
25 actually it should have been shared with the coroner.

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1 It wasn't shared with the Ferguson family, and it
2 doesn't appear to have formed the basis of any further
3 internal review of Raychel's case. In fact, it only
4 came to us following an issue on discovery and
5 a relinquishment of privilege.

6 So, Mr Chairman, that was the trust's approach.

7 There will be two issues to deal with in relation to
8 that. One, whether they were entitled to have that
9 approach, and another perhaps more significant is even
10 if they were entitled to it, should they have pursued it
11 in the circumstances?

12 But leaving all that was known, therefore, at the
13 time of the inquest at Altnagelvin and another expert
14 had formed the view about vomiting, and that Staff Nurse
15 Noble had her view about what was discussed, when it
16 actually came to giving evidence about it -- well,
17 Mr Chairman, it'll be a matter for those to compare the
18 evidence they gave at the inquest with whatever it is
19 they now say was being discussed during the review
20 meeting. And, of course, the coroner delivered his
21 verdict, which rejected that idea and does place
22 emphasis on severe post-operative vomiting.

23 Then, finally, Mr Chairman, litigation. That was
24 started by a letter of claim of 1 May 2003. It was
25 clear that what was at issue was the death of the

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1 Ferguson's daughter by negligence, breach of duty or
2 breach of statutory duty in relation to her medical
3 treatment.

4 The trust's denial of liability was comprehensive,
5 and the DLS wrote to Mr and Mrs Ferguson's solicitors to
6 emphasise that the trust does not accept that it or its
7 staff were negligent or that if there was any failure to
8 apply appropriate standards that the failure caused or
9 contributed to the death of Raychel Ferguson and,
10 therefore, liability is denied.

11 Well, given the verdict at inquest, the experts'
12 opinions and the findings at the review, it's not
13 immediately apparent, even now, why liability was not
14 admitted then and has not yet been admitted. It has
15 remained the trust's position throughout all those
16 intervening years and the PSNI investigation and these
17 deliberations at the inquiry that there was no
18 negligence on its part. The depth of the feelings of
19 Raychel's parents about the trust's failure to concede
20 liability for their daughter's death is reflected in the
21 opening submissions that were delivered by their senior
22 counsel and indeed their own testimony.

23 Any unjustified denial of liability is not only
24 a clinical governance matter and an issue touching upon
25 public confidence in and respect for the health service

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1 but as you might find, Mr Chairman, is of concern
2 because of any additional and unnecessary hurt and
3 distress that might be caused to the family by such
4 a failure to admit fault. But also it impedes open
5 investigation and, therefore, from the point of view of
6 this inquiry, and governance, learning lessons and
7 disseminating those lessons, but it will be a matter for
8 you to determine, Mr Chairman, in the light of all of
9 this, the appropriateness of the trust's conduct towards
10 the family. Thank you.

11 THE CHAIRMAN: Thank you very much.

12 Mr Stitt, can you indicate to me how long you might
13 be?

14 MR STITT: I would be probably no longer than half an hour.

15 THE CHAIRMAN: Well, I'm prepared to go now, break for lunch
16 at 1.40, and start with -- Mrs Noble's been patiently
17 waiting all morning and she heard me indicating she'd
18 give evidence from 2 o'clock. If you start now, we
19 finish at 1.40, we took a short lunch break, Mrs Noble
20 can be in the witness box, because her evidence will
21 finish today, Mrs Noble isn't going to have to come back
22 a second day, because she's already done that once, and
23 it's not going to happen again. Would you like to start
24 now?
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1 Submissions by MR STITT

2 MR STITT: Yes. As I've indicated, and in the light of what
3 Mr Quinn has said, I will provide a typescript of the
4 points I have made to you. They will be in the same
5 form. There will be no additions, except that I will
6 include the paragraphs in the opening to which I refer,
7 and they will be referred to in full in my submissions,
8 but it won't alter the submission in any way. It'll be
9 easier to read, in other words.

10 If I turn, firstly, Mr Chairman, to paragraph 65 of
11 the opening. This deals with the question of the
12 knowledge of the JHOs as to whether doctors Curran and
13 Devlin should have recognised the possibility that
14 Raychel was suffering from hyponatraemia:

15 "It is to be regretted that these very junior
16 doctors apparently did not recognise or consider this
17 possibility."

18 And the conclusion is drawn two lines further down:

19 "I believe this to be a serious governance issue."

20 It's against that background that I would ask the
21 tribunal to put into the balance the opinion of the
22 inquiry expert Mr Scott-Jupp, whose reference is, if
23 this could be pulled up, 222-005-007.

24 THE CHAIRMAN: Yes, that's the document. If you could give
25 us, please, page 7 of that document. Thank you.

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1 222-005-007.

2 MR STITT: I'll just read it. I have noted it down. He's
3 asked about the failure of the junior doctors to take on
4 board the possibility of hyponatraemia, not knowing
5 about it, and he says:

6 "If the same question were asked of any group of
7 doctors or nurses working on a children's ward at that
8 time, the same response would have been received."

9 And he's referring to UK-wide. I just put that in
10 as a balance.

11 THE CHAIRMAN: But I think he's making that point --

12 Mr Foster makes that point as an issue about governance
13 rather than as a criticism of doctors Curran and Devlin,
14 doesn't he?

15 MR STITT: He does. That's why I prefaced it by saying this
16 is a governance issue, but by the same token it's quite
17 clear when we're dealing with governance and the
18 standard of understanding, it's likely that any group of
19 doctors or nurses in any trust in the UK -- that's what
20 he's saying -- would have been in the same position.

21 It may be that if you find there should have been
22 more teaching in relation to hyponatraemia, which,
23 of course, is one of the conclusions you could reach,
24 I'm asking you to bear in mind that's the same lesson,
25 according to Dr Scott-Jupp, that could have been learned

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1 by almost every other trust, in his opinion.

2 THE CHAIRMAN: Yes, but it sort of feeds back and this is
3 not a isolated point, because this feeds back into
4 lessons having not been learned from the earlier deaths,
5 Mr Stitt.

6 MR STITT: It does.

7 THE CHAIRMAN: If there's a failure for lessons to be
8 learned, particularly in the Royal, and then to be
9 disseminated beyond Northern Ireland to the UK Health
10 Service, then you might get the same response in the UK.
11 If you get the same response in the UK it's because
12 people aren't learning lessons.

13 MR STITT: That's one conclusion which we could reach. I'm
14 not going to comment on that specifically.

15 THE CHAIRMAN: Thank you.

16 MR STITT: I refer to paragraph 100. This is an implied and
17 direct criticism of the director of nursing,
18 Irene Duddy. It says effectively that Staff Nurse Noble
19 was unable to recall and unable to differentiate the
20 director of nursing and the chief executive. So she was
21 asked who the nursing director was in the 1990s through
22 to 2001 and she was not able to recall.

23 And the conclusion which is reached is:

24 "This raises the issue of leadership given by the
25 director of nursing within the Altnagelvin Trust."

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1 And then this is the important quote, if I may, the
2 second last line of the paragraph:
3 "Given her lack of visibility to the nursing staff
4 on the wards, Ms Duddy was unable to understand the
5 nursing practices."
6 So a clear statement there that she had a lack of
7 visibility to the nursing staff on the wards.
8 The point which I would wish to make is, firstly,
9 it's unreasonable to ask one nurse one question, not the
10 other nurses, just this one nurse, and she says,
11 "I can't remember", and then translate that into a lack
12 of visibility to nursing staff. There's a clear
13 implication that effectively none of or few of the
14 nursing staff were aware of who she was.
15 The answer came from one nurse and one nurse only.
16 It came also, you will find, at the end of a long
17 session of cross-examination. It relates to a period
18 12 years earlier, and in all those circumstances I would
19 put forward on behalf of the trust that it is an
20 unreasonable conclusion to reach that there was a lack
21 of visibility to the nursing staff on the wards.
22 Ms Duddy will give her own evidence.
23 224.
24 THE CHAIRMAN: But I'm sorry, it doesn't reach a conclusion.
25 You've just said to me that it's an unreasonable

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1 conclusion to have reached. It doesn't reach
2 a conclusion. It specifically says at paragraph 100 of
3 the opening that this raises the issue. Why do you
4 suggest that something which is specifically raised as
5 an issue is presented as a conclusion?
6 MR STITT: It raises an issue in the first half of the
7 sentence and then reaches a conclusion of fact in the
8 second half of the sentence. The second half -- I'll
9 read the whole sentence:
10 "This raises the issue of leadership given by the
11 director of nursing within the Altnagelvin Trust."
12 Your point, sir. And that is also going on to make
13 another point:
14 "How, given her lack of visibility to the nursing
15 staff on the wards Ms Duddy was able to understand the
16 nursing practices and standards of care on Ward 6."
17 So whilst it might say it's raising an issue, it's
18 quite clearly landing a blow in the same sentence and
19 saying, "Given her lack of visibility to the nursing
20 staff, how she was able to understand the nursing
21 practices". That's a statement of fact, not it's up to
22 you, sir, to decide what her level of visibility was.
23 It's put there as a given "given her lack of visibility
24 to the nursing staff", and I'm saying that's
25 a conclusion which is raised, and I say it's

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1 a conclusion on the basis of the evidence of one nurse.
2 If it was going to be such a big point, one would
3 have thought that all the nurses would have been quizzed
4 on the same point and then perhaps the evidence would
5 reflect that eight out of nine nurses didn't know the
6 identity of the director of nursing. But it may well be
7 that the other seven did know her and might well have
8 said she was on the wards every week.
9 THE CHAIRMAN: Okay.
10 MR STITT: I ask you, sir, if you would look at
11 paragraph 224. This is the conclusion, which is
12 a reasonable and fair -- and may I also say for the
13 record that it is acknowledged that the opening has
14 got -- a great deal of scholarship and effort has been
15 put into it, which is helpful not only to you but to all
16 the parties. So when I make these points, I acknowledge
17 at the same time the amount of effort and trouble that
18 has gone into composing the document.
19 Paragraph 224. It's a matter for you, Mr Chairman,
20 to assess the scope and thoroughness of the critical
21 incident review, and it is. Earlier in the section, and
22 I won't rehearse the paragraphs, there are criticisms of
23 the review conducted by Dr Fulton that the proper form
24 wasn't used, the critical incident form wasn't used
25 according to the protocol, and not all the witnesses

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1 were present, the two junior doctors weren't there, and
2 so on, and those are noted. But I think it's only fair
3 to put in balance and ask you to consider in balance at
4 this stage before the evidence is called that the
5 governance inquiry expert, Dr Swainson, at page 226 --
6 if this could be pulled up -- 226-002-023. I'll read
7 a little of paragraph 78.
8 Notwithstanding the points which were made, which
9 were critical, and it's obviously up to you, I would ask
10 you to put into the balance this point when considering
11 the case as a whole at this stage:
12 "The critical review initiated by Dr Fulton was
13 sound. It was important to conduct this quickly so that
14 events were fresh and thus not possible to have everyone
15 concerned attend, but there were sufficient people
16 present to begin the process."
17 And he continues to make other observations.
18 Paragraph 79:
19 "Doctors Nesbitt and Fulton moved swiftly to inform
20 colleagues."
21 I think that's accepted and noted by counsel to the
22 inquiry.
23 So whilst one can be critical of certain aspects of
24 the inquiry, it's obviously this expert who has been
25 briefed with all the documents and who is the most

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1 recent expert to opine in relation to the inquiry, says
2 the critical review was sound.
3 256. A very short point. This is the meeting
4 in September with the family, and it says:
5 "The medical director and the director of nursing
6 were both absent."
7 I'll deal again with the director of nursing, that's
8 Ms Duddy. There were good reasons why she could not be
9 there, and I haven't had the opportunity yet to discuss
10 this with Ms Anyadike-Danes, but I will do so. But
11 I don't feel in an open forum that it's appropriate, but
12 I will pass on this information to the inquiry as to why
13 she was not there.
14 THE CHAIRMAN: Okay. Well, that's fine. Could I just say
15 as a general point, over the next few days, because I'm
16 afraid there is an issue about Ms Anyadike-Danes for the
17 next few days, would you communicate and generally would
18 people communicate with Mr Stewart?
19 MR STITT: Of course. I'll do that as soon as we have our
20 short luncheon interval. It's not a big point.
21 326. Three lines from the bottom. This is
22 correspondence in relation to the witness statements
23 which were sent by Mrs Brown to the coroner. What
24 happened was witness statements were sent, purportedly
25 sent in late 2001, but -- sorry, early 2002, but did not

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1 If I may pull up the third and final document,
2 022-038-099. This is Mrs Brown writing once again to
3 Mr Leckey when she's been told that they've received the
4 statements, there's been a telephone conversation
5 between the two of them, their office:
6 "I enclose for your attention a complete set of
7 statements already provided to you. I also enclose
8 a copy of my letter. This letter with the original
9 statements appears to have gone astray."
10 And that's where the quote comes from.
11 The point being this is a new address this is
12 Victoria street Belfast. And in answer to it's gone
13 astray, the only conclusion which can be reached is that
14 the original statements were posted to Newtownabbey. One
15 would have thought obviously they would be forwarded to
16 Belfast, but that's the best explanation --
17 THE CHAIRMAN: Somehow gone astray. The most likely
18 explanation is they went astray as the coroner was
19 moving from one office to another?
20 MR STITT: Yes, exactly, sir. It was left in the air
21 hanging up. It's a small point.
22 It's suggested at 326 that the list of 13 witnesses
23 is remarkable as it omits all the surgical witnesses to
24 Raychel's post-operative care. Well, in fact, Dr Makar
25 was a surgical doctor and he saw Raychel in the early

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1 arrive.
2 Then Mrs Brown was approached again by the coroner
3 and she then sent the whole thing again. Three lines
4 from the bottom:
5 "Unfortunately, the letter enclosing the statements
6 went astray."
7 And "astray" is highlighted just as a quotation.
8 There's hanging in the air a question mark as to what's
9 happened there.
10 For the record, I would like this document pulled
11 up. 022-070-170. This is a letter to Mrs Brown from
12 the coroner, dated 5 December 2001. The important point
13 about the date of this letter is two things. One is the
14 date December 2001, and the second is its address, which
15 is Church Road, Newtownabbey, which I believe used to be
16 old Petty Sessions many years ago, which some of us
17 might remember.
18 So that's where he was at that time.
19 If the next document could be pulled up, that's
20 022-054-151.
21 This is a letter to the coroner with nine
22 statements, it's dated 25 January 2002, so we've moved
23 on obviously a month, six weeks, but the important thing
24 is the address is still the same, Church Road,
25 Newtownabbey. This is what's happened, we believe.

