Tuesday, 27 August 2013

(10.00 am)

THE CHAIRMAN: Good morning, ladies and gentlemen. Those of you who are familiar with the history of the inquiry know that what happens as each segment starts is that a detailed written submission is prepared and circulated a week in advance of the opening. That was done last Tuesday. There have been some amendments to it, which I think were circulated yesterday.

What will happen today is that Ms Anyadike-Danes will highlight some of the more important issues which are set out in that opening, and after she has done that we will go on to start hearing the evidence, and we will do that through Mrs Noble. There are bits and pieces of housekeeping to be done, but what I want to do this morning is to allow Ms Anyadike-Danes to deliver the oral highlights of the written opening. We will then take a break and do the housekeeping and hear from Mrs Noble, and then from tomorrow onwards we'll go through the witnesses in the order which is set out in the witness schedule. Mr Stitt?

MR STITT: Mr Chairman, arising out of your observations, we have indicated that we would wish to make some brief responses to the opening. We have done so through some e-mails, and I note the alacrity with which the response

was received from the inquiry team.

I wish to seek your permission to make a short address. I have not provided anything in writing in advance, and the reason for that, sir, is that until sometime late -- more than halfway through Saturday, I was out of the jurisdiction on vacation. I have spent Sunday and Monday looking at the most comprehensive opening which has been prepared and there are some points which I would wish to make. They'll not be lengthy but I do believe they're important, and I will undertake to reduce them to writing in exactly the same form as I would give them orally.

I would say that there was no secretarial back-up on Sunday and the Bar Library was closed on Monday where the secretarial back-up is. That's the logistical reason why the normal protocol of submitting a written suggested opening was not followed on this occasion.

I will be brief, but I would ask, sir, that you seriously consider my application. My clients do think it's important, there are net issues, all it will be is to highlight those issues, it will be reduced to writing and with absolute clarity.

THE CHAIRMAN: I'm envious that you were still on holiday until the weekend. Beyond that, I'm not sure it will be necessary for you to reduce it to writing if we're going

to have it on the transcript, but it's a matter for you.

MR STITT: I thought it would be helpful. That having been said, sir, in my own defence I have spent a considerable amount of August working on this case.

THE CHAIRMAN: Okay. It's not perfect, but I am content if, on your assurance, that these are net issues which you're going to address, rather than anything more fundamental.

MR STITT: This is not a general trawl through the evidence. This is not the time or the place for that.

THE CHAIRMAN: No. I'm content for that to be done.

Mr Quinn?

MR QUINN: On reflection, I think we would like a copy of Mr Stitt's response. Even though it's in the transcript, it's just useful to have his response to compare against the opening that's going to be presented by learned counsel for the inquiry.

THE CHAIRMAN: In that event, if you deliver it after Ms Anyadike-Danes today, Mr Stitt, hopefully we can have that by the close of business on Friday.

MR STITT: Yes.

THE CHAIRMAN: Thank you.

MR QUINN: Thank you, sir.

THE CHAIRMAN: Ms Anyadike-Danes?

MS ANYADIKE-DANES: Thank you very much. Good morning.

Mr Chairman, the investigation into --

THE CHAIRMAN: Sorry, Ms Anyadike-Danes, to interrupt you.

I should have asked, are you appearing for both trusts in this segment? Is this opening on behalf of both the old Altnagelvin, now Western, and the old Royal, now Belfast?

MR STITT: No, I'm Altnagelvin.

THE CHAIRMAN: Right. And you're for Belfast, Mr McAlinden. Do you intend to open or not?

MR McALINDEN: No.

MS ANYADIKE-DANES: The investigation into the governance issues in Raychel's case, and the process and results of which are described in the written opening, Mr Chairman, that you have mentioned, that has all been informed by the investigations not just into Raychel's case but into the cases of Adam, Claire and Lucy, because that has involved the Royal Group of Hospitals trusts in the mid-1990s as well as the 2000, mid-2000s, and also the Sperrin Lakeland Trust from 2000 to the mid-2000s. This has allowed us to look at systems, procedures and approaches there and compare them and contrast them.

An aid to that, Mr Chairman, has been the consolidated chronology that I think I probably first

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So that's clearly going to be an issue.

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

down at the bottom.

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

The role of clinical director was primarily a leadership role within the department, and issues relating to standards of care or poor performance would be directed to the clinical director in the first instance, but it was the medical director who was responsible to the trust for monitoring the quality of medical care at Altnagelvin. As I've said, at the time of Raychel's admission that person was Dr Fulton. He was a consultant dermatologist and his principal responsibilities are set out in his job description.

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

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

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

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

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

MS ANYADIKE-DANES: 312-014-001.

THE CHAIRMAN: Thank you.

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

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

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

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

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

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

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

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

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

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

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

So if I move then to education and training.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Each directorate was required to undertake training

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

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

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

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

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

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

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

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

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

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

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

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

Dr Haynes observes:

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

understand how abnormalities could arise."

Ms Ramsay, who was the nursing expert for the inquiry, has concluded that there just simply was no clear system in place.

Raychel was allocated to Staff Nurse Patterson -- that was her named nurse under that system -- but Staff Nurse Patterson did not provide continuous care for Raychel. Sister Millar has described how on days staff were allocated to designated areas in the ward, and on nights the staff worked as a team for all patients. So that led Margaret Doherty to advise that the named nurse allocation was not totally compliant because of turnover of patients and so forth.

In fact, there was an audit report done on that, which showed that only 83 per cent of patients appeared to have an allocated named nurse on admission, and 84 per cent of those patients had almost no contact with their named nurse during their hospital stay.

Professor Swainson, who's the governance expert for the inquiry, has observed that the concept of a named nurse for a whole episode of care may have resulted in better communication with the parents:

"Even on a single shift, a nurse with responsibility for a child could have resulted in better recognition of the child's deteriorating clinical state."

And we'll go on to see that that pattern of a number of people looking at Raychel, particularly over 8 June when she deteriorated, that was a pattern not just of the nurses but also of the junior doctors.

There are criticisms made also of the computerised nursing care planning system. That's dealt with in some detail in the written opening, so I don't propose to go into that now.

I would like to focus on something that did cause some concern, which is communication between the nursing and medical staff. In fact, communication generally was a matter of concern, so I'm going to look at that in a number of respects. The first, though, is this between the nurses and medical staff.

Dr Jenkins was instructed by the trust in relation to Raychel's case. He gave an interview to that UTV Insight programme on 7 June, When Hospitals Kill. He was asked in the course of that interview what he thought were the great lessons to be learned from Lucy and Raychel's death.

He said:

"Communication is at the heart of so many problems where a doctor makes a judgment as to the treatment of a child and passes that information on, but perhaps doesn't write it down or someone mishears what they say,

and I think the communication and the record keeping, which gives a written record of what a doctor prescribes or the treatment that a doctor wants a child to have, that to me is at the core of this. That is a thing that can best protect our children".

As we have listened to the evidence in the clinical section, one will be able to see just the areas in which that communication was perhaps not as effective as it might have been, and in some cases was totally absent.

In her report to the inquiry -- so if we look now at the governance aspect of that -- Sally Ramsay observed that there were no communication protocols available at the time, and that was shared by Mr Foster, who found evidence of poor, as he termed it, vertical communication between members of the surgical teams.

Sister Millar highlights a situation whereby attempts were made by the nurses to contact the surgical SHO initially, and then the SHO to come and give Raychel some IV anti-emetic for her vomiting. However, they didn't answer their bleeps immediately. And she says that there was difficulty in contacting the surgical doctors as they were in theatre and didn't answer their bleeps, which is a situation that Mr Foster regarded as being very unsatisfactory.

The fact that the doctor responsible for Raychel's

care was not known to the nurses had the result that she was seen by several junior doctors during the day. Well, that might not have been the only reason why she was seen by several junior doctors. As we'll come on to see that seems to have been the system.

Mr Gilliland didn't know the details of his patients who were admitted on the 7th, at least that seems to be the case, and that is also a matter of concern for Mr Foster, and he says suggestive of serious vertical communication problems in the Altnagelvin Hospital.

Dr Makar himself described the confusion as to the identity of the on-call consultant surgeon. Mr Foster says, as he develops his concern about communication:

"There was obviously confused communication between the doctors and nurses, and a mindset that did not seem to accept that a serious problem was occurring."