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1 hours of the morning. And she also, secondly, tells the
2 coroner in the same correspondence that she is seeking
3 a report from Dr Zafar, who made the note in the
4 morning. He was the surgical SHO and did the ward
5 round. So I think that statement at 326 in the last
6 sentence needs to be balanced by those two references.
7 349. This deals with the Jenkins report. We know
8 that the Jenkins report -- it says:
9 "This report may not have met Altnagelvin's
10 requirements because Dr Declan Warde, consultant
11 paediatric anaesthetist, Dublin, was commissioned on
12 3 December 2002 to prepare an independent report."
13 So there's a pejorative statement there about the
14 reasons for changing horses, as it were.
15 But if one looks at paragraph 345, there's reference
16 to counsel's advices of 7 October 2002. It says:
17 "I would advise a report should be obtained from an
18 independent consultant paediatric anaesthetist who
19 should comment on the management of this case."
20 Now, Dr Jenkins is a paediatrician and Dr Warde was
21 a paediatric anaesthetist, so there really had been an
22 instruction given or a suggestion given by a colleague
23 that this particular specialty should be involved. This
24 just didn't come up when the Jenkins report came in.
25 THE CHAIRMAN: No, but what ultimately happened is that the

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1 paediatric anaesthetist's report was not produced to the
2 coroner.
3 MR STITT: I'm coming to that, but that's a different point.
4 The point is made here that really the sense of the
5 paragraph is that because the trust didn't like the
6 Jenkins report, they commissioned the Warde report. The
7 Warde report had been advised two months, three months
8 before the Jenkins report was received.
9 THE CHAIRMAN: I get your point, thank you.
10 MR STITT: 317. This section, 317, 318 and 319 --
11 THE CHAIRMAN: We're going back now?
12 MR STITT: I do apologise, sir, it's slightly out of sync.
13 317 to 319 is essentially a summary of the role of the
14 risk management coordinator, Mrs Brown.
15 I would ask you simply to -- at 319 there's the last
16 sentence:
17 "Accordingly, there was potential scope for the duty
18 of the doctor to offer all relevant information to
19 conflict with Mrs Brown's task as RMCO to defend medical
20 negligence claims."
21 So she has her role, she is the central point, she
22 was involved in most of the respects, not all the
23 respects that are set out, but it's still held up for
24 criticism that there may be a conflict.
25 I just ask you to consider the report from

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1 Dr Swainson at paragraph 45. He says that this that
2 what she was doing was essentially the same as one would
3 expect in any trust.
4 THE CHAIRMAN: Yes, but does that answer the point whether
5 there's a potential for conflict? We've had this before
6 with the Royal. Dr Murnaghan ended up in a very, very
7 similar position in the Royal and it's a concern. This
8 may be the way things are done right across the Health
9 Service, but it's a concern that somebody who's
10 responsible, for instance, providing information to the
11 coroner is also the person who's centrally involved in
12 defending or preparing the defence of medical negligence
13 cases.
14 MR STITT: That is an argument.
15 THE CHAIRMAN: No, it's a concern. It's not an argument.
16 I'm putting it as a concern.
17 MR STITT: It's not a concern articulated by Dr Swainson.
18 THE CHAIRMAN: No.
19 MR STITT: You will consider this further.
20 THE CHAIRMAN: Sorry, you continue, Mr Stitt. If we're
21 going to go nitpicking through the opening, saying,
22 "Swainson doesn't agree with this and Swainson doesn't
23 agree with that", it's a pretty unproductive and very
24 unhelpful response to a huge opening on behalf of the
25 inquiry, so let's not go there.

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1 MR STITT: I have made my point. I actually had a much,
2 much longer list of points, and I too, sir, agreed that
3 it would be disingenuous and not a good use of the
4 inquiry's time to lengthen. If some of the points are
5 less attractive to you, sir, that I understand.
6 Let me move on, if I may, to paragraph 355.
7 THE CHAIRMAN: That's about the Warde report.
8 MR STITT: Yes. The sentence six lines down:
9 "It was not given to the PSNI to assist in police
10 enquiries."
11 That's potentially an important point, somehow that
12 the police should have been given the Warde report.
13 It should be put into the balance, and this will be
14 evidence, and it will be given by Mrs Brown, that she
15 liaised with a Detective Cross and provided all
16 documents requested by him. She then sent the Warde
17 report with all the other documents to the inquiry on
18 13 December 2004, and the Warde report, as we know, has
19 been in the inquiry's possession since then, document
20 number 139.
21 We've no reason to believe that the inquiry would
22 withhold any documents from the PSNI. Any argument that
23 there can be in relation to privilege, which we've
24 touched on from time to time, is not made in relation to
25 a PSNI investigation, it's to do with civil proceedings.

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1 So there's no question, I would like to make that clear,
2 of an acceptance that there was any attempt to withhold
3 a Warde report from the PSNI. [inaudible] asked for it
4 and it was given, and we knew it was on the public
5 website of the inquiry.
6 The Warde report issue, I put it no more detailed
7 than that, has been dealt with very thoroughly and in
8 great detail by counsel to the inquiry. The first
9 point, we have an expert report from counsel, Dr Dolan,
10 Dr Bridget Dolan. She has opined in a large number of
11 areas, but may I just ask you to refer in your own time,
12 sir -- I'll just quote two short quotes, paragraph 4.35,
13 and I will set it out in my written summary of these
14 submissions:
15 "In both Northern Ireland, England and Wales, there
16 is no general statutory or common law duty of disclosure
17 to a coroner."
18 And in the next paragraph, 4.36:
19 "There is no duty to provide opinion evidence from
20 third parties who have had at some later stage become
21 appraised of the facts surrounding the death, for
22 example, where healthcare staff learn of facts which led
23 them to suspect medical mismanagement by others or where
24 an expert opinion on the case has been obtained by an
25 interested party prior to the inquest."

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1 You may turn to me, sir, and you may say, "Well, the
2 Francis report is recommending a statutory duty of
3 candour", that, sir, is one of 290 recommendations. It
4 hasn't been implemented in Great Britain and, in any
5 event, Northern Ireland is devolved when it comes to
6 Health Service matters.

7 Thirdly, the Francis report, where there was
8 criticism of a document not being given to the coroner,
9 dealt with an involvement report from the lead A&E
10 specialist dealing with factual circumstances
11 surrounding the death of the patient. It's quite
12 different to an independent expert's report.

13 THE CHAIRMAN: It is. Somebody who's factually involved has
14 responsibility to give that evidence to the coroner. In
15 fact, the doctors have a specific obligation under the
16 code of conduct. It might also apply through
17 the Coroner's Act. I think there might be a distinction
18 here between what lawyers see as our world and what the
19 public sees, and the difference might be summarised as
20 this. If a member of the public, for instance Mr and
21 Mrs Ferguson, know, as they now do, that
22 Altnagelvin Trust received an expert's report in
23 preparation for the inquest which was critical of
24 Raychel's care and buried that, as they might see it,
25 they might find it very hard to reconcile that with the

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1 same hospital saying, "We're telling you what we know,
2 we're being open with you about what we know and we will
3 learn the lessons from this disaster".

4 I have worked nearly as long as you have, Mr Stitt,
5 in the world of privilege and deciding what disclosure
6 to make, but the public might see it rather differently
7 to the way that lawyers do.

8 MR STITT: Yes. The answer to that is that every party, and
9 I use the term "party", and I know you're discriminating
10 in a proper sense between a public body and an
11 individual, but everybody has the right to commission
12 a report where there's a possibility that that body or
13 person might be the subject of criticism, for instance
14 in a coroner's hearing. That same body or person has
15 a right to challenge the expert report that has been
16 commissioned by, in this case, the coroner. The expert
17 report may be factually wrong.

18 THE CHAIRMAN: Yes.

19 MR STITT: It may be medically wrong, and for those reasons
20 it is not unusual for parties to inquests to obtain
21 their own evidence. One thing that's absolutely clear
22 is there is no legal requirement for that party to
23 provide to the coroner a copy of a privately retained
24 independent expert's report. Just in the same way as if
25 the Ferguson family had retained an expert, and that

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1 expert had said, "Well, I believe that the treatment
2 provided at the hospital was exemplary in every
3 respect", one would have to accept that they were
4 entitled not to put that forward as it's a matter of
5 opinion.

6 The fact of the matter is that Dr Sumner was
7 a recognised expert, he was retained by the coroner, and
8 that was the evidence upon which the coroner reached his
9 verdict.

10 THE CHAIRMAN: That's right, and I don't think that this
11 opening suggests that the trust didn't have that
12 privilege. The query in the opening is whether this
13 is -- maybe the underlying note is whether this is
14 really the way things should be, because you weren't
15 involved in this segment of the inquiry, you didn't hear
16 Mr Leckey's evidence. Mr Leckey is concerned about
17 this.

18 MR STITT: I know that. I have read that and I have been
19 advised. I wasn't here. I'm aware of what he said
20 in relation to that. I'm reflecting the de facto
21 position.

22 THE CHAIRMAN: Sorry, the de facto position, I don't think,
23 is disputed, but this isn't a case that we're involved
24 in, this is an inquiry which looks at what has happened
25 and then makes recommendations about the future. One of

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1 the issues that must be legitimate to look at is, even
2 if organisations are doing what they're allowed to
3 do, (a) should they be exercising their discretion
4 in that way and, secondly, if they are, and that has
5 consequences for families, then should that be allowed
6 to continue? That's the context in which I'm looking at
7 it.

8 MR STITT: Well, it may be that that would require
9 a statute. It certainly would drive a coach and horses
10 through the law as it currently stands and as it stood
11 in 2001, we're obviously 12 years further down the line.

12 THE CHAIRMAN: And the public might think that if a hospital
13 who has treated a child who has died then receives
14 a report, preparing for an inquest, which says that the
15 hospital's treatment was defective and contributed to
16 the child's death, then since the public has paid for
17 that report and since the public is paying for the
18 hospital services in the first place, then the public is
19 entitled to know what the contents of that report are.
20 That's the issue, Mr Stitt. I'm not disagreeing with
21 you, but there's also another point about whether the
22 trust or a trust, any trust for that matter, should then
23 be allowed to run a line at the inquest which is
24 inconsistent with its own expert report.

25 MR STITT: Two points. Let me deal with each of them. The

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1 first point is that any departure along the lines to
2 which you suggest, in other words that a trust using
3 public money should be required to disclose that report
4 when in fact there's a full and comprehensive report
5 already before the coroner, would be completely new law
6 and indeed, in my respectful submission, practice, and
7 I can only remind you, sir, of your observation at
8 page 94 on the opening day of this section of the
9 inquiry when you said that there was no obligation on
10 the trust to disclose the Warde report. And if I may
11 say so, from a legal perspective -- and I understand the
12 distinction between the legal perspective and the public
13 perception, but nonetheless the trust, in my respectful
14 submission, were acting entirely legally properly on the
15 Warde issue.

16 The second point you make is essentially running
17 a line. The fact of the matter is there were a number
18 of nurses who gave evidence that in their opinion the
19 vomiting was not severe or prolonged. At one point --
20 and there's an opinion of Dr Jenkins, who said he
21 concurs with Dr Sumner, and Dr Sumner says that the
22 vomiting was severe and prolonged. The two best sources
23 of evidence here are the family and the nurses. In no
24 particular order, the nurses and the family. There is
25 a debate as to the amount of vomit and the extent of the

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1 vomiting. We've heard the evidence, I'm not going to go
2 over it again, but the fact of the matter is when I was
3 representing the nurses in this section of the
4 inquiry -- I'm not going to go into any detail about
5 what was or what was not said in consultations, but
6 there were views expressed as to the amount of the
7 vomit. And if the trust has that and is being told that
8 by nurses, notwithstanding the fact that the family feel
9 very, very strongly that the nurses are wrong, the trust
10 is entitled, in my respectful submission, to have that
11 evidence tested, both before the coroner and it's one of
12 the issues before you.

13 I acknowledge that the recorded -- and the method of
14 recording vomit has been accepted. The plus system has
15 been attacked. There's no argument to put up against
16 that. There's a very, very -- this is a highly unusual
17 case insofar as experts have said it is a rare
18 phenomenon for someone to die of dilutional
19 hyponatraemia, and one of the experts said it was
20 "vanishingly rare", I think was the expression. I'll
21 come back to who that was. But if I may simply say that
22 you will consider in your recommendations what the
23 appropriate approach of a trust should be, but I should
24 ask finally in relation to this point that you -- ask
25 you to bear in mind not only the law in 2001 but the

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1 practice in 2001.
2 THE CHAIRMAN: Yes.
3 MR STITT: And if I may turn to one final point on this --
4 I'm nearly finished. It's quarter to, but I'll be very
5 brief. There have been a number of -- there's a number
6 of observations in the opening which refer to the DLS
7 receiving statements from involved persons for approval,
8 to Mrs Brown receiving documents or sending them back
9 for amendment, and there's an implied criticism that
10 there's a conspiracy to make sure that everything
11 tallies and that the statements meet the requirements of
12 the trust. That's an implication which is rife -- not
13 rife but it appears in the opening.

14 Now, might I say, my firm instructions are from the
15 DLS that they would never instruct a witness what to
16 put, the details of what to put in a statement. I can
17 say as a member of the Bar that I have never instructed
18 a witness as to what should or should not go into his or
19 her statement. I make it clear as an absolute rule that
20 they are advised this is their evidence and what goes in
21 and what you sign is your evidence and it's not for me
22 to influence you in relation to that.

23 But there are times when a lay witness understands
24 the importance of their statement. I'll give you four
25 or five very brief examples. There might be

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1 typographical errors, it might have to be sent back for
2 that reason. There could be grammatical errors or, more
3 importantly, logical non-sequiturs, which the witness
4 has not picked up on. There could be a failure to deal
5 with an important issue which the coroner might regard,
6 one could reasonably regard, as important and relevant,
7 germane to the issues which the witness might not
8 appreciate, and the statement might have to be sent back
9 to cover this point. What happened at 12.30 in the
10 morning, for instance?

11 It can happen -- and this happens in psychiatric
12 cases -- that the lengthy statement from a psychiatric
13 witness can inadvertently include sensitive, personal
14 medical details of a person's history, which are not
15 appropriate for the public domain. That's a very
16 sensitive area and one in which a witness will need to
17 be advised as to the possible ramifications for the good
18 of the patient or for the good of the deceased in cases
19 where it's a suicide. And in relation to a coroner's
20 statement, the witness is asked to sign the bottom of
21 every page.

22 In my submission, it would be wrong to simply infer
23 that because statements are sent back or because there
24 are discussions with witnesses, or there is a discussion
25 about their statements, that there's an implication that

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1 they have been got at.

2 THE CHAIRMAN: I accept your examples are perfectly
3 legitimate examples. For instance, if a witness failed
4 to address an issue, then inevitably the witness is
5 going to be asked for a second statement, and that's
6 entirely appropriate. Unfortunately, I have experience
7 in this inquiry of something being done which does not
8 fit into any of those categories. I just give the
9 example. It was Dr Webb in Claire's case who said that
10 he thought he had -- I can't remember the precise terms.
11 We can look them up. I think he at least regretted that
12 before he left duty on a particular evening, he had not
13 ensured that Claire was admitted into paediatric
14 intensive care. He put that into his statement and
15 he was advised that it was inappropriate for that to be
16 in the statement and that it might be removed.

17 The person who advised him of that was hugely senior
18 to him in the Health Service and he took the advice of
19 a much more senior person. So what was in fact removed
20 from the information forwarded to the coroner in that
21 instance was at least a regret, if not an
22 acknowledgment, by a doctor that the doctor had made
23 a mistake. And the advice that was given to Dr Webb as
24 he explained it to the inquiry was that it's not for you
25 to say what mistakes you made or what went wrong, it's

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1 for the coroner to find.

2 Now, that's not a typo, that's not correcting
3 grammar, that's not a failure to address an issue,
4 that's something which goes centrally to the role of the
5 coroner. If I understood that the referring back of
6 statements was only along the lines that you have set
7 out, I would not have a concern at all. Not one
8 concern, Mr Stitt. My concern, as I'm sure is
9 understood by DLS and by the Royal, goes much deeper
10 than that.

11 MR STITT: Yes. I, with respect, would agree with you.
12 There's a difference between the general and the
13 particular. And you will descend into the particular
14 during the course -- you have descended into the
15 particular during the course of the clinical hearings
16 and you will do again in this section.

17 I'm just saying that my point is a more general
18 point, where there's a sideswipe taken at the risk
19 management office in Altnagelvin for apparently --
20 that's the implication -- being too close to it, and
21 a suggestion that there has been some form of
22 interference with statements. That's the point that I'm
23 making, that's the objection we're taking.

24 If you find as a matter of fact, sir, that has
25 happened improperly, so be it.

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1 THE CHAIRMAN: The reason it's in the opening is that the
2 earlier evidence at this inquiry, with some of the other
3 children, has alerted us that on at least one previous
4 relevant occasion there was what I will for the moment
5 describe as a questionable intervention to have
6 a witness statement changed. Okay?

7 MR STITT: That's noted. Nothing would surprise me in the
8 last 25 years in the taking of statements. There must
9 be many examples which are perhaps borderline or beyond,
10 but I'm suggesting -- and I think you agree, sir --
11 there are good reasons for reviewing statements.

12 THE CHAIRMAN: Absolutely. If the DLS was forwarding
13 statements full of typos and spelling mistakes and
14 gobbledegook, the coroner might ask questions, or if
15 Mrs Brown was doing that, the coroner might ask
16 questions.

17 MR STITT: It goes further than typos or spelling mistakes,
18 it's a question of trying to help the inquiry or the
19 coroner.

20 The final point deals with the final section. I'll
21 be brief. There's a criticism of the trust for not
22 admitting liability.

23 The trust initially made a firm denial of liability
24 in a letter that was quoted. At that stage, whilst,
25 of course, the verdict of the coroner was known, there

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1 are and there were certain technical issues. They
2 become more unravelled as time has gone on, particularly
3 after the inception of your inquiry, dealing with the
4 action plan, is that something which should have been
5 done with foresight or only with hindsight? The amount
6 of the extra fluid, how much was it over the entirety of
7 the period? Whether U&Es would actually have made
8 a difference in this particular case. Was the vomiting
9 severe and prolonged? And indeed, there's Dr Kirkham's
10 report where she's not convinced that the aetiology of
11 the brain swelling was actually hyponatraemia but was
12 some other process which was aggravated, and we know
13 about that.

14 I'm not going to delve into those, but could I refer
15 you to a letter, if this letter could be pulled up,
16 326-002-001.

17 This is a letter of 30 June 2005. May I take you
18 halfway down, sir, to the sentence which begins six or
19 seven lines down in the first paragraph:

20 "There is no doubt that during the course of that
21 inquiry the actions of the trust will be subjected to
22 full and complete investigation. If the trust are found
23 to be at fault in any way, then we make it absolutely
24 clear that it would be deeply apologetic for its
25 failings. The trust has already expressed and now

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1 repeats its clear sentiments of sorrow and deep regret
2 in relation to the death of Raychel Ferguson."
3 The position is that the trust has maintained its
4 position since the inception of the inquiry that
5 liability has not been admitted, but it will read the
6 findings of the inquiry carefully and will respond
7 appropriately to the details of your findings, sir, when
8 they are made. That has been the position which has
9 been articulated more than once in correspondence and
10 more than once in the High Court.
11 THE CHAIRMAN: I'm sorry, does that mean the trust's
12 position on the High Court litigation is pending while
13 I finish the inquiry and write the report?
14 MR STITT: Yes.
15 THE CHAIRMAN: The trust has heard a run of witnesses go
16 through the witness box, one after another, and admit in
17 different ways failing after failing after failing, and
18 it can't make a decision on what to do in the High Court
19 until I write a report about that? I'm sorry, Mr Stitt,
20 that's almost unbelievable.
21 MR STITT: Well, I'm sorry that it is, sir, but the decision
22 was taken that if this matter is going to inquiry, it
23 will be thoroughly examined and all of the relevant
24 factors will be looked at. It's quite clear that
25 everyone in this inquiry, this section of the inquiry,

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1 has learnt a lot since February of this year and will
2 continue to learn more in the next week or two.
3 THE CHAIRMAN: Well, let me remind you of something which
4 again in a segment of the inquiry you weren't involved
5 in, we had a witness who was involved from the Royal in
6 Claire's case, and he said in the witness box, in the
7 presence of Mr and Mrs Roberts, that as he walked out of
8 the inquest, he said, either to himself or to somebody
9 else, that "If the Roberts sue, we'll have to admit
10 liability because of what I've just heard at the
11 inquest".
12 Now, in that case, of course what happened was that
13 the Roberts didn't sue, and the first that they heard
14 that there was any admission of liability or that there
15 would have been any admission of liability wasn't from
16 any communication they ever had with the trust but from
17 a witness at the inquiry describing how he, on hearing
18 the evidence to the inquiry, said "If they come to sue
19 us, we'll have to admit liability because we didn't do
20 an electrolyte test on the morning after Claire was
21 admitted for treatment".
22 Now, if a senior figure in the Royal could give that
23 indication and make that decision on the basis of what
24 he heard in an inquest, I'm lost as to why the trust is
25 waiting for the end of this evidence and my report.

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1 MR STITT: Might I just say that one of the most recent
2 reports we've had is that from the advisor's
3 consolidated report, and it makes reference to
4 litigation, and it says there's a danger with litigation
5 that it could prevent the proper implementation of steps
6 to improve the system and could hamper lessons being
7 learnt, and it repeats that twice. It doesn't say or
8 make any criticism at any point, none of the advisers
9 make the point adverse to the trust, that liability
10 should have been admitted.
11 THE CHAIRMAN: Okay. You'll have that in its full form to
12 me in writing on Friday?
13 MR STITT: Yes.
14 MR QUINN: Mr Chairman, I just want to make one point which
15 I think is relevant in the case, and that is about the
16 point you made earlier about the public purse being
17 involved and when the reports from Warde and Jenkins are
18 paid for by the Trust why they shouldn't be available to
19 everyone who feels that they have an input into the
20 National Health Service. I also want to make the point
21 for the record that not only --
22 THE CHAIRMAN: That's how we might feel as users of the
23 National Health Service and as taxpayers, but as
24 a matter of law what Mr Stitt has said is right.
25 MR QUINN: I totally agree.

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1 THE CHAIRMAN: The concern that I have here, and I might not
2 be the only one here, is if there's an uneasy
3 distinction between the legal position and what should
4 be the position.
5 MR QUINN: I totally agree. I totally agree they are within
6 their legal rights not to release the report, but when
7 the report is paid for by the public purse it somehow
8 seems wrong from the public perception that that report
9 is not released.
10 It also brings me to another point that I'll deal
11 with very briefly, and that is the ongoing litigation
12 issue that was dealt with at the end of the opening by
13 the learned counsel to the inquiry. I should put on the
14 record that in fact the refusal of the trust to admit
15 liability in the case that is currently pending under
16 litigation by the Fergusons has driven the public purse
17 now to meet a further requirement, and that is an
18 expert's report dealing with causation and negligence
19 in relation to the death of Raychel. That means that
20 the Fergusons have the benefit of Legal Aid and that the
21 public purse will be put to that expense in going to get
22 that report when, in my view, certainly from what I have
23 heard in the inquiry, that report is unnecessary. And
24 I feel that that's a point that has to be highlighted,
25 given your earlier comment, sir, in relation to the cost

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1 of the earlier reports from Jenkins and Warde.
2 MR STITT: May I just respond to that point, if I may?
3 At the hearing in June before Mr Justice Gillen, he
4 asked as to the state of play in relation to the
5 plaintiff's medical evidence, and junior counsel for the
6 plaintiff, I'm advised by counsel who was representing
7 the trust, was that they were going to rely upon the
8 evidence which had been adduced at this inquiry.
9 THE CHAIRMAN: Right. Okay.
10 MR STITT: If that's not right, I'm sure I'll be corrected.
11 MR QUINN: It's not right. That was the initial response
12 but then we were told because of an exchange of
13 correspondence we were then -- we were forced to go and
14 get a report in relation to causation and the negligence
15 issues as directed by Mr Justice Gillen.
16 THE CHAIRMAN: Okay. Right. We had better wrap up the
17 openings at that point. We'll break. We'll have to
18 give it 2.30 to give a little time. Mrs Noble, we will
19 have you in the witness box at 2.30, and you'll be
20 finished before you set off home tonight. Thank you.
21 (2.00 pm)
22 (The Short Adjournment)
23 (2.30 pm)
24 THE CHAIRMAN: Just before we start Mrs Noble's evidence,
25 Mr Stitt, one of the points you made before lunch was

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1 that in terms of providing information to the police
2 that the inquiry had the report from Dr Warde, and the
3 inquiry could, therefore, have provided it to the
4 police.
5 MR STITT: It wasn't so much the inquiry could, it was
6 assumed it was a public document and it was out there.
7 THE CHAIRMAN: Except it wasn't by that stage. This is one
8 of a number of documents originally provided by
9 Altnagelvin, which were then reclaimed at the time when
10 Mr Justice Stephens represented the trust. And after
11 the documents had been provided to us, a claim was made
12 for privilege, and it was indicated to me that that had
13 been overlooked. On that basis, I recovered the CDs and
14 the hard copy documents from all the parties to which
15 they had been distributed and returned them to
16 Altnagelvin trust, including the inquiry's copies.
17 So it is correct to say that at one point the
18 inquiry had received them, but within days Mr Stephens
19 was in to see me with Mr McGinnis, who will, of course,
20 remember this, to claim privilege for them and to
21 reclaim them and require their return. So I had
22 a passing possession of those documents. Okay?
23 MR STITT: Yes.
24 THE CHAIRMAN: That's not what was suggested earlier on.
25 Mr Stewart?

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1 MR STEWART: Thank you, sir. I call Staff Nurse Ann Noble,
2 please.
3 MRS ANN NOBLE (called)
4 Questions from MR STEWART
5 THE CHAIRMAN: Mrs Noble, have a seat, please. Thank you
6 for coming back.
7 MR STEWART: Good afternoon, staff nurse. Since last you
8 were with us, you provided a further witness statement,
9 which appears at WS049/4, a statement which you have
10 dated 25 June 2013. Are you content that the inquiry
11 should adopt that as part of your formal evidence?
12 A. Yes.
13 Q. Thank you. Your evidence last time ranged far and wide,
14 and if I can take you to a part of your evidence that
15 dealt with the time you were on duty shortly after
16 midnight of 8 into 9 June of 2001. That was at a time,
17 correct me if I'm mistaken, that you were the lead nurse
18 on duty in Ward 6?
19 A. Yes.
20 Q. And at that time Raychel had vomited some coffee-ground
21 vomits?
22 A. Yes.
23 Q. Raychel had been complaining of a headache, Raychel was
24 noticed to be flushed.
25 A. Yes.

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1 Q. In that context, I now would ask you to consider these
2 documents, starting at 316-085-013. This -- I'm sure
3 you've had a chance to see this.
4 A. Yes.
5 Q. This is a note, taken by Sister Little, of what she says
6 was a telephone conversation with yourself on 10 or
7 11 June. Can I, first of all, ask you, is it correct
8 that Sister Little did indeed talk with you --
9 A. I have no recollection of that telephone call.
10 Q. So when she gives evidence to the inquiry by a witness
11 statement that she did have a conversation with you and
12 that she took this note of this conversation, you
13 wouldn't wish to dispute that?
14 A. I honestly have no recollection of that phone call.
15 Q. Do you have any recollection of any of the matters noted
16 by Sister Little in this note? Can I take you down to
17 the first page there, towards the bottom. It's
18 approximately 10.30 to 10.45 pm, parents went home, from
19 there on.
20 Do you see the next note is approximately 12.30 am:
21 "Fiona Bryce report to Ann, that's you ..."
22 A. Yes.
23 Q. "... Raychel was [it looks like] behaving funny?
24 Confused."
25 Could you have said that to Sister Little?