He says further:

"These were very junior doctors and they did not inform their senior colleagues. As I have mentioned on more than one occasion in my report, the paediatric SHOs must have been present on the ward virtually constantly and I cannot understand why the nursing staff did not speak to them."

Well, we know that they spoke to at least one, which was Dr Butler, who changed Raychel's IV bag at about

midday.

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

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

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

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

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

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

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

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

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

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

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

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

He points out:

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

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

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

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

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

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

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

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

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

Then to move to clinical protocols.

The responsibility for incorporating clinical guidelines into the work of Altnagelvin was written into the written terms of clinicians' employment. Examination of the clinical issues arising from Raychel's case has drawn attention to the absence in 2001 of written clinical guidelines or protocols in a number of these respects, Mr Chairman, which you might consider to be quite important in relation to Raychel's case.

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

Clarifying medical responsibility for surgical cases on paediatric wards.

Decision to operate on children at night.

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

Supervision and management of post-operative children.

Prescription of intravenous fluids in post-operative children.

Managing intravenous fluids.

Post-operative measurement of serum electrolytes.

Effective patient handovers.

Post-take ward rounds.

Management of post-operative nausea and vomiting.

Discharge of children from hospital or the transfer of patients between hospitals.

And the making of records and/or record keeping for staff above JHO level.

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

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

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

operate.

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

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

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

Mr Gilliland has acknowledged that the NCEPOD

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

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

services in Northern Ireland, which made the recommendations that there should be adherence to the NCEPOD recommendations concerning the supervision of junior anaesthetic and surgical staff.

THE CHAIRMAN: It might be different, mightn't it, if there was any evidence that consideration had been given within Altnagelvin to implementing NCEPOD reports and they decided "we can do A, B and C, but D and E is a bit beyond us at the moment"?

MS ANYADIKE-DANES: That might be the case. In which case, you'd expect to see that recorded somewhere, that they made a conscious decision that: we are not following this recommendation because we have this alternative practice which will deliver the same objectives, or we don't accept those are viable optatives. Something.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: Notwithstanding all of that, immediately following Raychel's inquest Altnagelvin's communications department produced a document entitled "Potential media questions and some suggested answers arising from Raychel Ferguson inquest and our statement".

That document included this as a potential question that Altnagelvin might have to deal with:

"How can the public be sure that there are no other procedures and practices in Altnagelvin that might lead

to this kind of tragedy happening again?"

The suggested answer was:

"The public should be reassured that Altnagelvin practises in accordance with the highest professional standards as required by the various Royal Colleges in the United Kingdom. We constantly audit our work against these standards and ensure we keep up to date with the new developments and new treatment options."

Mr Chairman, whether that claim was warranted ultimately will be a matter for you after the evidence.

Moving to audit, the service agreement for the provision of hospital services between the trust and the board provided that:

"Each specialty will be required to participate in clinical audit on a multidisciplinary basis as appropriate and individual professions will also be required to initiate audit projects in relevant circumstances. Audit projects should be designed to develop suitable guidelines and treatment protocols from which outcomes can be measured."

Dr Parker was the clinical audit coordinator for the hospitals, and the clinical director of surgery and critical care also bore some responsibility for that.

But Dr Parker has advised that he can find no record of any audits initiated following the identification of

clinical risks in Raychel's case:

"I did not receive any correspondence following the critical incident review requesting an audit be undertaken by the audit department. I did not sit on a critical incident review panel."

But he does say, though:

"An individual critical incident review doesn't usually trigger an audit. If there was a suggestion that several cases were similar an audit would have a role to establish the facts."

So it will be a matter for evidence whether the features of Raychel's case, particularly in relation to the responsibility for paediatric surgical cases and also for the provision of fluid management therapy, whether any of those fell within the sort of subject that should have given rise to a critical incident review.

Apart from the critical incident review meeting that actually took place, there's no indication that Raychel's case was examined in the context of a multidisciplinary audit, whether in 2001 or at all for that matter, nor is there any indication that any individual aspect of her care or treatment was subject to audit, and only a limited number of clinical audit committee meeting minutes have been provided to the

inquiry. So they might have happened, but we haven't seen evidence of it yet.

Altnagelvin did perform an audit of fluid balance charts in February 2003. That audit did not extend to Ward 6 because it was said to use different intake/output charts to other wards. So we don't know, but we hope to find out, whether those charts in relation to the children on Ward 6 have been the subject of audit, and if they have, what has been the result.

On 25 March 2002, the then CMO, Dr Henrietta Campbell, wrote to the trust to announce the department's guidelines on prevention of hyponatraemia in children.

She stated:

"It will be important to audit compliance with the guidance and locally develop protocols and to learn from clinical experience."

So we will see the extent to which that requirement was met.

I turn now to medical responsibility for patients. Raychel was admitted under the care of Mr Gilliland, she was an emergency admission for those purposes, but it was his responsibility to oversee her care and be available for consultation and delivery of care as

required.

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

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

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

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

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

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

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

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

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

Dr Johnson observed that:

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

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

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

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

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

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

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

But he felt that:

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

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

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

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

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

interactions between the clinical staff and Raychel.

Then if I pull up 328-004-001. This is a new table that has been prepared. What you see there is it's really focusing on the surgeons because it's the surgical team.

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

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

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

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

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

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

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

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

However, the importance of consultants supervising

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

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

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

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

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

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

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

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

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

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

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

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

And Professor Swainson is of the view that:

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

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

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

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

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

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

The neurosurgeons in Belfast had accepted:

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

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

mention of surgery and the transfer to Belfast.

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

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

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

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

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

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

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

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

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

And Dr Sumner has observed:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And:

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

Then you get to the penultimate step:

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

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

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

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

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

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

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

very important to have had.

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

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

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

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

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

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

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

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

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

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

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

THE CHAIRMAN: Sorry, I see what you mean. Sorry, I misunderstood the sense of it, because we know there was some degree of openness at the meeting?

MS ANYADIKE-DANES: Yes, in fact I think, Mr Chairman, it was proposed there would be minutes taken of it. Then I think there was some disquiet about that, so to encourage free discussion, if I can put it that way, it was decided not to take them.

What one might have thought would happen is that some detailed notes would be made afterwards to get the sense of what the discussion was and so forth. And in fact, so far as we are aware, these two pages, leaving aside another document called the "Action sheet", which I'll come to in a second, these two pages are what exist, so far as Mr Fulton is concerned, from that meeting.

In fact, it's not entirely clear when these were taken. That's part of the problem now, and that was part of Dr Fulton's problem when he was trying to help us with whether a particular person was there or that person's name appeared because that was somebody to whom he spoke afterwards and got part of the chronology from.

But if one looks at 013, these seem to be his notes. He will be taken through, and you have seen them before, Mr Chairman, and it'll be a matter for later on as to

whether in all the circumstances those could be regarded as adequate.

Also an action plan was produced. If we pull down those two sheets and pull up instead 026-011-014. There we are. That's the action sheet.

The purpose of that was to describe the deficiencies identified by members of the review team and, presumably, to identify a way forward. Staff Nurse Noble gave evidence at the review, considered and concluded that there had been excess intravenous fluids administered and a failure to monitor electrolytes.

And Dr Nesbitt reviewed the infusion rate of Solution No. 18 and he felt it was too high for Raychel's weight. However, it's not clear that the notes that you'd seen previously do record that there was excessive fluid, although the failure to monitor might be inferred from item 2 here where it says, "Daily U&E, all post-ops".

Dr Haynes is critical of this, he says that the daily electrolyte essay is required for all children receiving intravenous post-operative fluids and this is merely re-instating something which had clearly, in his view, fallen by the wayside over the years of Altnagelvin:

"... and I suggest that this occurred because of the

lack of consultant ownership of the issues."

So one perhaps might have wanted to know if there was any discussion as to how something that he regarded as so fundamental needed to be part of an action plan.

The deficiencies in record keeping are not directly noted, although one might infer it from item 4, "Monitor urinary output and query vomit", also and 6 "Fluid balance documentation", but it might be noteworthy that only seven months before Raychel's admission, in fact in November 2000, there was a benchmarking exercise of standards of care to examine Altnagelvin's performance against other acute hospitals in Northern Ireland, and the report identified areas that needed to be addressed, some patients who were on intake/output charts had information missing. In fact, seven were incomplete out of 14, and to address these issues, it will be necessary to involve staff and get their suggestions.