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1 A. No, because I do not recall Fiona Bryce saying that to
2 me. To my recollection, that conversation never
3 happened. I was never told at any time that Raychel was
4 funny or behaving funny or confused. If I had been made
5 aware of that situation, as I was going on my break
6 I would have instructed the staff nurses who were behind
7 to go and make an assessment of Raychel.
8 Q. Yes.
9 A. And I think in light of what happened to Raychel
10 afterwards, that would be a very pertinent piece of
11 information to have recalled, and I didn't recall it.
12 I asked -- I actually asked Sister Gilchrist, or Staff
13 Nurse Gilchrist at the time, did she have any
14 recollection of Staff Nurse Bryce saying that, and she
15 hadn't. Staff Nurse Bryce, I also questioned, did she
16 tell me that, and she said she could not recall having
17 told me that either.
18 Q. Well, let's just start, if we may, slowly and look at it
19 bit by bit. If this was taken by Sister Little, as she
20 says, during the course of a phone conversation with
21 you, it was being done within a matter of a couple of
22 days, a day or two, of Raychel's death?
23 A. I can only assume so.
24 Q. And at that time, your memory of the events of that
25 evening would be as fresh as they could be?

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1 A. Yes.
2 Q. And would you agree, one can think of little reason why
3 Sister Little would choose to invent anything to put in
4 this note?
5 A. But is this solely on the basis of my conversation with
6 Sister Little or is it on the basis of Fiona Bryce's
7 conversation with Sister Little? Because I don't know
8 whether she means that Fiona Bryce had told
9 Sister Little that she had reported to me that I had --
10 I certainly don't recall that conversation, and it did
11 not happen as far as I am concerned.
12 Q. Well, I am more interested in, first of all,
13 establishing whether or not the conversation with
14 Sister Little happened.
15 A. I can't recall the conversation.
16 Q. It seems likely in the immediate aftermath of a very
17 serious incident --
18 A. Yes.
19 Q. -- that Sister Little, your superior, would come to you
20 when you were the senior nurse on duty at that time to
21 ask what happened.
22 A. Yes.
23 Q. That seems quite plausible, doesn't it?
24 A. Yes, it does.
25 Q. And it seems quite plausible that given the pages of

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1 this document which were all written in good writing,
2 that she was at pains to take down from you in
3 a telephone conversation what you were telling her?
4 A. Well, I wrote a statement of the events that had
5 happened to Raychel very, very shortly after it
6 happened.
7 Q. Yes, I know.
8 A. And I would have included something as important as
9 a staff nurse telling me that Raychel was behaving funny
10 or was confused.
11 Q. All right. Because, as you quite clearly point out, the
12 importance is that if you were told that there was
13 a confusion or oddity of behaviour, a disorientation,
14 that's an important feature, isn't it?
15 A. Of course.
16 Q. And if that was put on top of a child who's already
17 continuing to vomit, complaining of headaches,
18 exhibiting a flushed complexion, this on top of it would
19 be important to compel you to go to a doctor, wouldn't
20 it?
21 A. Yes.
22 Q. So for this to be part of the information available to
23 you at the time is critical?
24 A. Yes.
25 Q. And your response to it is critical?

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1 A. Yes.
2 Q. Now, you did make a statement, you made a statement on
3 14 June, which is just three, maybe four days after this
4 note was taken by Sister Little. That appears at
5 022-101-314. This is the first page, and you have
6 addressed it to Therese Brown, risk assessment manager,
7 and you have dated it 14 June. I wonder can we bring up
8 alongside that the second page, 315.
9 First of all, this is being made again only a matter
10 of days after it when your mind is fresh. Can you see
11 down the left-hand side of both those pages there's some
12 handwriting, some annotation which have been blacked
13 out, do you know whose handwriting that is?
14 A. No.
15 Q. This is a statement provided by you to the RMC0 and it
16 was for the purposes of presumably forward submission to
17 the coroner; is that right?
18 A. Yes.
19 Q. Can I take you to the second page, 315, and the
20 paragraph beginning at 0035 hours, in other words to the
21 same period as we were just referring to in nurse
22 little's note. There we have at 0035 hours, Staff Nurse
23 F Bryce, this is you recording, Staff Nurse F Bryce
24 noted that Raychel was becoming restless again.
25 A. Yes. Restless.

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1 Q. Can I ask you to describe what "restless again" means?
2 A. Well, I can't recall exactly, but when I questioned
3 Staff Nurse Gilchrist regarding the previous document
4 and I said at no time did Staff Nurse Bryce communicate
5 to me that Raychel was behaving funny or confused,
6 Nurse Gilchrist said to me, "No, she was restless", and
7 I had put that in my statement. I remember them
8 communicating that she was restless, not funny or
9 confused.
10 Q. All right. The point of my question is asking you about
11 "restless again". This is a further example of
12 restlessness, this being reported to you.
13 A. Well, I can't recall exactly when she was restless
14 previous to that, but I know that she had been vomiting
15 and she had had a headache, and I expected that she was
16 a bit restless. I can't recall exactly when --
17 Q. Okay.
18 A. What she was referring to at that time.
19 Q. "As I was on my break with Nursing Auxiliary Lynch,
20 staff nurses Gilchrist and Bryce were dealing with her."
21 They were dealing with her. So according to this,
22 you were on your break when it's noted at 0035 hours
23 that she's becoming restless again; is that correct?
24 A. Yes, I had gone on my break at approximately 12.30.
25 Q. So if you're on your break, you're not there on the

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1 ward?
2 A. I was not there on the ward, no.
3 Q. So if in fact you were told, as the notes from
4 Sister Little would suggest, at 12.30 that Raychel was
5 perhaps confused, you shouldn't have gone on your break?
6 A. No.
7 Q. No. You definitely would then have attended to the
8 matter?
9 A. Or I would have told Staff Nurse Gilchrist or Staff
10 Nurse Bryce to go and make an assessment of her and tell
11 the doctor.
12 Q. You definitely wouldn't have gone away, would you?
13 A. I wouldn't have gone away until I'd instructed them what
14 I had wanted them to do.
15 Q. And you should have put it in the notes as well?
16 A. Yes.
17 Q. And would you agree with me, with hindsight that would
18 have been really an occasion when you would have got
19 a doctor?
20 A. Yes.
21 Q. But according to this, you're not there and Gilchrist
22 and Bryce are dealing with her.
23 A. Yes.
24 Q. When you made this statement, did you have any
25 conversation after you made the statement, after you

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1 submitted it to Mrs Brown, did you have any conversation
2 with her about the content of it?
3 A. I can't recall. I may have read it to her, but I can't
4 recall any exact conversations.
5 Q. Did you make any subsequent statements, just like this
6 but a little bit different?
7 A. I can't recall.
8 Q. Did anyone suggest to you that you make any changes to
9 this statement?
10 A. No.
11 Q. No, right. Now, can I ask for this document to be put
12 up alongside 314. It's 022-101-314. I beg your pardon.
13 It's 012-008-100.
14 Here's another statement made by you bearing the
15 same date. And do you see that after the first
16 paragraph, which concludes "Staff Nurse D Patterson
17 documented her admission details", there's a second
18 paragraph, and in this second version you note:
19 "She informed me that Mr Makar, surgical SHO, had
20 prescribed intravenous Hartmann's ..."
21 And that is a paragraph which doesn't appear in the
22 first statement. Can you inform me at what stage you
23 produced a second statement with that in it?
24 A. I can't recall. It's been so long ago.
25 Q. Because you see, that second statement has marked at the

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1 bottom "Coroner", and that is the copy of the statement
2 that was forwarded either by the trust or its solicitor
3 to the coroner, whereas the first version comes from
4 Altnagelvin's own files.
5 A. Yes.
6 Q. Can you think back, were there any conversations with
7 a solicitor?
8 A. I think we had a conversation with the barrister
9 representing the hospital going into the coroner's
10 inquest, but I can't recall the exact --
11 Q. Long before that, can you recall any occasion when you
12 would have changed your statement?
13 A. I can't recall exactly. I honestly can't recall.
14 Q. All right.
15 A. It was so long ago, I can't recall.
16 Q. I want to go to that same paragraph we were dealing with
17 a moment ago, so if we bring up the first one again at
18 022-101-315 and 012-008-102.
19 On the right-hand side of the screen is the initial
20 statement that you submitted on 14 June. On the
21 left-hand side of the screen is the second version,
22 second statement, also dated 14 June. It's the
23 paragraph, if we can highlight on both, the paragraph
24 commencing at 0035 hours.
25 Do you see originally you wrote:

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1 "Raychel was becoming restless again."
2 A. Mm-hm.
3 Q. The second version has omitted the word "again":
4 "Noted that Raychel was becoming restless."
5 You may think that's just one small word, but it
6 might mean something, and it's been deliberately taken
7 out. Can you tell us how that happened?
8 A. I have no conscious reason as to why it was taken out or
9 omitted. I can't recall having told anybody to take it
10 out or been instructed by anybody to take it out.
11 Q. Could you be suggesting that this was done without your
12 knowledge?
13 A. It was one word. I doubt I would have noticed.
14 Q. All right. You may remember back to the right-hand side
15 of the screen again, in your first statement you
16 indicated that:
17 "As I was on my break ..."
18 In other words, you weren't on the ward.
19 Go to the left-hand side and you have written:
20 "And as I was going on my break ..."
21 Now, either you were on the ward or you weren't.
22 A. I left the ward at approximately 12.30 and both were
23 written -- both statements were written after the event.
24 I suppose I didn't pay particular attention as to
25 whether I was going or as I was -- had gone on my break.

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1 I honestly ...
2 Q. Particular attention is paid by you when you made the
3 first statement:
4 "As I was on my break."
5 And particular attention must have been made by you
6 when you chose to amend that. I want you to tell me, if
7 you can, why you made that change.
8 A. I don't recall.
9 THE CHAIRMAN: You understand the broad point, Mrs Noble?
10 These are not two entirely separate statements.
11 A. Yes.
12 THE CHAIRMAN: The language in them is almost identical. Do
13 you understand?
14 A. Yes.
15 THE CHAIRMAN: If you look at the right-hand side of the
16 screen, for instance, at the next paragraph:
17 "At 0300 hours whilst administering medication to
18 a patient adjacent to Raychel."
19 That's exactly the same as the first line.
20 A. Mm-hm.
21 THE CHAIRMAN: So you haven't at some later stage apparently
22 gone off and written out a completely separate, brand
23 new statement. What appears to have happened is that
24 one of your statements -- I think they're both dated
25 14 June, aren't they?

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1 MR STEWART: Yes.
2 THE CHAIRMAN: So you have a statement dated 14 June and it
3 has been tweaked.
4 A. Mm-hm.
5 THE CHAIRMAN: Let me just put it that way, it's been
6 tweaked. Okay? It may or may not be sinister. It may
7 be innocent. You have just told Mr Stewart you can't
8 recall, is that right?
9 A. I can't recall it, and I can only assume it may be to
10 make it read better. I'm not sure. I wasn't
11 consciously asked by anybody to change it for any
12 particular reason.
13 MR STEWART: We move on through the paragraph. In the
14 original version, nurses Gilchrist and Bryce "were
15 dealing with her". On the revised version, nurses
16 Gilchrist and Bryce "were going to attend to her".
17 This is not accidental.
18 A. I ...
19 Q. A moment ago, you agreed with me that if you had been
20 told that Raychel was confused or behaving strangely,
21 you would never have left the ward. You would have
22 attended to that because that was important. Could it
23 be that you heard about this and just went on your
24 break?
25 A. No.

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1 Q. And because that was not a good thing to do, you had to
2 revise your statement to have you there "I was going on
3 my break", so that any information that came to you was
4 something that you could and would have dealt with
5 because you were there?
6 A. I would never have made a conscious decision to change
7 anything to make it appear better for myself.
8 Q. Could you explain then in any way that I can understand
9 how this came about without conscious intention on your
10 part?
11 A. I can't recall.
12 Q. The notes that you filled out, the episodic care plan,
13 if we go to 020-027-064. That's a paragraph of 9 June
14 at 0600 hours there "Carry care forward". You brought
15 this forward from an earlier entry on the care plan, and
16 you have written:
17 "Child continued to vomit and be nauseated. Vomited
18 coffee grounds twice. Doctor contacted. IV Valoid
19 given with effect."
20 I'm sure you have been taken over this before, but
21 if you were there and she vomited after that was given,
22 why do you write "given with effect"?
23 A. Because the amount of vomitus was less and she had
24 vomited less frequently. The effect isn't instantaneous
25 with medications, it can sometimes mean that the amount

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1 and frequency becomes less, and I would call that
2 effective in that she didn't continue to vomit.
3 Q. You would call that effective?
4 A. Yes.
5 Q. With effect?
6 A. Yes.
7 Q. Then you have written:
8 "Continued on PR Flagyl."
9 Whatever that is. Then you have written around
10 3 am:
11 "Child was noted to be restless."
12 Why didn't you write at 12.30 am "child was noted to
13 be restless", because that's what you were informed?
14 A. I was informed that she was restless, but I had been
15 in the room administering medication to a child adjacent
16 to Raychel, and I could hear her becoming restless and
17 was alerted to that fact by --
18 Q. I apologise for interrupting you, but I'm asking you why
19 you didn't enter the child was restless or indeed
20 restless again, as you said in the original statement,
21 for 12.30. Was that because you weren't there?
22 A. Well, because Staff Nurse Gilchrist and Piona Bryce went
23 to see Raychel and made an assessment of her, and when
24 I came back from my break they told me that Raychel had
25 vomited a mouthful of vomit and appeared to settle.