Mr Chairman, we'll be endeavouring to find out what actually happened in the light of that because that's an indicator that some improvement might be required, and that, as I say, is happening seven months before Raychel.

Dr Haynes finds it obvious from reading the documents that had been given to him that documentation of fluid balance in the hospital was not of a high

standard prior to Raychel's death. Why that should have been the case in the light of the benchmarking report is something to be further considered.

But if we go to what might have been reflected in the notes of the review meeting from what we have since learnt in the evidence, Sister Millar recalled telling the review meeting:

"I had for some time been unhappy with the system within the hospital for caring for surgical children. There was always a difficulty in getting doctors, there weren't enough of them. I said that I thought it was totally unfair that the nurses had such responsibility for the surgical children. I had spoken about this before and I know I had spoken about it at the sisters' meetings".

Staff Nurse Noble said:

"There should have been more senior doctors responsible for overseeing fluid management of surgical children."

And then Sister Millar again acknowledged:

"It was recognised at the meeting that there was a failure in the documentation. The main issue that was discussed that day though was fluids".

And Staff Nurse Noble conceded -- and this is an important point that she brought out -- that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the vomit that happened.

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

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

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

After the review meeting, Staff Nurse Noble and

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

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

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

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

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

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

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

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

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

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

MS ANYADIKE-DANES: Indeed.

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

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

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

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

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

THE CHAIRMAN: Yes.

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

THE CHAIRMAN: Yes.

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

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

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

In addition to Mrs Ferguson, also present were her

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

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

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

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

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

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

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

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

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

But in fairness to him he says:

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

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

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

Dr Haynes shares the view. He says:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Then:

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

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

Then it goes on, further episode of vomiting, and then the sodium result that you see.

Then, finally, if I just pick up 128. The top bit is going through that BMJ published case. That was a case that was published before Raychel's admission, but leaving that aside, there it identifies:

"Received excessive maintenance fluids."

So it might have -- well, it's a matter to be asked whether any consideration was given to explaining things in that relatively simple way in terms just of the chronology of her case as had been developed there by Dr Nesbitt.

Just then going on to the Altnagelvin -- I'll move on from Altnagelvin to dissemination and move into the CMO's working group.

THE CHAIRMAN: When would be convenient to break?

MS ANYADIKE-DANES: Now, because I was just about to go into something.

THE CHAIRMAN: We'll finish Ms Anyadike-Danes' opening after a 15-minute break. And, Mr Stitt, then hopefully we'll deal with yours. So if Ms Noble is waiting to get on, we'll take her evidence after lunch at about 2 o'clock. I take it Ms Noble is here? Just so that she knows that the way things are going, it'll be 2 o'clock, but we will start Ms noble's evidence at 2 o'clock.

(12.03 pm)

(A short break)

(12.20 pm)

THE CHAIRMAN: Ms Anyadike-Danes.

MS ANYADIKE-DANES: Thank you.

The first point is, how did this issue of Solution No. 18 get into the CMO's working group at all to be part of guidelines?

The reality of it is that very shortly, as I indicated, after Raychel died, the CMO was contacted and was told about Raychel's death. In fact, Dr Fulton has described to the coroner that on 18 June there happened to be a meeting of medical directors. Dr Carson was there, and he was the medical adviser to the CMO, and he described at that meeting the circumstances of Raychel's death.

There were also a number of other anaesthetists present, and the interesting thing is that some of them said that they had heard of similar situations, although it wasn't clear to Dr Fulton whether they were describing fatalities or near misses or incidents of that sort. But in any event, he suggested that there should be regional guidelines. He told the medical directors that it was his opinion that there was evidence that Solution No. 18 was hazardous in

post-operative children.

I'm going to touch on a matter later on as to the extent to which the whole suggestion for guidelines fell on very receptive ears because there were concerns already in the community about the use of it for post-operative paediatric cases. I'll come to that in a minute.

In any event, four days after that, Dr Fulton telephoned the CMO personally and informed her of the death, and he suggested that she should publicise the dangers of hyponatraemia when using low saline solutions, and he said there was a need for guidelines. The CMO at that time was thinking that CREST, who was the regional guidelines group, could do that. What he did do, he, in the form of Altnagelvin, took the matter directly to the CMO and that may prove to have been crucial in how quickly things moved.

It is a matter for you to consider, Mr Chairman, whether the Children's Hospital could have done something rather similar after Adam had died, but in any event, once communication had been made with the CMO, things did seem to move rather quickly.

Dr Fulton raised the matter with Mr Bradley, he was the chief nursing officer for the western area health board. He raised that in mid-June, so that was pretty

quick as well. He also telephoned Dr McConnell, he was the director of public health at the Western Health and Social Services Board, to inform him.

Mr McConnell, of course, would have known from the previous year about Lucy's death and he would have known that the rate of fluid replacement at the Erne was identified as a matter of concern in relation to Lucy's death. Mr McConnell raises the issue at the next meeting of directors of public health on 2 July, which is a meeting to which both the CMO and her deputy attend, and they refer to this death at Altnagelvin, who is Raychel, due to hyponatraemia, caused by fluid imbalance. He says that the current evidence shows that certain fluids are used incorrectly post-operatively and it was agreed that there should be guidelines.

But interestingly enough, even before then, Dr Taylor had been able to advise the Sick Child Liaison Group on 26 June, so that's very quickly after Raychel's death, that work is to take place on agreed guidelines from the Department of Health. So that's what happened.

The CMO set up a regional group to review hyponatraemia and bring forward guidelines. As part of that she sought advice, and Dr Carson responded to that on 30 July.

It's worth looking at this. It's an e-mail,

actually, and the reference for it is 021-056-135.

There we are. It's quite short, but it includes some quite important information. So, first of all, he attaches a document drawn up by Dr Taylor, and I'll go to that in a minute.

But what he says is:

"The document reflects current opinion among experts in the management of these children. However, it does not yet command full support amongst paediatricians."

So there's a distinction there between, one would assume, the anaesthetists who think this is the way forward, if I can put it that way, and some paediatricians who remain unsure.

He gives an explanation for why the paediatricians are unsure, but then he goes on to say:

"The problem today of dilutional hyponatraemia is well recognised."

And he gives a reference to the BMJ editorial:

"... and the anaesthetists in the Children's Hospital would have approximately one referral from within the hospital per month, and there was also a previous death approximately six years ago in a death in Mid-Ulster and Bob Taylor thinks there have been five to six deaths over a ten-year period of children with seizures. There is obviously a need to

get better agreement between anaesthetists, intensivists and paediatricians."

So the split between those who see this as the way forward appear to be the anaesthetists and intensivists, with some of the paediatricians perhaps not.

What we think was the attached document is a two-page document, we can pull that up pretty quickly too. If we could have them alongside each other. 043-101-223 and 224.

There is a bit of manuscript notation on this, which can be addressed during the hearing. I'm not concerned with that at the moment.

If you can see first:

"The dilutional hyponatraemia documented in otherwise healthy children following routine elective surgery."

You can see the class of children at risk, often female, post-operatively, and that, of course, was Raychel.

Then you can see in the third paragraph:

"The sick child."

It talks about how the glucose is metabolised and what the significance of that is, and the loss of fluid from the circulation. Then the ADHD causing the response and the kidneys to retain water.

Then you can see that that all ends up as a double whammy, as he describes it.

The final sentence before one gets into the recommendations:

"Therefore, to prevent hyponatraemia, we must limit the free water component of intravenous fluids and monitor urine output and serum chemistry."

This is what is being described as current opinion, in other words what was already known.

The question is, how, if that's the case, that didn't translate into or was not reflected in Raychel's care at the time. Incidentally, that reference that he talks about in the BMJ, you can see that there on the second page. So that will be considered further, and Dr Taylor is going to come and give evidence.

The result of all of that was that the CMO asked her deputy to assemble a working group to consider hyponatraemia in children, and the group was to make recommendations on the fluid balance in children and it was to be presented to the special advisory committees on surgery, paediatrics and anaesthetics.

It held its first meeting on 26 September. It's not known at this stage how the group was actually selected. If I just pull up the first sheet, you can see who attended. If we pull up 007-048-094.

That is who was there, with apologies from Dr Jenkins. He does participate later on, but he just presumably couldn't be there on that particular date.

You can see where they're from. In terms of the children's cases, who this inquiry is most concerned with, you can see you have got Dr Taylor from the Children's Hospital, Dr Lowry, from Craigavon, that is Conor, Dr Nesbitt obviously, Mr Marshall, he's a surgeon from the Erne Hospital, that's Lucy, of course, and then you see your way down.

But as I say, we don't know how Dr Darragh put together that group. What we do have, though, is an interesting comment from Professor Savage, who was Adam's nephrologist, and he had correctly identified in Adam's case dilutional hyponatraemia, and he writes to Dr Darragh 1 October 2001 expressing concerns, so after the first meeting:

"... that someone in my position only hears about such a group on the grapevine."

In any event, the group that was there had knowledge of hyponatraemia and of Raychel's case and collectively, not individually but collectively, they had knowledge of all the cases that are being scrutinised by this inquiry.

If we pull up something that we prepared to assist

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

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

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

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

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

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

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

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

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

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

to those participating about the other cases --

THE CHAIRMAN: Thank you.

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

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

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

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

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

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

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

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

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

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

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

You'll recall Dr Nesbitt's evidence, and this is what they say. In fact, what they're doing is they're dealing with a part of the opening which deals with Dr Nesbitt's evidence, and what they say is that:

"It is stated that Dr Nesbitt conducted a telephone survey."

Just as it's recorded there, and goes on to say:

"Children's Hospital anaesthetists have recently changed their practice and moved away ..."

Then comes their contribution:

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

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

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

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

In any event --

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

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

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

MS ANYADIKE-DANES: No.

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

MS ANYADIKE-DANES: Yes.

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

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

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

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

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

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

THE CHAIRMAN: Yes. Okay.

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

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

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

The other matter is that, leaving aside --

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

MS ANYADIKE-DANES: Yes.

THE CHAIRMAN: Right.

MS ANYADIKE-DANES: Yes.

THE CHAIRMAN: Thank you.

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

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

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

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

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

Then as to that point, Dr Crean contacted the

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

Then he notes that Dr Crean told him:

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

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

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

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

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

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

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

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

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

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

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

But notwithstanding what was recorded in the

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

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

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

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

from the meeting note.

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

He made clear:

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

opinion their actions did not amount to negligence."

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

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

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

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

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

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

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

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

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

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

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

He did, however, add the observation that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE CHAIRMAN: Thank you very much.

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

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

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

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

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

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

And the conclusion is drawn two lines further down:

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

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

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

222-005-007.

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

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

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

THE CHAIRMAN: But I think he's making that point -- Mr Foster makes that point as an issue about governance rather than as a criticism of doctors Curran and Devlin, doesn't he?

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

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

by almost every other trust, in his opinion.

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

MR STITT: It does.

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

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

THE CHAIRMAN: Thank you.

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

And the conclusion which is reached is:

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

And then this is the important quote, if I may, the second last line of the paragraph:

"Given her lack of visibility to the nursing staff on the wards, Ms Duddy was unable to understand the nursing practices."

So a clear statement there that she had a lack of visibility to the nursing staff on the wards.

The point which I would wish to make is, firstly, it's unreasonable to ask one nurse one question, not the other nurses, just this one nurse, and she says, "I can't remember", and then translate that into a lack of visibility to nursing staff. There's a clear implication that effectively none of or few of the nursing staff were aware of who she was.

The answer came from one nurse and one nurse only. It came also, you will find, at the end of a long session of cross-examination. It relates to a period 12 years earlier, and in all those circumstances I would put forward on behalf of the trust that it is an unreasonable conclusion to reach that there was a lack of visibility to the nursing staff on the wards.

Ms Duddy will give her own evidence.

224.

THE CHAIRMAN: But I'm sorry, it doesn't reach a conclusion. You've just said to me that it's an unreasonable

conclusion to have reached. It doesn't reach a conclusion. It specifically says at paragraph 100 of the opening that this raises the issue. Why do you suggest that something which is specifically raised as an issue is presented as a conclusion?

MR STITT: It raises an issue in the first half of the sentence and then reaches a conclusion of fact in the second half of the sentence. The second half -- I'll read the whole sentence:

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

Your point, sir. And that is also going on to make another point:

"How, given her lack of visibility to the nursing staff on the wards Ms Duddy was able to understand the nursing practices and standards of care on Ward 6."

So whilst it might say it's raising an issue, it's quite clearly landing a blow in the same sentence and saying, "Given her lack of visibility to the nursing staff, how she was able to understand the nursing practices". That's a statement of fact, not it's up to you, sir, to decide what her level of visibility was. It's put there as a given "given her lack of visibility to the nursing staff", and I'm saying that's a conclusion which is raised, and I say it's

a conclusion on the basis of the evidence of one nurse.

If it was going to be such a big point, one would have thought that all the nurses would have been quizzed on the same point and then perhaps the evidence would reflect that eight out of nine nurses didn't know the identity of the director of nursing. But it may well be that the other seven did know her and might well have said she was on the wards every week.

THE CHAIRMAN: Okay.

MR STITT: I ask you, sir, if you would look at paragraph 224. This is the conclusion, which is a reasonable and fair -- and may I also say for the record that it is acknowledged that the opening has got -- a great deal of scholarship and effort has been put into it, which is helpful not only to you but to all the parties. So when I make these points, I acknowledge at the same time the amount of effort and trouble that has gone into composing the document.

Paragraph 224. It's a matter for you, Mr Chairman, to assess the scope and thoroughness of the critical incident review, and it is. Earlier in the section, and I won't rehearse the paragraphs, there are criticisms of the review conducted by Dr Fulton that the proper form wasn't used, the critical incident form wasn't used according to the protocol, and not all the witnesses

were present, the two junior doctors weren't there, and so on, and those are noted. But I think it's only fair to put in balance and ask you to consider in balance at this stage before the evidence is called that the governance inquiry expert, Dr Swainson, at page 226 -- if this could be pulled up -- 226-002-023. I'll read a little of paragraph 78.

Notwithstanding the points which were made, which were critical, and it's obviously up to you, I would ask you to put into the balance this point when considering the case as a whole at this stage:

"The critical review initiated by Dr Fulton was sound. It was important to conduct this quickly so that events were fresh and thus not possible to have everyone concerned attend, but there were sufficient people present to begin the process."

And he continues to make other observations. Paragraph 79:

"Doctors Nesbitt and Fulton moved swiftly to inform colleagues."

I think that's accepted and noted by counsel to the inquiry.

So whilst one can be critical of certain aspects of the inquiry, it's obviously this expert who has been briefed with all the documents and who is the most

recent expert to opine in relation to the inquiry, says the critical review was sound.

256. A very short point. This is the meeting in September with the family, and it says:

"The medical director and the director of nursing were both absent."

I'll deal again with the director of nursing, that's Ms Duddy. There were good reasons why she could not be there, and I haven't had the opportunity yet to discuss this with Ms Anyadike-Danes, but I will do so. But I don't feel in an open forum that it's appropriate, but I will pass on this information to the inquiry as to why she was not there.

THE CHAIRMAN: Okay. Well, that's fine. Could I just say as a general point, over the next few days, because I'm afraid there is an issue about Ms Anyadike-Danes for the next few days, would you communicate and generally would people communicate with Mr Stewart?

MR STITT: Of course. I'll do that as soon as we have our short luncheon interval. It's not a big point.

326. Three lines from the bottom. This is correspondence in relation to the witness statements which were sent by Mrs Brown to the coroner. What happened was witness statements were sent, purportedly sent in late 2001, but -- sorry, early 2002, but did not

arrive.

Then Mrs Brown was approached again by the coroner and she then sent the whole thing again. Three lines from the bottom:

"Unfortunately, the letter enclosing the statements went astray."

And "astray" is highlighted just as a quotation. There's hanging in the air a question mark as to what's happened there.

For the record, I would like this document pulled up. 022-070-170. This is a letter to Mrs Brown from the coroner, dated 5 December 2001. The important point about the date of this letter is two things. One is the date December 2001, and the second is its address, which is Church Road, Newtownabbey, which I believe used to be old Petty Sessions many years ago, which some of us might remember.

So that's where he was at that time.

If the next document could be pulled up, that's 022-054-151.

This is a letter to the coroner with nine statements, it's dated 25 January 2002, so we've moved on obviously a month, six weeks, but the important thing is the address is still the same, Church Road, Newtownabbey. This is what's happened, we believe.