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1 Q. Why didn't you put that into the --
2 A. I didn't feel I needed to write that down because she
3 appeared to settle at that time.
4 THE CHAIRMAN: If you're writing then by 6.00 in the
5 morning, things had gone terribly wrong, hadn't they?
6 A. Yes.
7 THE CHAIRMAN: Well, surely at that time if you're writing
8 a note of what has happened and you know things have
9 gone disastrously wrong at 6 am, why not add in the
10 detail, because it may well be that something you did
11 not attach much significance to at 12.30 might actually
12 have been more significant than you'd thought?
13 A. Well ...
14 THE CHAIRMAN: Do you see what I mean? When you're doing
15 all this together -- because it's not as if you wrote
16 that note two or three days later, you wrote it within
17 a few hours of the disaster.
18 A. Uh-huh.
19 THE CHAIRMAN: So why not put in all the detail?
20 A. Unless I didn't become -- I didn't realise it at the
21 time, and at 6 o'clock in the morning the events of the
22 night that had gone on previously were still very
23 shocking and I tried to get down the important points,
24 and those were the important points that I felt at that
25 time.

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1 MR STEWART: Of course, at that time, if you had been
2 informed that she was confused and behaving funny,
3 that is something that you would have put in, wouldn't
4 you?
5 A. Yes.
6 Q. Absolutely. Can we move on through Sister Little's note
7 of her telephone interview with you to the fourth page
8 of that at 316-085-021. The fourth line from the top,
9 third line down:
10 "Transferred to treatment room. Blotchy rash over
11 body [something] spots. Query due to vomiting?"
12 Is that something that you told Sister Little?
13 A. No, it was something that Dr Trainor, the paediatric
14 registrar, had noticed on Raychel.
15 Q. So in fact, for Sister Little to record that from you,
16 could well be absolutely accurate because you got it
17 from Dr Trainor?
18 A. Possibly. I don't recall a conversation.
19 Q. At the time of transfer to the treatment room, she was
20 up until that stage still on Ward 6. That should have
21 been noted by you in the care plan, shouldn't it?
22 A. Well, the treatment room is in Ward 6. I didn't think
23 I had to clarify that she was still in Ward 6.
24 Q. Well, I was asking whether or not you should have
25 written down that she had a rash on her body and whether

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1 or not that might have been due to vomiting? Wasn't
2 that an important thing to put down?
3 A. Yes. It was just there was so much happening at that
4 time.
5 Q. I would like to ask you in relation to your statement,
6 the first statement you made or the one that eventually
7 went to the coroner, which is 012-008-100. This is
8 written a couple of days after the critical incident
9 review that you'd attended, which was chaired by the
10 medical director, Dr Fulton.
11 You have told the inquiry about the number of
12 problems that were identified at that review, and you
13 gave evidence about the failure to assess Raychel's
14 U&Es. You gave evidence about how the review addressed
15 the issue of whether or not excess fluids had been
16 administered, and you gave evidence that the review had
17 indeed discussed and decided that the vomiting had been
18 both prolonged and severe.
19 Can I ask you why those features of the case, which
20 to your knowledge existed, were not included by you in
21 your statement?
22 A. Because my experience at the time of children vomiting
23 post-operatively, I had experienced children who had
24 vomited just as much and had recovered uneventfully.
25 That was my experience.

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1 Q. The question is this. You have been to a review and
2 you have all discussed some of the -- perhaps
3 the shortcomings, things that could have been done
4 better, and you decided that Raychel's sodium levels
5 could have been checked, her U&Es taken. Why didn't you
6 put that fact, the fact that you'd discussed it and the
7 review decided that this was something that wasn't done,
8 why didn't you put that in the statement?
9 A. Because nurses -- we alerted the doctors to come and see
10 Raychel. It wasn't my job to order electrolyte profiles
11 or U&Es, it was the doctor's job to come and make an
12 assessment of their patient, to look at their fluid
13 balance chart, to speak to the parents, to make an
14 assessment of how much it was vomited, and for them to
15 make the decision to order blood tests. It wasn't my
16 job at that time to do that or to suggest it to them.
17 Q. But was it your position to make a note of it in your
18 statement as a relevant fact of the circumstances of the
19 case for the coroner?
20 A. I didn't think to do it at that time.
21 Q. Fair enough.
22 THE CHAIRMAN: The coroner was told about what had been done
23 after Raychel's death by other people from Altnagelvin.
24 In other words, it might appear that he was being
25 reassured that this wouldn't happen again because of

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1 what had been done in Altnagelvin afterwards; right? So
2 the information which was being given to the coroner was
3 not restricted to the precise note or impression that
4 every doctor or nurse had about how Raychel was at
5 9 o'clock, 10 o'clock, 11 o'clock, 12 o'clock. Right?
6 A. Right.
7 THE CHAIRMAN: So sometimes it's suggested: oh, the coroner
8 should only be given factual information about the
9 patient. But in this case the coroner was actually
10 getting some more information. He was getting some more
11 information about what had followed on and what steps
12 had been taken after the event.
13 Now, one of the steps that was taken after the event
14 was that you were one of the people who were at
15 a meeting and, as you described to me earlier this year,
16 you and Sister Millar, I think, who you gave primary
17 credit for, spoke up quite loudly about things that you
18 were unhappy about and things that might be done better.
19 But am I right in understanding that none of that is in
20 your statement to the coroner?
21 A. That's right.
22 THE CHAIRMAN: Now, since other people in Altnagelvin
23 decided to give the coroner information about what was
24 changed afterwards and what Raychel's death led on to,
25 can you help me by indicating why you didn't contribute?

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1 A. I wasn't asked. I wasn't asked about anything
2 afterwards. I was asked to give an account of what had
3 happened to Raychel.
4 THE CHAIRMAN: Right. Right, so it must have been other
5 people who were then asked to say what had happened
6 after the event, but not you.
7 A. I wasn't asked.
8 THE CHAIRMAN: Thank you.
9 MR STEWART: At the meeting, the critical incident review
10 meeting, did you discuss the blotchy rash on Raychel's
11 body that was thought perhaps, query, to be due to
12 vomiting; was that discussed?
13 A. I can't recall exactly. I think it possibly may have
14 been, but I can't recall the exact conversation.
15 Q. Dr Fulton has told the inquiry that at the meeting the
16 nurses said that the Ferguson family told them during
17 8 June that the family believed that Raychel's vomiting
18 was repeated and severe. At the critical incident
19 meeting, do you remember anyone saying, "I don't know
20 about the vomiting, but the Ferguson family, they
21 mentioned it to us and this is what they said", was that
22 mentioned?
23 A. I can't recall.
24 Q. You can't recall?
25 A. I can't recall.

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1 Q. At that meeting were you aware of a comparative absence
2 of doctors in that meeting as opposed to nurses?
3 A. I didn't make a conscious awareness that some of the
4 doctors weren't there. I just thought that the doctors
5 were there that could be available.
6 Q. Because in terms of the care and treatment of Raychel on
7 the 8th and 9th, really what was being looked at was the
8 nursing, what was being done, what was being missed;
9 is that right?
10 A. Well, I thought everybody that had any indication to
11 be -- any involvement with Raychel was asked to the
12 meeting.
13 Q. Well, there are quite a number of people who weren't
14 there who did have --
15 A. I didn't invite them. I didn't make the list.
16 Q. No, I appreciate that, I'm not for one second suggesting
17 that you had anything to do with that. But there are
18 a number of people who you might have expected should
19 have been there who were involved in her case, Dr Zafar,
20 the surgical SHO --
21 A. Mm-hm.
22 Q. -- who did the post-take ward round, he wasn't at the
23 meeting.
24 A. No.
25 Q. Nor Dr Johnson or Dr Bhalla, nor Dr Devlin, nor

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1 Dr Curran, nor Dr Trainor, nor Dr Butler, nor Dr Date.
2 All absent. So it must have been a group of nurses
3 sitting around feeling as though you were being singled
4 out perhaps? Doctors weren't there, you were.
5 A. It was acknowledged that there was a lack of medical
6 staff there but the consultant paediatrician was there,
7 Dr Nesbitt was there, and Sister Millar was there.
8 Obviously senior personnel.
9 THE CHAIRMAN: Sorry, when you say it was acknowledged that
10 there was a lack of medical staff there --
11 A. I remember between the nurses, we knew, we recognised
12 that there wasn't any of the surgeons there, Mr Makar,
13 we did note it.
14 MR STEWART: You did note it?
15 A. We did note it, it was spoken about between -- I know
16 Sister Millar and myself noticed it.
17 Q. I would have thought you must have sat there feeling
18 pretty isolated. All the doctors who were supposed to
19 be in charge and looking after Raychel weren't there,
20 and there you were being cross-examined about what
21 happened to her?
22 A. We were there to give whatever input we could to
23 determine what had happened to Raychel and what had gone
24 wrong. I don't think we were there feeling that we were
25 being cross-examined. We were there to just give a full

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1 and frank idea of what had happened and the events of
2 the night.
3 Q. Yes, because really the big question must have been how
4 could it have been that a patient deteriorated on the
5 ward in front of nurses to the extent where she
6 collapsed and died. That must have been the big
7 question: what happened?
8 A. Yes.
9 Q. And was that why the nurses then sort of said: well, the
10 doctors weren't there, we couldn't get them?
11 A. Well, when Raychel was -- appeared to settle, to go to
12 sleep, her vomiting had appeared to become less, and
13 I felt Raychel was starting to settle, as in my
14 experience previously I had noted children who had
15 previously vomited for a good few times during the day
16 who had also been on IV fluids, the same IV fluids,
17 Solution 18, and who once they'd got a first night over
18 post-operatively had recovered. This was the first
19 time, in my experience, that I had ever encountered
20 anything like this. And it appeared that Raychel was
21 settling because the wee girl went to sleep. And
22 I would not have chosen to go and disturb her thinking
23 that she had finally found a bit of rest and she was
24 going to sleep.
25 But we continually monitored the patients throughout

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1 the night, both myself and Nursing Auxiliary Lynch,
2 whenever the other girls were going on breaks, we always
3 did a ward round and you made -- you looked at the
4 patients to see if they were sleeping, and appeared to
5 be sleeping comfortably, and up until that time Raychel
6 did appear to be settled and sleeping.
7 THE CHAIRMAN: Let me go along with you on that. That must
8 have made it all the more shocking for you --
9 A. We were in total shock. Total shock.
10 THE CHAIRMAN: When you went into this meeting -- I mean,
11 this meeting was called the critical incident review,
12 and it's to review what had happened; is that right?
13 A. Mm-hm.
14 THE CHAIRMAN: So you walk into a meeting and for the most
15 part the nurses are there, but there's a shortage of
16 doctors.
17 A. Mm-hm.
18 THE CHAIRMAN: Well, at what point did you -- you said a few
19 moments ago that you and Sister Millar acknowledged that
20 or noted that. Was that after the meeting you were
21 saying it to each other or was it before -- or, sorry,
22 during the meeting?
23 A. I can't remember, it was probably during it, and I think
24 somebody had told us that Dr Curran was just a locum
25 doctor, and that's why he wasn't able to come.

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1 I remember somebody saying something along those lines.
2 THE CHAIRMAN: Okay. Apart from trying to work out what had
3 happened for the benefit of the hospital and for the
4 benefit of the Fergusons, you would want to know
5 yourself what had gone wrong, wouldn't you?
6 A. Yes. Well, I was aware that her sodium had dropped to
7 118 and that was entirely significant.
8 THE CHAIRMAN: Right. Okay.
9 MR STEWART: It would have been significant as opposed to
10 settling down to sleep, she was actually restless again,
11 wouldn't it?
12 A. She became restless in that she seized.
13 Q. No, no, this is at 12.30.
14 A. Oh, 12.30.
15 Q. Yes. Restless again. That was significant?
16 A. Well, up until then I didn't think it was significant.
17 Q. Tell me, at the time, when you go on breaks, when you
18 take a break, how long do you go away for?
19 A. At night-time, the first break would have been 45
20 minutes.
21 Q. And subsequent breaks?
22 A. Subsequent breaks, on night duty you may have got
23 a break, you may not have got a break. It depended on
24 the amount of admissions and whether you could
25 facilitate somebody going off the ward, and we didn't

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1 leave the ward, we usually had a cup of tea in the
2 kitchen.
3 Q. On this particular occasion you were away for an hour
4 and a half?
5 A. Yes, uh-huh.
6 Q. And that particular evening, the nurses on that shift
7 was yourself and Nurse Auxiliary Lynch?
8 A. That's right.
9 Q. I take it that an auxiliary is not a qualified
10 children's nurse.
11 A. That's right.
12 Q. And you are not either?
13 A. No.
14 Q. So when you're on duty, you and Nurse Auxiliary Lynch,
15 neither of you are qualified children's nurses?
16 A. No.
17 Q. And when you were off duty, who was there,
18 Nurse Patterson?
19 A. Nurse Gilchrist and Nurse Bryce, and there was another
20 area in Ward 6, the infant area --
21 Q. Yes.
22 A. -- and Nurse Patterson, I believe, was in there.
23 Q. That's quite a separate area, isn't it?
24 A. Yes, that's a separate area --
25 Q. A separate handover --

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1 A. We don't get a report on the children in the infant
2 unit.
3 Q. And tell me this, in relation to Nurse Gilchrist's
4 qualifications and those of Nurse Bryce, were they both
5 qualified children's nurses?
6 A. Nurse Gilchrist wasn't a sick children's nurse at that
7 time but Nurse Bryce was.
8 Q. So when, for example, you were away on your hour and
9 a half's break, the only qualified children's nurse on
10 the ward is Nurse Bryce?
11 A. Well, Nurse Patterson was a qualified children's --
12 Q. She's dealing with a different group of patients?
13 A. Yes.
14 Q. So is that a concern that that period of -- it may only
15 be an hour and a half, but it may be the critical hour
16 and a half, is it a concern that really there's only one
17 qualified children's nurse there?
18 A. Well, it wasn't my job to say who -- the sisters made
19 out the off duty and they tried to ensure that there was
20 a sick children's nurse on on every shift. And that's
21 what they did.
22 Q. But when you were on your shift, you were in charge, you
23 weren't a children's nurse, and the auxiliary with you
24 helping you wasn't either. Were you given any training
25 or assessment to assess your fitness for this role?