If I may pull up the third and final document, 022-038-099. This is Mrs Brown writing once again to Mr Leckey when she's been told that they've received the statements, there's been a telephone conversation between the two of them, their office:

"I enclose for your attention a complete set of statements already provided to you. I also enclose a copy of my letter. This letter with the original statements appears to have gone astray."

And that's where the quote comes from.

The point being this is a new address this is Victoria street Belfast. And in answer to it's gone astray, the only conclusion which can be reached is that the original statements were posted to Newtownabbey. One would have thought obviously they would be forwarded to Belfast, but that's the best explanation --

THE CHAIRMAN: Somehow gone astray. The most likely explanation is they went astray as the coroner was moving from one office to another?

MR STITT: Yes, exactly, sir. It was left in the air hanging up. It's a small point.

It's suggested at 326 that the list of 13 witnesses is remarkable as it omits all the surgical witnesses to Raychel's post-operative care. Well, in fact, Dr Makar was a surgical doctor and he saw Raychel in the early

hours of the morning. And she also, secondly, tells the coroner in the same correspondence that she is seeking a report from Dr Zafar, who made the note in the morning. He was the surgical SHO and did the ward round. So I think that statement at 326 in the last sentence needs to be balanced by those two references.

349. This deals with the Jenkins report. We know that the Jenkins report -- it says:

"This report may not have met Altnagelvin's requirements because Dr Declan Warde, consultant paediatric anaesthetist, Dublin, was commissioned on 3 December 2002 to prepare an independent report."

So there's a pejorative statement there about the reasons for changing horses, as it were.

But if one looks at paragraph 345, there's reference to counsel's advices of 7 October 2002. It says:

"I would advise a report should be obtained from an independent consultant paediatric anaesthetist who should comment on the management of this case."

Now, Dr Jenkins is a paediatrician and Dr Warde was a paediatric anaesthetist, so there really had been an instruction given or a suggestion given by a colleague that this particular specialty should be involved. This just didn't come up when the Jenkins report came in.

THE CHAIRMAN: No, but what ultimately happened is that the

paediatric anaesthetist's report was not produced to the coroner.

MR STITT: I'm coming to that, but that's a different point. The point is made here that really the sense of the paragraph is that because the trust didn't like the Jenkins report, they commissioned the Warde report. The Warde report had been advised two months, three months before the Jenkins report was received.

THE CHAIRMAN: I get your point, thank you.

MR STITT: 317. This section, 317, 318 and 319 --

THE CHAIRMAN: We're going back now?

MR STITT: I do apologise, sir, it's slightly out of sync. 317 to 319 is essentially a summary of the role of the risk management coordinator, Mrs Brown.

I would ask you simply to -- at 319 there's the last sentence:

"Accordingly, there was potential scope for the duty of the doctor to offer all relevant information to conflict with Mrs Brown's task as RMCO to defend medical negligence claims."

So she has her role, she is the central point, she was involved in most of the respects, not all the respects that are set out, but it's still held up for criticism that there may be a conflict.

I just ask you to consider the report from

Dr Swainson at paragraph 45. He says that this that what she was doing was essentially the same as one would expect in any trust.

THE CHAIRMAN: Yes, but does that answer the point whether there's a potential for conflict? We've had this before with the Royal. Dr Murnaghan ended up in a very, very similar position in the Royal and it's a concern. This may be the way things are done right across the Health Service, but it's a concern that somebody who's responsible, for instance, providing information to the coroner is also the person who's centrally involved in defending or preparing the defence of medical negligence cases.

MR STITT: That is an argument.

THE CHAIRMAN: No, it's a concern. It's not an argument. I'm putting it as a concern.

MR STITT: It's not a concern articulated by Dr Swainson.

THE CHAIRMAN: No.

MR STITT: You will consider this further.

THE CHAIRMAN: Sorry, you continue, Mr Stitt. If we're going to go nitpicking through the opening, saying, "Swainson doesn't agree with this and Swainson doesn't agree with that", it's a pretty unproductive and very unhelpful response to a huge opening on behalf of the inquiry, so let's not go there.

MR STITT: I have made my point. I actually had a much, much longer list of points, and I too, sir, agreed that it would be disingenuous and not a good use of the inquiry's time to lengthen. If some of the points are less attractive to you, sir, that I understand.

Let me move on, if I may, to paragraph 355.

THE CHAIRMAN: That's about the Warde report.

MR STITT: Yes. The sentence six lines down:

"It was not given to the PSNI to assist in police enquiries."

That's potentially an important point, somehow that the police should have been given the Warde report.

It should be put into the balance, and this will be evidence, and it will be given by Mrs Brown, that she liaised with a Detective Cross and provided all documents requested by him. She then sent the Warde report with all the other documents to the inquiry on 13 December 2004, and the Warde report, as we know, has been in the inquiry's possession since then, document number 139.

We've no reason to believe that the inquiry would withhold any documents from the PSNI. Any argument that there can be in relation to privilege, which we've touched on from time to time, is not made in relation to a PSNI investigation, it's to do with civil proceedings.

So there's no question, I would like to make that clear, of an acceptance that there was any attempt to withhold a Warde report from the PSNI. [inaudible] asked for it and it was given, and we knew it was on the public website of the inquiry.

The Warde report issue, I put it no more detailed than that, has been dealt with very thoroughly and in great detail by counsel to the inquiry. The first point, we have an expert report from counsel, Dr Dolan, Dr Bridget Dolan. She has opined in a large number of areas, but may I just ask you to refer in your own time, sir -- I'll just quote two short quotes, paragraph 4.35, and I will set it out in my written summary of these submissions:

"In both Northern Ireland, England and Wales, there is no general statutory or common law duty of disclosure to a coroner."

And in the next paragraph, 4.36:

"There is no duty to provide opinion evidence from third parties who have had at some later stage become appraised of the facts surrounding the death, for example, where healthcare staff learn of facts which led them to suspect medical mismanagement by others or where an expert opinion on the case has been obtained by an interested party prior to the inquest."

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

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

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

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

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

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

THE CHAIRMAN: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

practice in 2001.

THE CHAIRMAN: Yes.

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

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

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

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

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

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

they have been got at.

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

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

for the coroner to find.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

repeats its clear sentiments of sorrow and deep regret in relation to the death of Raychel Ferguson."

The position is that the trust has maintained its position since the inception of the inquiry that liability has not been admitted, but it will read the findings of the inquiry carefully and will respond appropriately to the details of your findings, sir, when they are made. That has been the position which has been articulated more than once in correspondence and more than once in the High Court.

THE CHAIRMAN: I'm sorry, does that mean the trust's position on the High Court litigation is pending while I finish the inquiry and write the report?

MR STITT: Yes.

THE CHAIRMAN: The trust has heard a run of witnesses go through the witness box, one after another, and admit in different ways failing after failing after failing, and it can't make a decision on what to do in the High Court until I write a report about that? I'm sorry, Mr Stitt, that's almost unbelievable.

MR STITT: Well, I'm sorry that it is, sir, but the decision was taken that if this matter is going to inquiry, it will be thoroughly examined and all of the relevant factors will be looked at. It's quite clear that everyone in this inquiry, this section of the inquiry,

has learnt a lot since February of this year and will continue to learn more in the next week or two.

THE CHAIRMAN: Well, let me remind you of something which again in a segment of the inquiry you weren't involved in, we had a witness who was involved from the Royal in Claire's case, and he said in the witness box, in the presence of Mr and Mrs Roberts, that as he walked out of the inquest, he said, either to himself or to somebody else, that "If the Roberts sue, we'll have to admit liability because of what I've just heard at the inquest".

Now, in that case, of course what happened was that the Roberts didn't sue, and the first that they heard that there was any admission of liability or that there would have been any admission of liability wasn't from any communication they ever had with the trust but from a witness at the inquiry describing how he, on hearing the evidence to the inquiry, said "If they come to sue us, we'll have to admit liability because we didn't do an electrolyte test on the morning after Claire was admitted for treatment".

Now, if a senior figure in the Royal could give that indication and make that decision on the basis of what he heard in an inquest, I'm lost as to why the trust is waiting for the end of this evidence and my report.

MR STITT: Might I just say that one of the most recent reports we've had is that from the advisor's consolidated report, and it makes reference to litigation, and it says there's a danger with litigation that it could prevent the proper implementation of steps to improve the system and could hamper lessons being learnt, and it repeats that twice. It doesn't say or make any criticism at any point, none of the advisers make the point adverse to the trust, that liability should have been admitted.

THE CHAIRMAN: Okay. You'll have that in its full form to me in writing on Friday?

MR STITT: Yes.

MR QUINN: Mr Chairman, I just want to make one point which I think is relevant in the case, and that is about the point you made earlier about the public purse being involved and when the reports from Warde and Jenkins are paid for by the Trust why they shouldn't be available to everyone who feels that they have an input into the National Health Service. I also want to make the point for the record that not only --

THE CHAIRMAN: That's how we might feel as users of the National Health Service and as taxpayers, but as a matter of law what Mr Stitt has said is right.

MR QUINN: I totally agree.

THE CHAIRMAN: The concern that I have here, and I might not be the only one here, is if there's an uneasy distinction between the legal position and what should be the position.

MR QUINN: I totally agree. I totally agree they are within their legal rights not to release the report, but when the report is paid for by the public purse it somehow seems wrong from the public perception that that report is not released.

It also brings me to another point that I'll deal with very briefly, and that is the ongoing litigation issue that was dealt with at the end of the opening by the learned counsel to the inquiry. I should put on the record that in fact the refusal of the trust to admit liability in the case that is currently pending under litigation by the Fergusons has driven the public purse now to meet a further requirement, and that is an expert's report dealing with causation and negligence in relation to the death of Raychel. That means that the Fergusons have the benefit of Legal Aid and that the public purse will be put to that expense in going to get that report when, in my view, certainly from what I have heard in the inquiry, that report is unnecessary. And I feel that that's a point that has to be highlighted, given your earlier comment, sir, in relation to the cost

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

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

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

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

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

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

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

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

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

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

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

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

"Raychel was becoming restless again."

A. Mm-hm.

Q. The second version has omitted the word "again":

"Noted that Raychel was becoming restless."

You may think that's just one small word, but it might mean something, and it's been deliberately taken out. Can you tell us how that happened?

A. I have no conscious reason as to why it was taken out or omitted. I can't recall having told anybody to take it out or been instructed by anybody to take it out.

Q. Could you be suggesting that this was done without your knowledge?

A. It was one word. I doubt I would have noticed.

Q. All right. You may remember back to the right-hand side of the screen again, in your first statement you indicated that:

"As I was on my break ..."

In other words, you weren't on the ward.

Go to the left-hand side and you have written:

"And as I was going on my break ..."

Now, either you were on the ward or you weren't.

A. I left the ward at approximately 12.30 and both were written -- both statements were written after the event. I suppose I didn't pay particular attention as to whether I was going or as I was -- had gone on my break.

I honestly ...

Q. Particular attention is paid by you when you made the first statement:

"As I was on my break."

And particular attention must have been made by you when you chose to amend that. I want you to tell me, if you can, why you made that change.

A. I don't recall.

THE CHAIRMAN: You understand the broad point, Mrs Noble? These are not two entirely separate statements.

A. Yes.

THE CHAIRMAN: The language in them is almost identical. Do you understand?

A. Yes.

THE CHAIRMAN: If you look at the right-hand side of the screen, for instance, at the next paragraph:

"At 0300 hours whilst administering medication to a patient adjacent to Raychel."

That's exactly the same as the first line.

A. Mm-hm.

THE CHAIRMAN: So you haven't at some later stage apparently gone off and written out a completely separate, brand new statement. What appears to have happened is that one of your statements -- I think they're both dated 14 June, aren't they?

MR STEWART: Yes.

THE CHAIRMAN: So you have a statement dated 14 June and it has been tweaked.

A. Mm-hm.

THE CHAIRMAN: Let me just put it that way, it's been tweaked. Okay? It may or may not be sinister. It may be innocent. You have just told Mr Stewart you can't recall, is that right?

A. I can't recall it, and I can only assume it may be to make it read better. I'm not sure. I wasn't consciously asked by anybody to change it for any particular reason.

MR STEWART: We move on through the paragraph. In the original version, nurses Gilchrist and Bryce "were dealing with her". On the revised version, nurses Gilchrist and Bryce "were going to attend to her".

This is not accidental.

A. I ...

Q. A moment ago, you agreed with me that if you had been told that Raychel was confused or behaving strangely, you would never have left the ward. You would have attended to that because that was important. Could it be that you heard about this and just went on your break?

A. No.

Q. And because that was not a good thing to do, you had to revise your statement to have you there "I was going on my break", so that any information that came to you was something that you could and would have dealt with because you were there?

A. I would never have made a conscious decision to change anything to make it appear better for myself.

Q. Could you explain then in any way that I can understand how this came about without conscious intention on your part?

A. I can't recall.

Q. The notes that you filled out, the episodic care plan, if we go to 020-027-064. That's a paragraph of 9 June at 0600 hours there "Carry care forward". You brought this forward from an earlier entry on the care plan, and you have written:

"Child continued to vomit and be nauseated. Vomited coffee grounds twice. Doctor contacted. IV Valoid given with effect."

I'm sure you have been taken over this before, but if you were there and she vomited after that was given, why do you write "given with effect"?

A. Because the amount of vomitus was less and she had vomited less frequently. The effect isn't instantaneous with medications, it can sometimes mean that the amount

and frequency becomes less, and I would call that effective in that she didn't continue to vomit.

Q. You would call that effective?

A. Yes.

Q. With effect?

A. Yes.

Q. Then you have written:

"Continued on PR Flagyl."

Whatever that is. Then you have written around 3 am:

"Child was noted to be restless."

Why didn't you write at 12.30 am "child was noted to be restless", because that's what you were informed?

A. I was informed that she was restless, but I had been in the room administering medication to a child adjacent to Raychel, and I could hear her becoming restless and was alerted to that fact by --

Q. I apologise for interrupting you, but I'm asking you why you didn't enter the child was restless or indeed restless again, as you said in the original statement, for 12.30. Was that because you weren't there?

A. Well, because Staff Nurse Gilchrist and Fiona Bryce went to see Raychel and made an assessment of her, and when I came back from my break they told me that Raychel had vomited a mouthful of vomit and appeared to settle.

Q. Why didn't you put that into the --

A. I didn't feel I needed to write that down because she appeared to settle at that time.

THE CHAIRMAN: If you're writing then by 6.00 in the morning, things had gone terribly wrong, hadn't they?

A. Yes.

THE CHAIRMAN: Well, surely at that time if you're writing a note of what has happened and you know things have gone disastrously wrong at 6 am, why not add in the detail, because it may well be that something you did not attach much significance to at 12.30 might actually have been more significant than you'd thought?

A. Well ...

THE CHAIRMAN: Do you see what I mean? When you're doing all this together -- because it's not as if you wrote that note two or three days later, you wrote it within a few hours of the disaster.

A. Uh-huh.

THE CHAIRMAN: So why not put in all the detail?

A. Unless I didn't become -- I didn't realise it at the time, and at 6 o'clock in the morning the events of the night that had gone on previously were still very shocking and I tried to get down the important points, and those were the important points that I felt at that time.

MR STEWART: Of course, at that time, if you had been informed that she was confused and behaving funny, that is something that you would have put in, wouldn't you?

A. Yes.

Q. Absolutely. Can we move on through Sister Little's note of her telephone interview with you to the fourth page of that at 316-085-021. The fourth line from the top, third line down:

"Transferred to treatment room. Blotchy rash over body [something] spots. Query due to vomiting?"

Is that something that you told Sister Little?

A. No, it was something that Dr Trainor, the paediatric registrar, had noticed on Raychel.

Q. So in fact, for Sister Little to record that from you, could well be absolutely accurate because you got it from Dr Trainor?

A. Possibly. I don't recall a conversation.

Q. At the time of transfer to the treatment room, she was up until that stage still on Ward 6. That should have been noted by you in the care plan, shouldn't it?

A. Well, the treatment room is in Ward 6. I didn't think I had to clarify that she was still in Ward 6.

Q. Well, I was asking whether or not you should have written down that she had a rash on her body and whether

or not that might have been due to vomiting? Wasn't that an important thing to put down?

A. Yes. It was just there was so much happening at that time.

Q. I would like to ask you in relation to your statement, the first statement you made or the one that eventually went to the coroner, which is 012-008-100. This is written a couple of days after the critical incident review that you'd attended, which was chaired by the medical director, Dr Fulton.