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1 A. Not formally. But my experience, having been a junior
2 staff nurse for those amount of years previous to, and
3 working along with senior nurses and learning from the
4 knowledge that they would -- imparted to me, I felt
5 fully able to do the job.
6 THE CHAIRMAN: Roughly how many years had you been nursing
7 children?
8 A. About 11 years, 10/11 years at that time. I didn't get
9 a sick children's nurse qualification because it would
10 have meant going to Belfast or going across the water to
11 England to gain a qualification. I had five children.
12 I didn't -- I worked night duty to facilitate that.
13 MR STEWART: I understand. Did you always work nights?
14 A. For the most time when the children were young, yes.
15 Q. If you were on night duty, how can you present yourself
16 for ongoing training or career development or --
17 A. Well, if there was study days that we needed to attend,
18 we were either given time in lieu, we would have come in
19 on our days off, we would have maybe done day duty for
20 a week. I didn't exclusively work night duty. I would
21 have come in for maybe a period of a week, maybe, and
22 did a week or maybe two weeks' day duty.
23 Q. Can I ask you about the staffing levels on Ward 6. Were
24 they a matter of concern at that time?
25 A. No.

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1 Q. Were you aware of there being excessive workloads or
2 unduly taxing workloads?
3 A. I think working in the children's ward is always taxing.
4 You wouldn't have to have a lot of patients, you just
5 need one sick patient to have a very taxing night.
6 THE CHAIRMAN: So the ward could be half empty but it could
7 still be quite taxing?
8 A. Yes, you could have a very busy night. You could have
9 a diabetic child needing a lot of intervention.
10 THE CHAIRMAN: So it's not a numbers issue --
11 A. No.
12 THE CHAIRMAN: -- it depends on what the cross-section is of
13 children who are in that night are?
14 A. Yes.
15 MR STEWART: I want to read a number of things to you to
16 gauge your reaction to them and you can tell us whether
17 or not they're right.
18 This is a letter from Sister McKenna and
19 Sister Millar to Mrs Doherty, who was the clinical
20 services manager at paediatrics. It's at 321-051-004
21 and at 005. This is February 2001, so this is some few
22 months before Raychel's admission.
23 It's signed by Mary McKenna, senior staff nurse, and
24 Sister Millar. It's to do with the situation as it is
25 in Ward 6. It covers a taxing series of incidents, and

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1 then it goes on at the top of page 2 to say:
2 "The situation today is not unique. It appears to
3 be a repetitive cycle of events on the children's ward
4 over the last number of weeks and months."
5 Then the claim is made:
6 "Morale of staff is falling as staff are mentally
7 and physically exhausted, many from working extra hours
8 and they are now frustrated at little apparent
9 improvement in the staffing situation."
10 Do you remember that being the case?
11 A. I worked night duty and there was usually always a full
12 complement of staff on night duty. During the day,
13 whenever there were maybe ward rounds going on and
14 different investigations being carried out which would
15 have resulted in staff having to leave the ward, leaving
16 the ward not as well staffed as it should have been,
17 maybe Sister McKenna and Sister Millar were more aware,
18 but on night duty I know that they did their best to
19 make sure there was a full complement of staff on night
20 duty, and as well as that there was less activity -- on
21 night duty there was less doctors' rounds. You know,
22 our job was to make sure that the children had their
23 medication that the admissions were admitted, that
24 anybody who came in ill was seen to. So the workload
25 wouldn't have been as heavy on night duty, but they

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1 definitely ensured or did their best to ensure that
2 there was a full complement of staff on nights
3 especially.
4 Q. The fact that you were accompanied by an auxiliary
5 nurse, does that mean that somebody had dropped out and
6 the auxiliary nurse was standing in?
7 A. No, it was hard to fit in breaks sometimes and, as
8 I said, I had taken the first of the first breaks and
9 the second -- the first -- the first of the first breaks
10 and my second break together, which was why I was off
11 the ward for an hour and a half at that time, because
12 I tended to be -- I usually would have had maybe a day's
13 work done by the time I'd gone to work and I benefited
14 from taking my two breaks together at the beginning of
15 the night and was then able to work throughout the rest
16 of the night.
17 Q. Okay.
18 A. It was just to facilitate breaks and a lot of the time
19 the staff didn't leave the ward.
20 Q. Well, Staff Nurse McKenna and Sister Millar continue:
21 "This ward is usually divided into four areas, yet
22 some days it is divided into three with one trained
23 member of staff being a named nurse with more than eight
24 patients, and possibly up to 14. We feel this ridicules
25 the ethos of holistic care and we find that we are

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1 practising task orientated care. We are now meeting
2 this challenge annually and we have brought our concerns
3 forward before by writing but unfortunately have not
4 found solutions, and yet we are faced with repeated
5 situations time and time again. I appreciate that
6 you are equally as frustrated as we are, but we are now
7 at the situation where we feel things may be unsafe and
8 staff find it very difficult to cope with the condition
9 which we are now finding ourselves in at present."
10 Can you recall occasions of difficulty coping?
11 A. Sometimes on night duty, yes. Sometimes. But we did
12 our very best. We would have gone without our breaks to
13 facilitate, ensuring that the patients got --
14 THE CHAIRMAN: I'm sure that must be right, but your broad
15 description is you're not saying there was an ongoing
16 regular problem that you were short staffed --
17 A. On night duty. It could have been totally different
18 during the day.
19 MR STEWART: Do you remember any attempts to scrutinise and
20 audit the work of Ward 6, benchmarking exercise,
21 monitoring exercises?
22 A. I just remember that Sister McKenna was frequently going
23 to meetings about benchmarking. I don't know the
24 details of it.
25 Q. Well, there's one of them which was a matter which arose

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1 in November 2000. It's relevant because of its
2 proximity to Raychel's admission. That's at WS323/1,
3 page 45. This is to do with physical needs, and it is
4 in fact the second group of bullet points, dealing with
5 areas that need to be addressed following this audit,
6 which is to do with IV treatment.
7 This seems to be Ward 6 because most of the bullet
8 points refer to children, and the second bullet point
9 notes that an area that needs to be addressed:
10 "Some patients who were on intake/output charts had
11 information missing. Some seven out of 14 were
12 incomplete."
13 Do you have any knowledge of this sort of
14 a benchmarking audit exercise?
15 A. I can't recall it exactly.
16 Q. Do you have any recall of anything being done, measures
17 being put in place, tuition being rolled out for you,
18 that would have addressed the issues of input/output
19 charts and how they were to be filled in?
20 A. Frequently at handovers the importance of maintaining
21 strict intake and output charts would have been
22 reiterated by sisters, and as I said, a lot of this
23 would have happened maybe during the day and at handover
24 at night, especially if sister was communicating, she
25 make sure that she would say, "Look, girls, may be sure

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1 all the intake and output is accurately recorded".
2 Q. When you did those handovers, did you do them walking
3 round the ward beside each individual patient's bed or
4 did you do them at a station?
5 A. We did them in an office. In the nurses' --
6 Q. In the office?
7 A. Yes.
8 Q. Because this self-same benchmarking exercise noted at
9 page 39, WS323/1, page 39, as a negative, number 4
10 there:
11 "The retiring and oncoming nurses in charge do not
12 make walking rounds of the patients together."
13 Was it ever suggested on Ward 6 that it might be
14 a good idea, an improvement to do a walking round
15 together?
16 A. I think it was suggested, but they felt that maybe it
17 was a bit of a breach of confidentiality because the
18 patients weren't in individual rooms and you would be
19 breaching confidentiality if you were in a four-bedded
20 room talking and giving a handover on a patient that
21 another relative of another patient would hear. So it
22 was deemed that it maybe wouldn't be appropriate.
23 Q. It was for that reason that the importance of filling
24 out the notes correctly was stressed?
25 A. In the office, yes, uh-huh.

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1 Q. Because note taking was critical then to communication?
2 A. Yes.
3 Q. Because it was really the only way of communication?
4 A. Yes.
5 THE CHAIRMAN: I don't quite understand. The nursing
6 handover, there was the discussion about doing that by
7 actually walking round the ward doing it, but it was
8 decided not to do that for reasons of confidentiality?
9 A. Mm-hm.
10 THE CHAIRMAN: Is that not how doctors do their ward rounds
11 typically?
12 A. Yes.
13 THE CHAIRMAN: Why would you not do a walking ward round --
14 or how would nurses not do a walking ward round while
15 doctors do? What's the difference in confidentiality?
16 A. I'm not entirely sure. Maybe sometimes a lot of social
17 issues might be discussed with the nurses that the
18 doctors would be made aware of but it would be maybe the
19 nurses' responsibility to check up with social workers
20 were followed up and things like that, so maybe on
21 social --
22 THE CHAIRMAN: Like a non-accidental injury case or
23 a neglect case?
24 A. Yes.
25 THE CHAIRMAN: Okay.

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1 MR STEWART: Just to continue the theme of what was
2 highlighted in November 2000, to page 49 of the same
3 document. WS323/1, page 49. This was a section to
4 evaluate the nursing care objectives, and at the top it
5 says:
6 "This section was the lowest scoring at
7 81 per cent."
8 That seems to be an improvement over the previous 74
9 per cent.
10 It notes:
11 "Patients' notes showed improvement in documenting
12 on parental involvement. However, we were able to see
13 in this section of evaluation what problems happened as
14 a result of not individualising care plans."
15 So this looks like the updated care plan we were
16 looking at a moment ago. Do you recall this being
17 brought to your attention as something which required
18 improvement?
19 A. We're continually to strive to improve communication and
20 documentation, even today.
21 Q. Yes, of course, but do you recall in the months before
22 Raychel's admission whether or not anyone said, "We've
23 got to make an effort here on the episodic care plan, on
24 updating it, on individualising it and on following it?"
25 A. Sisters would have been continually telling you to do

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1 so.
2 Q. And do you recall any particular incident or instance of
3 that?
4 A. I can't recall it exactly. I can't recall.
5 Q. At the bottom of that page, the advice is given to
6 address these issues, staff are now asked to print and
7 revise the actions on the care plan they select after
8 admitting a patient. And that is, I presume, to get the
9 correct care plan for the individual patient?
10 A. Yes.
11 Q. For example, you'd want to get post-operative nausea and
12 vomiting onto your care plan if that was a possibility
13 post-operatively?
14 A. Yes.
15 Q. And it's also recommended that the care plans need to be
16 revised to delete unnecessary material and add in the
17 appropriate ones. This already commenced on the wards,
18 but you can't remember that being specifically
19 addressed.
20 There was also, I think, a junior monitor report,
21 and that was a peer appraisal. Do you remember any
22 occasions when, for example, nurses from other hospitals
23 might come and walk around your ward and the comments be
24 shared?
25 A. No, not on night duty.

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1 Q. Not on night duty. Can I ask you about the meeting with
2 Mrs Ferguson on 3 September 2001. I know that you've
3 already been asked quite a lot about this the last time
4 you were with us.

5 On that occasion, you conceded, in fact perhaps it
6 hadn't been good enough not to tell Mrs Ferguson about
7 some of the deficiencies in the care given to Raychel.
8 You accepted the minutes or the minute of the meeting as
9 accurate.

10 If at that time you had remembered being told that
11 Raychel had suffered confusion, that would have been
12 something that you'd have brought to their attention?

13 A. Yes.

14 Q. Naturally, because it was important. What about the
15 rash, the blotchy rash that was perhaps brought about by
16 vomiting? Was that something which should have been
17 brought to their attention?

18 A. But I felt that that was something that the doctors
19 would have discussed with Raychel, or Raychel's parents,
20 because at the end of the day Raychel had passed away
21 because of her sodium and not because of her rash,
22 secondary to vomiting.

23 Q. You see, I'm going to the minute itself at 022-084-219.
24 You'll see the fourth paragraph down commencing:

25 "Dr McCord said that when he saw Raychel, he was

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1 concerned. Children have fits but Raychel looked
2 unwell. Raychel had a faint rash and when you hear of
3 a rash you immediately think of meningitis."

4 Well, that was an opportunity for you to join in the
5 conversation and say "Yes", and you also think perhaps
6 vomiting because that's what was discussed.

7 A. Well, Dr McCord was the consultant paediatrician.
8 I felt he was better qualified to answer those questions
9 and communicate that to the family. I was there in my
10 capacity as the staff nurse on duty that night, and
11 I was there to answer any questions that the family
12 would have had as to how Raychel had been. There was
13 a consultant paediatrician, a consultant anaesthetist,
14 the chief executive and Sister Millar all there.

15 Q. You see, you were there in your capacity as a staff
16 nurse.

17 A. Yes.

18 Q. And, therefore, you had certain obligations and duties
19 as a registered nurse. Those are set out in the UKCC
20 code of conduct and they're further explained by the
21 guidelines of professional practice.

22 Each clause of the code of conduct begins with the
23 statement that:

24 "As a registered nurse, midwife or health visitor,
25 you are personally accountable for your practice and

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1 in the exercise of your professional accountability
2 must ..."

3 And whatever it is.

4 So I would suggest that you are responsible as
5 a registered nurse for your own actions and you can't
6 simply hide behind somebody else giving a view that
7 perhaps you can differ from, especially when it's to do
8 with telling parents of a child what happened to their
9 child.

10 A. At that time, I felt that the consultant was doing
11 a good job of speaking to Mrs Ferguson, at that time.

12 Q. Can I ask for page 314-003-016 to be shown? This is
13 your UKCC guidelines for professional practice in 1996,
14 which were in force at the time of your meeting with
15 Mrs Ferguson in September 2001, and paragraph 24 under
16 the blunt heading "Truthfulness":

17 "Patients and clients have a legal right to
18 information about their condition; registered
19 practitioners providing care have a professional duty to
20 provide such information. A patient or client who wants
21 information is entitled to an honest answer."

22 Could you have done more to be honest with
23 Mrs Ferguson at that meeting?

24 A. If I had been asked a question by Mrs Ferguson I would
25 have answered it honestly.

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1 Q. When you found Raychel after her collapse, where were
2 you and where was auxiliary nurse Lynch?