You have told the inquiry about the number of problems that were identified at that review, and you gave evidence about the failure to assess Raychel's U&Es. You gave evidence about how the review addressed the issue of whether or not excess fluids had been administered, and you gave evidence that the review had indeed discussed and decided that the vomiting had been both prolonged and severe.

Can I ask you why those features of the case, which to your knowledge existed, were not included by you in your statement?

A. Because my experience at the time of children vomiting post-operatively, I had experienced children who had vomited just as much and had recovered uneventfully. That was my experience.

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

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

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

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

Dr Curran, nor Dr Trainor, nor Dr Butler, nor Dr Date. All absent. So it must have been a group of nurses sitting around feeling as though you were being singled out perhaps? Doctors weren't there, you were.

A. It was acknowledged that there was a lack of medical staff there but the consultant paediatrician was there, Dr Nesbitt was there, and Sister Millar was there. Obviously senior personnel.

THE CHAIRMAN: Sorry, when you say it was acknowledged that there was a lack of medical staff there --

A. I remember between the nurses, we knew, we recognised that there wasn't any of the surgeons there, Mr Makar, we did note it.

MR STEWART: You did note it?

A. We did note it, it was spoken about between -- I know Sister Millar and myself noticed it.

Q. I would have thought you must have sat there feeling pretty isolated. All the doctors who were supposed to be in charge and looking after Raychel weren't there, and there you were being cross-examined about what happened to her?

A. We were there to give whatever input we could to determine what had happened to Raychel and what had gone wrong. I don't think we were there feeling that we were being cross-examined. We were there to just give a full

and frank idea of what had happened and the events of the night.

Q. Yes, because really the big question must have been how could it have been that a patient deteriorated on the ward in front of nurses to the extent where she collapsed and died. That must have been the big question: what happened?

A. Yes.

Q. And was that why the nurses then sort of said: well, the doctors weren't there, we couldn't get them?

A. Well, when Raychel was -- appeared to settle, to go to sleep, her vomiting had appeared to become less, and I felt Raychel was starting to settle, as in my experience previously I had noted children who had previously vomited for a good few times during the day who had also been on IV fluids, the same IV fluids, Solution 18, and who once they'd got a first night over post-operatively had recovered. This was the first time, in my experience, that I had ever encountered anything like this. And it appeared that Raychel was settling because the wee girl went to sleep. And I would not have chosen to go and disturb her thinking that she had finally found a bit of rest and she was going to sleep.

But we continually monitored the patients throughout

the night, both myself and Nursing Auxiliary Lynch, whenever the other girls were going on breaks, we always did a ward round and you made -- you looked at the patients to see if they were sleeping, and appeared to be sleeping comfortably, and up until that time Raychel did appear to be settled and sleeping.

THE CHAIRMAN: Let me go along with you on that. That must have made it all the more shocking for you --

A. We were in total shock. Total shock.

THE CHAIRMAN: When you went into this meeting -- I mean, this meeting was called the critical incident review, and it's to review what had happened; is that right?

A. Mm-hm.

THE CHAIRMAN: So you walk into a meeting and for the most part the nurses are there, but there's a shortage of doctors.

A. Mm-hm.

THE CHAIRMAN: Well, at what point did you -- you said a few moments ago that you and Sister Millar acknowledged that or noted that. Was that after the meeting you were saying it to each other or was it before -- or, sorry, during the meeting?

A. I can't remember, it was probably during it, and I think somebody had told us that Dr Curran was just a locum doctor, and that's why he wasn't able to come.

I remember somebody saying something along those lines.

THE CHAIRMAN: Okay. Apart from trying to work out what had happened for the benefit of the hospital and for the benefit of the Fergusons, you would want to know yourself what had gone wrong, wouldn't you?

A. Yes. Well, I was aware that her sodium had dropped to 118 and that was entirely significant.

THE CHAIRMAN: Right. Okay.

MR STEWART: It would have been significant as opposed to settling down to sleep, she was actually restless again, wouldn't it?

A. She became restless in that she seized.

Q. No, no, this is at 12.30.

A. Oh, 12.30.

Q. Yes. Restless again. That was significant?

A. Well, up until then I didn't think it was significant.

Q. Tell me, at the time, when you go on breaks, when you take a break, how long do you go away for?

A. At night-time, the first break would have been 45 minutes.

Q. And subsequent breaks?

A. Subsequent breaks, on night duty you may have got a break, you may not have got a break. It depended on the amount of admissions and whether you could facilitate somebody going off the ward, and we didn't

leave the ward, we usually had a cup of tea in the kitchen.
Q. On this particular occasion you were away for an hour and a half?
A. Yes, uh-huh.
Q. And that particular evening, the nurses on that shift was yourself and Nurse Auxiliary Lynch?
A. That's right.
Q. I take it that an auxiliary is not a qualified children's nurse.
A. That's right.
Q. And you are not either?
A. No.
Q. So when you're on duty, you and Nurse Auxiliary Lynch, neither of you are qualified children's nurses?
A. No.
Q. And when you were off duty, who was there, Nurse Patterson?
A. Nurse Gilchrist and Nurse Bryce, and there was another area in Ward 6, the infant area --
Q. Yes.
A. -- and Nurse Patterson, I believe, was in there.
Q. That's quite a separate area, isn't it?
A. Yes, that's a separate area --
Q. A separate handover --

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

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

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

then it goes on at the top of page 2 to say:

"The situation today is not unique. It appears to be a repetitive cycle of events on the children's ward over the last number of weeks and months."

Then the claim is made:

"Morale of staff is falling as staff are mentally and physically exhausted, many from working extra hours and they are now frustrated at little apparent improvement in the staffing situation."

Do you remember that being the case?

A. I worked night duty and there was usually always a full complement of staff on night duty. During the day, whenever there were maybe ward rounds going on and different investigations being carried out which would have resulted in staff having to leave the ward, leaving the ward not as well staffed as it should have been, maybe Sister McKenna and Sister Millar were more aware, but on night duty I know that they did their best to make sure there was a full complement of staff on night duty, and as well as that there was less activity -- on night duty there was less doctors' rounds. You know, our job was to make sure that the children had their medication that the admissions were admitted, that anybody who came in ill was seen to. So the workload wouldn't have been as heavy on night duty, but they

definitely ensured or did their best to ensure that there was a full complement of staff on nights especially.

Q. The fact that you were accompanied by an auxiliary nurse, does that mean that somebody had dropped out and the auxiliary nurse was standing in?

A. No, it was hard to fit in breaks sometimes and, as I said, I had taken the first of the first breaks and the second -- the first -- the first of the first breaks and my second break together, which was why I was off the ward for an hour and a half at that time, because I tended to be -- I usually would have had maybe a day's work done by the time I'd gone to work and I benefited from taking my two breaks together at the beginning of the night and was then able to work throughout the rest of the night.

Q. Okay.

A. It was just to facilitate breaks and a lot of the time the staff didn't leave the ward.

Q. Well, Staff Nurse McKenna and Sister Millar continue:

"This ward is usually divided into four areas, yet some days it is divided into three with one trained member of staff being a named nurse with more than eight patients, and possibly up to 14. We feel this ridicules the ethos of holistic care and we find that we are

practising task orientated care. We are now meeting this challenge annually and we have brought our concerns forward before by writing but unfortunately have not found solutions, and yet we are faced with repeated situations time and time again. I appreciate that you are equally as frustrated as we are, but we are now at the situation where we feel things may be unsafe and staff find it very difficult to cope with the condition which we are now finding ourselves in at present."

Can you recall occasions of difficulty coping?

A. Sometimes on night duty, yes. Sometimes. But we did our very best. We would have gone without our breaks to facilitate, ensuring that the patients got --

THE CHAIRMAN: I'm sure that must be right, but your broad description is you're not saying there was an ongoing regular problem that you were short staffed --

A. On night duty. It could have been totally different during the day.

MR STEWART: Do you remember any attempts to scrutinise and audit the work of Ward 6, benchmarking exercise, monitoring exercises?

A. I just remember that Sister McKenna was frequently going to meetings about benchmarking. I don't know the details of it.

Q. Well, there's one of them which was a matter which arose

in November 2000. It's relevant because of its proximity to Raychel's admission. That's at WS323/1, page 45. This is to do with physical needs, and it is in fact the second group of bullet points, dealing with areas that need to be addressed following this audit, which is to do with IV treatment.