3 A. Raychel was nursed in a four-bedded unit in Room I on
4 Ward 6, and on the right-hand side there was a bed near
5 the corridor and there was a bed against the window, and
6 Raychel was in the bed against the window. I was
7 directly opposite administering PR paracetamol to
8 a child. Nursing Auxiliary Lynch was diagonally
9 opposite to Raychel with another child, and the curtain
10 was pulled, and I had heard a bit of rustling of clothes
11 and Nursing Auxiliary Lynch called me to say, "Ann,
12 I think Raychel's fitting".

13 I came out from behind the curtain, went over to
14 Raychel, established she was fitting. Dr Johnson was
15 outside. I alerted him immediately. I had noted in
16 between times that Raychel had become incontinent and
17 when Dr Johnson was there, we had got oxygen on board,
18 and he had instructed me to go and bring drugs to stop
19 her seizure.

20 Q. Can I ask for page 316-085-014. This is back to
21 Sister Little's account of her telephone interview with
22 you. Fifth line down:

23 "Ann attending [perhaps] ..."

24 A. Yes.

25 Q. "... to other two patients. Elizabeth sitting with

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1 Raychel, approximately 3.05 am."
2 Elizabeth Lynch, I take it, sitting with Raychel?
3 A. Elizabeth was not sitting with Raychel.
4 Q. Why would you say -- why on earth would you say she was
5 sitting with Raychel?
6 A. I don't recall telling this Sister Millar -- or
7 sister -- Sister Little.
8 Q. Why would Sister Little record such a thing if wasn't
9 said to her?
10 A. You'll have to ask Sister Little.
11 Q. We certainly will if necessary. Because if --
12 A. I was there that night. I know exactly where Nursing
13 Auxiliary Lynch was. Nursing Auxiliary Lynch was beside
14 another patient who had hydrocephalus and she was
15 sitting with her.
16 Q. Sitting with another patient?
17 A. Yes, she was sitting with another patient.
18 Q. That wasn't the patient you were with?
19 A. No. The patient I was with had her mother with her.
20 Q. When you were thinking about what had happened and when
21 you were working on your statement to go to the coroner,
22 I take it that you and the other nurses would have
23 regularly met to discuss what was happening about the
24 inquest, what was happening about your statements, what
25 you remembered?

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1 A. You mean our statements initially, individually?
2 Q. Yes. And you must have continually updated each other
3 on developments?
4 A. I'm sure we did discuss it, yes.
5 Q. In fact, you must have been discussing the case quite
6 a lot?
7 A. Yes, to establish what had gone wrong.
8 Q. Yes. Were you involved in any subsequent nurses'
9 meetings with Mrs Margaret Doherty, Mrs Witherow?
10 A. I can't recall them. I didn't take minutes of those
11 meetings. I can't recall them.
12 Q. You can't recall?
13 A. I can't recall.
14 Q. Could you have had additional nurses' meetings?
15 A. Possibly. I can't recall them. There was meetings and
16 I can't remember what they were all in relation to.
17 I know that I did attend meetings, yes.
18 Q. All right. Do you remember being interviewed by anybody
19 about this case?
20 A. I don't remember being -- I remember my statement,
21 writing my statement and maybe going over my statement,
22 but I don't remember a formal interview with anybody.
23 Q. All right. Were you telephoned by anybody else or
24 even -- to your recollection?
25 A. Not to my recollection.

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1 Q. Not Sister Little, I mean.
2 A. No, not on my recollection.
3 Q. I want to make reference to a letter written to the
4 coroner himself by the solicitor for the trust. It
5 appears at 160-163-001.
6 This is dated 29 March 2002, so it's nine months
7 after Raychel died. Go to page 003 of that. The second
8 paragraph there is the relevant paragraph:
9 "Another issue ..."
10 This is the trust solicitor writing to the coroner
11 to alert the coroner to what the trust essentially will
12 be saying at the inquest:
13 "... which is of concern to the trust is Dr Sumner's
14 conclusions in page 4 of his report in the comments
15 numbered 2 and 5 that the deceased suffered very severe
16 and prolonged vomiting. This conclusion is strongly
17 disputed by the trust. The nurses who were caring for
18 the deceased during the relevant period have been
19 interviewed in detail about this matter and they are all
20 of the opinion that the vomiting suffered by the
21 deceased was neither severe nor prolonged."
22 What do you say to the proposition that you were
23 interviewed in detail about this matter?
24 A. I don't recall a personal one-to-one interview, being
25 interviewed about that, unless we were -- at the meeting

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1 it was discussed that at that time our experience of
2 post-operative nausea and vomiting. We had seen
3 a patient who had vomited as much, sometimes more than
4 Raychel, and who had recovered uneventfully.
5 Q. You're talking about the critical incident review
6 meeting, are you?
7 THE CHAIRMAN: I'm sorry to interrupt. Mrs Noble, is that
8 not a bit like saying, "I have seen a child who falls
9 3 feet and walks away uninjured and I have seen a child
10 who falls 3 feet and breaks her ankles"? Not every
11 child has the same reaction to the same event --
12 A. No.
13 THE CHAIRMAN: -- isn't that right?
14 A. I appreciate that.
15 THE CHAIRMAN: And some children fall off a wall, rub
16 themselves down, cry a bit, and walk off. Some children
17 never walk again. So when you say "I have seen other
18 children who have vomited as badly if not worse and
19 nothing went wrong", it's not really the question, is
20 it?
21 A. But that's what my experience was at that time with the
22 knowledge that I had at that time.
23 THE CHAIRMAN: Some children may get cancer and recover and
24 some children who get cancer don't.
25 A. Yes.

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1 THE CHAIRMAN: So it's a question of how each child deals
2 with whatever has gone wrong.
3 A. Yes.
4 THE CHAIRMAN: The fact that other children had something as
5 bad or worse and were fine, that doesn't really address
6 the question of -- I mean, that might make it a bit
7 harder to understand Raychel's case, but it means you
8 just have to dig a bit harder to understand what went
9 wrong, doesn't it?
10 A. Yes, I appreciate that now.
11 THE CHAIRMAN: And it also means that you do get worried if
12 a child is vomiting five or six or seven times. I think
13 you gave evidence quite early in -- you gave evidence
14 in February, but it was comparatively early in the
15 sequence of the evidence that we heard until Easter, and
16 some of the later witnesses were saying after the second
17 vomit but certainly after the third you're calling
18 a doctor or you should be calling a doctor because this
19 isn't the way it should be. Right? And we're talking
20 about a girl who, in the morning after her operation,
21 was sitting with her father colouring at a table, but as
22 the day goes on she gets worse, she deteriorates, she's
23 not sitting at the table anymore and she's vomiting and
24 she's vomiting.
25 A. But a doctor was called to give her an anti-emetic and

1 to make an assessment of her. I mean, at the end of the
2 day, Raychel's parents obviously had felt that she was
3 settled enough to feel that they could have gone home,
4 and I, as the nurse in charge that night, felt that she
5 was settling, I felt that the anti-emetic had worked and
6 that her vomit was less in amount and frequency and that
7 she was settling down for the night.
8 THE CHAIRMAN: Well, I think Mr and Mrs Ferguson might say
9 they weren't that reconciled. There's a bit more to
10 Mr and Mrs Ferguson coming backwards and forwards
11 because Mr Ferguson was on the phone to his wife, on the
12 evidence I've heard, expressing his frustration that
13 he wasn't being listened to and she was vomiting, but
14 I've got your general point.
15 MR STITT: If I may, coming in from the Trust perspective
16 rather than a nursing representative, you have said that
17 Raychel was sitting with father at the table in the
18 morning, but she wasn't doing that later in the day,
19 which is obviously a general observation about her
20 status. There was, and I wish I had the reference right
21 in front of me, but I don't, but there is evidence from
22 one of the nurses that at about 6.30 am --
23 THE CHAIRMAN: She walking along the corridor.
24 MR STITT: That's disputed. The family totally dispute
25 that, but it is a piece of evidence.

1 THE CHAIRMAN: Sorry, Mr Stewart.
2 MR STEWART: I'm not entirely clear why you keep telling the
3 inquiry that you were content she was settling and at
4 the same time you made that statement saying she was
5 restless again. Those seem to be inconsistent.
6 A. It was communicated to me by Staff Nurse Bryce that she
7 was becoming restless. I hadn't made the assessment
8 myself. I was going on my break. But when I came back
9 from my break, she had appeared to settle. It wouldn't
10 be unusual for a child to become a wee bit restless. It
11 wouldn't have been unusual, but it is -- when you know
12 what you know now, it is unusual, I do appreciate that.
13 Q. Just to go back to what we were discussing, you say
14 you have no recollection of being interviewed
15 specifically about the vomiting unless, of course, it
16 was the discussion at the critical incident review
17 meeting on 12 June. Is that correct?
18 A. Possibly. I'm not entirely sure what you're trying to
19 get at.
20 Q. The only meeting or the only situation which could
21 approximate to an interview that you underwent or
22 attended was the critical incident review of the
23 12 June. Is that correct?
24 A. Yes.
25 Q. At that meeting you have told the inquiry that it was

1 recognised that because Raychel had been vomiting all
2 day, that the vomiting was severe and prolonged. That
3 was your evidence to the inquiry.
4 A. I'm not sure if it had been -- if I had said that her
5 vomiting was severe and profound at that meeting.
6 Q. We can draw up the transcript evidence of
7 27 February 2013, page 172. Line 6, this is after some
8 debate, and Mr Wolfe puts it to you at line 6:
9 "So just to be clear, it was recognised that because
10 Raychel had been vomiting all day, that that vomiting
11 was severe and prolonged?
12 "Answer: Yes."
13 Now, I seek to explore again. How could it be that
14 the coroner could be informed by the solicitors on
15 behalf of the trust that the nurses had been interviewed
16 and interviewed in detail about the vomiting and that it
17 was neither prolonged nor severe? How could those two
18 things be both correct?
19 A. When I gave that evidence, I had been listening to a lot
20 of evidence about Raychel's vomiting and certainly it
21 was recognised when you hear it put to you that her
22 vomiting was severe and prolonged, but I don't remember
23 it being acknowledged at the critical incident review
24 meeting that her vomiting had been severe or prolonged,
25 because, as I said, both myself and maybe other nurses

1 at that meeting had experienced children who had vomited
2 maybe more and been on the same IV fluid and had
3 recovered uneventfully.

4 Q. That's a different point.

5 THE CHAIRMAN: I'm sorry, Mrs Noble. Let me assume that
6 you're right that there were other children who were on
7 Solution No. 18 and who vomited a lot and recovered.

8 A. Yes.

9 THE CHAIRMAN: That doesn't mean that Lucy on
10 Solution No. 18, vomiting a lot, doesn't have severe and
11 prolonged vomiting. As I understand it, what you're
12 doing is you're drawing a distinction between children
13 who vomit a lot and recover, which had been your
14 experience before, and this girl, Raychel, who vomited
15 a lot and didn't recover. But the difference between
16 them isn't whether they -- the issue that you're being
17 asked about wasn't whether they recovered or not, the
18 issue was the amount of the vomiting.

19 Mr Wolfe's questions to you, and this is an extract
20 from them on the screen, were about whether it was
21 recognised that since Raychel had been vomiting all day,
22 that that vomiting was severe and prolonged, and the
23 answer you gave him was yes.

24 I understand that you didn't understand why it then
25 happened that Raychel didn't survive when other children

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1 did survive, and I entirely understand that, and a lot
2 of the experts have said: with all due respect, that's
3 not something that you should be expected to understand,
4 you might be expected to understand, but you'd expect to
5 see the warning signs of severe and prolonged vomiting.
6 But what that question and answer on the screen indicate
7 is that it was accepted at the 12 June meeting that
8 Raychel's vomiting had been severe and prolonged.

9 Now, is that a misunderstanding on my part? And you
10 understand, I'm distinguishing how much vomiting there
11 was from your shock and distress that Raychel didn't
12 recover?

13 A. I'm just not sure. I'm just not sure.

14 THE CHAIRMAN: Okay.

15 MR STEWART: Did anyone come and interview you about the
16 vomiting?

17 A. I was asked about the coffee-ground vomit.

18 Q. By whom?

19 A. I think it was -- it was Staff Nurse Gilchrist and I had
20 discussed it and I had communicated that at the critical
21 incident review meeting and that we had got a doctor to
22 come and see her. That's as much as I can recall.
23 I cannot go into any exact details about any other
24 conversations I had with anybody else regarding her
25 vomiting, I can't remember them.

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1 Q. Very well. Perhaps this might assist you. This is the
2 minute of the meeting on 3 September at 022-084-218.
3 Right in the middle of the page:

4 "Staff Nurse Noble left Raychel to settle and she
5 felt Raychel needed a rest after vomiting all day."

6 Does that jog your memory?

7 A. Yes, well, she had vomited at various stages throughout
8 the day. I didn't mean by that that she had vomited
9 continually all day. But she'd had episodic vomiting
10 that would have --

11 THE CHAIRMAN: But she'd had regular vomiting through the
12 day.

13 A. Well, episodic vomiting, yes.

14 MR STEWART: In early November 2002, you received a letter,
15 which is 022-017-053, which is from Mrs Brown, the risk
16 management coordinator, asking you -- telling you about
17 the listing of the date for hearing of the inquest,
18 which was to be in November 2002. It was subsequently,
19 as you will recall, adjourned to February 2003.

20 Mrs Brown writes to you to tell you:

21 "Dr Nesbitt and I met with the barrister yesterday."

22 You know who Dr Nesbitt is, he was at that time the
23 medical director of the trust:

24 "The barrister feels that it is important that we
25 counteract the comments made by Dr Sumner, the

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1 independent expert, in relation to the allegation of
2 excessive vomiting. To do this he feels it is important
3 that we bring along the nursing staff. If nursing staff
4 do not attend then it would be difficult for anyone to
5 explain what is meant by the plus plus in the notes and
6 the barrister is endeavouring to get permission from the
7 coroner for the nurses to attend."

8 What did you take from that letter? What did you
9 understand that to mean?

10 A. That the nurses should go along to the meeting to
11 explain the significance of the pluses and the vomiting.

12 Q. That you were to go along to the inquest and give
13 evidence to counteract Dr Sumner's comments? Was that
14 what you understood it to mean?

15 A. Well, to go to the inquest and explain to the coroner
16 whatever -- how we found Raychel's vomits to be.

17 Q. But you were being given a bit of a clue there, weren't
18 you, as to --

19 MR STITT: With respect, Mr Chairman, it couldn't be more
20 clear. I thought it was obvious by now that Dr Sumner,
21 experienced as he is, came to a conclusion based on the
22 notes. The nursing witnesses have given a different
23 view as to the nature and extent of the vomiting.
24 I would have thought it was not only sensible but
25 reasonable to ask the coroner for those witnesses to

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1 come and be tested in the coroner's court.
2 THE CHAIRMAN: That's fine, Mr Stitt. The witness is being
3 asked what she understood from this note.
4 MR STITT: No, the last question, and why I interrupted, was
5 it was being suggested that this witness was either
6 being pressurised or coached, and that was the purpose
7 of counteracting Dr Sumner. The point was to put
8 a balance into the coroner's inquest so that it wasn't
9 just one expert reading notes, but people who had been
10 there throughout the day could give their evidence,
11 which would either be accepted or rejected. It's
12 perfectly acceptable and good counsel's advice.
13 THE CHAIRMAN: It doesn't suggest to me she's being
14 pressurised or coached. I think she's being given
15 a steer, and being given a steer is quite separate from
16 being pressurised or coached.
17 MR STITT: I took it very clearly from the manner in which
18 the question was posed that it was being put in such
19 a way to suggest an attempt was being made to manipulate
20 the evidence.
21 THE CHAIRMAN: Let me tell you, Mr Stitt, I'm the chairman,
22 I didn't take that meaning for a second and I think that
23 this highlights this excessive sensitivity which has
24 been shown today and in correspondence received over the
25 last few days about the opening. Let me just try to

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1 bring it to an end. After Mrs Noble's evidence is
2 finished, perhaps you and your instructing solicitor
3 would have a discussion about this. It's getting rather
4 tiresome.
5 MR STITT: In addition, I did cut down my points because
6 there were so many pejorative comments that were
7 included in the opening.
8 THE CHAIRMAN: Well, I'm not sure if your advocacy is
9 supposed to be helping the trust, let me make it
10 absolutely clear to you that it's not. The idea that
11 this trust cannot accept some unavoidable inevitable
12 criticism at this stage of the inquiry, after the
13 evidence that I heard in February and March, really
14 leaves me very, very worried indeed about what this
15 trust faces up to when it doesn't have days and weeks of
16 evidence at an inquiry.
17 MR STITT: That's not the point, with respect, sir.
18 I accept entirely that there are matters which need to
19 be faced up to. The question to which I objected was
20 the clear implication that this witness was being
21 brought along at the suggestion of a barrister to
22 counteract the evidence of Dr Sumner, when in fact it
23 was nothing more than to put all the evidence into the
24 balance in front of a coroner in open inquest. No more
25 than that.

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1 MR STEWART: I have to say, if my contribution is invited to
2 this debate, this is the most extraordinarily worded
3 letter if it's merely asking a witness to come along to
4 say what she can remember, because it paints a picture
5 in the second part of the letter as to what the positive
6 aspects of the case may be, leading one to conclude that
7 the initial part is may be negative. The positive
8 aspects of this case or what was done afterwards, and
9 Dr Fulton, another very senior doctor and figure in the
10 trust, he'll give evidence in relation to that, and the
11 other positive note is the letter from Dr Campbell,
12 that's the chief medical officer, to Dr Nesbitt, the
13 barrister is keen to exploit this issue.
14 I would suggest that this letter is a bit of a clue
15 to you as to what sort of evidence would be very useful
16 for the trust if it goes along to the inquest.
17 A. At no time did I feel pressurised to change anything or
18 to -- I was there just to give my appreciation for what
19 had happened and my understanding of what her vomiting
20 was. To me, it wasn't -- it was never communicated that
21 we were going to make a difference to things that were
22 already established.
23 Q. I see. You didn't tell the coroner that Raychel had
24 suffered from prolonged vomiting, did you?
25 A. No. Not that I can recall.

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1 MR STEWART: Thank you.
2 THE CHAIRMAN: Thank you very much. Mrs Noble, just remain
3 for a moment. Can I ask you this: had you seen
4 Dr Sumner's report?
5 A. Not at that time, no.
6 THE CHAIRMAN: I am sorry, could you put back up on the
7 screen that note for me, please, just the last exhibit?
8 You see, if you look at paragraph 2:
9 "The barrister feels that it is important that we
10 counteract the comments made by Dr Sumner made in
11 relation to the allegation of excess vomiting."
12 Now, in a sense that note might not make very much
13 sense to you if you do not know what Dr Sumner has said.
14 So even if you hadn't seen the note, do you remember if
15 somebody had explained it to you or somebody had
16 summarised it for you?
17 A. I can't recall.
18 THE CHAIRMAN: Did you know at any stage that the trust had
19 then got another report from Dr Warde in the Republic?
20 A. I can't remember exactly. I honestly can't remember.
21 THE CHAIRMAN: You're aware of it now?
22 A. Yes.
23 THE CHAIRMAN: Right. But you can't recall whether you knew
24 about it before the inquest?
25 A. I can't remember exactly when I came to hear of it.

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1 THE CHAIRMAN: Okay.
2 Mr Quinn, any questions from the family?
3 MR QUINN: Sir, I wonder could I ask through you, sir,
4 whether or not the witness -- well, the inquiry having
5 established one point is that this witness agrees that
6 Raychel was vomiting all day. Now, the word "prolonged"
7 has been used in several pieces of correspondence and in
8 notes, and I would like, sir, through you, to ask the
9 witness, would she consider that vomiting all day would
10 represent prolonged?
11 THE CHAIRMAN: Yes. In other words, distinguishing
12 "prolonged" from "severe", but just doing it bit by bit.
13 MR QUINN: Well, I'm breaking it down into two parts.
14 THE CHAIRMAN: Let's put this fully in context. You have
15 heard the point that Mr Quinn has raised. Let's put it
16 fully in context.
17 This is a girl who was expected on the morning after
18 her operation to be starting to take oral fluids as the
19 day went on, to be eating at some point in the afternoon
20 or early evening, and probably to be discharged the
21 following day, and as she began to drink and as she
22 began to eat, then she'd be taken off the IV; isn't that
23 right?
24 A. Yes.
25 THE CHAIRMAN: You must have done that many times before?

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1 A. Yes.
2 THE CHAIRMAN: But she started vomiting in the morning and
3 she's still vomiting late in the evening. Whatever
4 about the amount of vomiting or whatever about how much
5 she vomited, the volume of it, would you agree that that
6 was prolonged vomiting?
7 A. Over a period of time, yes.
8 THE CHAIRMAN: Okay.
9 MR QUINN: The second point is, given that she was vomiting
10 coffee grounds and had two separate doctors called to
11 give her medication to prevent any further vomiting, and
12 given the concerns expressed by staff about the
13 vomiting, would she then concede that this was severe
14 vomiting?
15 THE CHAIRMAN: I think particularly of the evidence we heard
16 earlier this year that the coffee-ground vomiting is
17 a particularly important sign.
18 A. Yes.
19 THE CHAIRMAN: There's more than one interpretation, but it
20 can be an important indicator?
21 A. Yes.
22 THE CHAIRMAN: In light of that and having to call up
23 doctors twice for anti-emetics, would that be consistent
24 with severe vomiting?
25 A. Yes.

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1 MR QUINN: The third point is that, given that this witness
2 knew all of that before she attended any meetings,
3 before she attended a review meeting or met with the
4 family, would it be correct to say that she must have
5 had in her mind at that stage, immediately after the
6 death, that she was witnessing severe and prolonged
7 vomiting?
8 THE CHAIRMAN: I'm not sure it necessarily follows that
9 that's what she has in her mind. One of the purposes,
10 for instance, of a critical incident review is you do
11 reflect on what's happened.
12 MR QUINN: Yes.
13 THE CHAIRMAN: And you do reflect. But that would be
14 consistent with the answers she gave in February that at
15 the critical incident review meeting it was recognised
16 as severe and prolonged vomiting.
17 A. Mr O'Hara, I felt that Raychel was being treated for her
18 prolonged vomiting and she was given an anti-emetic and
19 that she was on continued IV fluids. That would give me
20 some ...
21 THE CHAIRMAN: I understand. And you thought this treatment
22 has worked before --
23 A. Yes.
24 THE CHAIRMAN: -- and --
25 A. I had no reason to think it wouldn't.

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1 THE CHAIRMAN: Thank you. Okay.
2 Mr Stitt?
3 MR STITT: Yes, Mr Chairman. May I ask you -- I'm going
4 back to the last point that I was involved in the
5 discussion with you and Mr Stewart. I have the original
6 opening at paragraph 347, which is relevant.
7 THE CHAIRMAN: Right.
8 MR STITT: It has been changed as a result of an e-mail
9 sent. I asked one of the ones perhaps to which you took
10 exception.
11 THE CHAIRMAN: I was taking exception to a pattern and
12 course not to an each individual action, Mr Stitt. If
13 this is how Day 1 is going, it's going to be a very long
14 haul over the next few weeks.
15 MR STITT: Mr Chairman, this is the one point where there's
16 obviously been a disagreement. You made one observation
17 earlier when you asked me not to go through every point
18 of a long and detailed opening, and I acknowledged the
19 merit of that immediately. But may I ask you to look,
20 if you would, at paragraph 347 as it was originally.
21 THE CHAIRMAN: I don't --
22 MR STITT: And this is the same letter that we've just
23 looked at that was sent to Staff Nurse Noble. The body
24 is exactly the same, but the wording -- and this is
25 where I'm coming from:

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1 "... was approached to make a statement. She can
2 have been left in little doubt as to what was expected
3 of her by Mrs Brown who wrote ..."
4 And the wording is then the same as the letter
5 that's just been referred to. That is the basis upon
6 which my interruption --
7 THE CHAIRMAN: I'm sorry, is this a question for the
8 witness? The witness is in the witness box now. We'll
9 deal with any submissions or any issues that you want to
10 raise again in a few minutes. Mr Stewart has finished
11 his questions, Mr Quinn has finished his questions.
12 Do you have any questions for Mrs Noble?
13 MR STITT: No.
14 THE CHAIRMAN: Thank you. Mrs Noble, thank you very much
15 for coming back again. You're now free to leave.
16 A. Thank you very much.
17 (The witness withdrew)
18 THE CHAIRMAN: Now, Mr Stitt.
19 MR STITT: We had e-mailed the inquiry team and taken
20 exception to the implication contained in the first
21 sentence of paragraph 347 as in the original opening:
22 "She can have been left in little doubt as to
23 what was expected of her by Mrs Brown."
24 THE CHAIRMAN: Yes.
25 MR STITT: And quite reasonably, the inquiry counsel altered

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1 that and left it in entirely neutral terms.
2 THE CHAIRMAN: Yes.
3 MR STITT: It was noted and that was the end of the matter.
4 The reason for my interjection was Mr Stewart was
5 following up not with the same words but clearly from
6 the same mindset and indicating and making the point, as
7 I saw it, that this witness was effectively being
8 coached, and that's where that came from.
9 I appreciate the reasonableness of the inquiry team
10 in altering 347 after we wrote to them, and I thought
11 the matter had been left at that, but clearly it hadn't
12 been. That, I found, was an unusual sentence to have
13 been included in an inquiry's opening. It's not just
14 a question of semantics, this reflects very strongly
15 against Mrs Brown. Very strongly.
16 THE CHAIRMAN: Right.
17 MR STITT: There is another point while I'm on my feet. It
18 is, sir, one that you drew to my attention just after
19 lunch. It's in relation to the Warde report and the
20 police involvement.
21 You correctly pointed out that in fact there had
22 been a meeting with representatives of various
23 interested parties, and the Warde report and other
24 documents were returned; that was within a few days. My
25 instructions are that the actual meeting itself was

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1 in December -- I beg your pardon, as I had indicated to
2 you, the documents were sent in December,
3 13 December 2004, as I'd indicated originally, but in
4 fact the meeting, my instructions tell me, was on
5 19 May 2005.
6 THE CHAIRMAN: Yes.
7 MR STITT: It wasn't a matter of days, it was five months
8 later. I don't know, and I'm not in a position to draw
9 any conclusions from that, but I just thought that --
10 THE CHAIRMAN: In terms of what? Because at that stage
11 there was no police investigation.
12 MR STITT: No, there wasn't. It was July of the same year,
13 whenever you were written to by the police, saying hold
14 everything --
15 THE CHAIRMAN: Okay, so I was wrong about it being a few
16 days. The correction is in fact it wasn't a few days,
17 it was a number of months. What is the consequence of
18 that correction?
19 MR STITT: I'm not sure what the consequences are. It was
20 important for this reason. I have been asking for
21 instructions this afternoon as to when and what steps
22 the police took to make enquiries of the trust
23 in relation to documentation. I don't have that answer
24 yet, but I thought it only proper, not for any
25 particular purpose, but just to indicate that that

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1 meeting was five months later.
2 THE CHAIRMAN: Thank you. Okay. Unless there's anything
3 more for today, ladies and gentlemen, we'll adjourn
4 until tomorrow morning.
5 Mr Stewart, do we know or do you have a view about
6 the order of tomorrow morning's witnesses? It's
7 Mr Gilliland and Ms Millar.
8 MR STEWART: I assume Mr Gilliland first, but subject to
9 their availability and your direction. I think
10 Ms Millar is available to come back on the Thursday, so
11 it makes sense to do Mr Gilliland first.
12 THE CHAIRMAN: Because Mr Gilliland is coming from his
13 consultant's responsibilities, we'll take him first.
14 MR STEWART: Yes, I'm grateful.
15 THE CHAIRMAN: Thank you very much. 10 o'clock tomorrow
16 morning.
17 (4.10 pm)
18 (The hearing adjourned until 10.00 am the following day)
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