This seems to be Ward 6 because most of the bullet points refer to children, and the second bullet point notes that an area that needs to be addressed:

"Some patients who were on intake/output charts had information missing. Some seven out of 14 were incomplete."

Do you have any knowledge of this sort of a benchmarking audit exercise?

A. I can't recall it exactly.

Q. Do you have any recall of anything being done, measures being put in place, tuition being rolled out for you, that would have addressed the issues of input/output charts and how they were to be filled in?

A. Frequently at handovers the importance of maintaining strict intake and output charts would have been reiterated by sisters, and as I said, a lot of this would have happened maybe during the day and at handover at night, especially if sister was communicating, she make sure that she would say, "Look, girls, may be sure

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

And whatever it is.

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

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

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

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

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

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

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

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

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

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

"Ann attending [perhaps] ..."

A. Yes.

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

Raychel, approximately 3.05 am."

Elizabeth Lynch, I take it, sitting with Raychel?

A. Elizabeth was not sitting with Raychel.

Q. Why would you say -- why on earth would you say she was sitting with Raychel?

A. I don't recall telling this Sister Millar -- or sister -- Sister Little.

Q. Why would Sister Little record such a thing if wasn't said to her?

A. You'll have to ask Sister Little.

Q. We certainly will if necessary. Because if --

A. I was there that night. I know exactly where Nursing Auxiliary Lynch was. Nursing Auxiliary Lynch was beside another patient who had hydrocephalus and she was sitting with her.

Q. Sitting with another patient?

A. Yes, she was sitting with another patient.

Q. That wasn't the patient you were with?

A. No. The patient I was with had her mother with her.

Q. When you were thinking about what had happened and when you were working on your statement to go to the coroner, I take it that you and the other nurses would have regularly met to discuss what was happening about the inquest, what was happening about your statements, what you remembered?

A. You mean our statements initially, individually?

Q. Yes. And you must have continually updated each other on developments?

A. I'm sure we did discuss it, yes.

Q. In fact, you must have been discussing the case quite a lot?

A. Yes, to establish what had gone wrong.

Q. Yes. Were you involved in any subsequent nurses' meetings with Mrs Margaret Doherty, Mrs Witherow?

A. I can't recall them. I didn't take minutes of those meetings. I can't recall them.

Q. You can't recall?

A. I can't recall.

Q. Could you have had additional nurses' meetings?

A. Possibly. I can't recall them. There was meetings and I can't remember what they were all in relation to. I know that I did attend meetings, yes.

Q. All right. Do you remember being interviewed by anybody about this case?

A. I don't remember being -- I remember my statement, writing my statement and maybe going over my statement, but I don't remember a formal interview with anybody.

Q. All right. Were you telephoned by anybody else or even -- to your recollection?

A. Not to my recollection.

Q. Not Sister Little, I mean.

A. No, not on my recollection.

Q. I want to make reference to a letter written to the coroner himself by the solicitor for the trust. It appears at 160-163-001.

This is dated 29 March 2002, so it's nine months after Raychel died. Go to page 003 of that. The second paragraph there is the relevant paragraph:

"Another issue ..."

This is the trust solicitor writing to the coroner to alert the coroner to what the trust essentially will be saying at the inquest:

"... which is of concern to the trust is Dr Sumner's conclusions in page 4 of his report in the comments numbered 2 and 5 that the deceased suffered very severe and prolonged vomiting. This conclusion is strongly disputed by the trust. The nurses who were caring for the deceased during the relevant period have been interviewed in detail about this matter and they are all of the opinion that the vomiting suffered by the deceased was neither severe nor prolonged."

What do you say to the proposition that you were interviewed in detail about this matter?

A. I don't recall a personal one-to-one interview, being interviewed about that, unless we were -- at the meeting

it was discussed that at that time our experience of post-operative nausea and vomiting. We had seen a patient who had vomited as much, sometimes more than Raychel, and who had recovered uneventfully.

Q. You're talking about the critical incident review meeting, are you?

THE CHAIRMAN: I'm sorry to interrupt. Mrs Noble, is that not a bit like saying, "I have seen a child who falls 3 feet and walks away uninjured and I have seen a child who falls 3 feet and breaks her ankles"? Not every child has the same reaction to the same event --

A. No.

THE CHAIRMAN: -- isn't that right?

A. I appreciate that.

THE CHAIRMAN: And some children fall off a wall, rub themselves down, cry a bit, and walk off. Some children never walk again. So when you say "I have seen other children who have vomited as badly if not worse and nothing went wrong", it's not really the question, is it?

A. But that's what my experience was at that time with the knowledge that I had at that time.

THE CHAIRMAN: Some children may get cancer and recover and some children who get cancer don't.

A. Yes.

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

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

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

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

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

Q. That's a different point.

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

A. Yes.

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

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

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

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

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

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

THE CHAIRMAN: Okay.

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

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

Q. By whom?

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

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

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

Does that jog your memory?

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

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

A. Well, episodic vomiting, yes.

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

Mrs Brown writes to you to tell you:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE CHAIRMAN: Okay.

Mr Quinn, any questions from the family?

MR QUINN: Sir, I wonder could I ask through you, sir, whether or not the witness -- well, the inquiry having established one point is that this witness agrees that Raychel was vomiting all day. Now, the word "prolonged" has been used in several pieces of correspondence and in notes, and I would like, sir, through you, to ask the witness, would she consider that vomiting all day would represent prolonged?

THE CHAIRMAN: Yes. In other words, distinguishing "prolonged" from "severe", but just doing it bit by bit.

MR QUINN: Well, I'm breaking it down into two parts.

THE CHAIRMAN: Let's put this fully in context. You have heard the point that Mr Quinn has raised. Let's put it fully in context.

This is a girl who was expected on the morning after her operation to be starting to take oral fluids as the day went on, to be eating at some point in the afternoon or early evening, and probably to be discharged the following day, and as she began to drink and as she began to eat, then she'd be taken off the IV; isn't that right?

A. Yes.

THE CHAIRMAN: You must have done that many times before?

A. Yes.

THE CHAIRMAN: But she started vomiting in the morning and she's still vomiting late in the evening. Whatever about the amount of vomiting or whatever about how much she vomited, the volume of it, would you agree that that was prolonged vomiting?

A. Over a period of time, yes.

THE CHAIRMAN: Okay.

MR QUINN: The second point is, given that she was vomiting coffee grounds and had two separate doctors called to give her medication to prevent any further vomiting, and given the concerns expressed by staff about the vomiting, would she then concede that this was severe vomiting?

THE CHAIRMAN: I think particularly of the evidence we heard earlier this year that the coffee-ground vomiting is a particularly important sign.

A. Yes.

THE CHAIRMAN: There's more than one interpretation, but it can be an important indicator?

A. Yes.

THE CHAIRMAN: In light of that and having to call up doctors twice for anti-emetics, would that be consistent with severe vomiting?

A. Yes.

MR QUINN: The third point is that, given that this witness knew all of that before she attended any meetings, before she attended a review meeting or met with the family, would it be correct to say that she must have had in her mind at that stage, immediately after the death, that she was witnessing severe and prolonged vomiting?

THE CHAIRMAN: I'm not sure it necessarily follows that that's what she has in her mind. One of the purposes, for instance, of a critical incident review is you do reflect on what's happened.

MR QUINN: Yes.

THE CHAIRMAN: And you do reflect. But that would be consistent with the answers she gave in February that at the critical incident review meeting it was recognised as severe and prolonged vomiting.

A. Mr O'Hara, I felt that Raychel was being treated for her prolonged vomiting and she was given an anti-emetic and that she was on continued IV fluids. That would give me some ...

THE CHAIRMAN: I understand. And you thought this treatment has worked before --

A. Yes.

THE CHAIRMAN: -- and --

A. I had no reason to think it wouldn't.

THE CHAIRMAN: Thank you. Okay.

Mr Stitt?

MR STITT: Yes, Mr Chairman. May I ask you -- I'm going back to the last point that I was involved in the discussion with you and Mr Stewart. I have the original opening at paragraph 347, which is relevant.

THE CHAIRMAN: Right.

MR STITT: It has been changed as a result of an e-mail sent. I asked one of the ones perhaps to which you took exception.

THE CHAIRMAN: I was taking exception to a pattern and course not to an each individual action, Mr Stitt. If this is how Day 1 is going, it's going to be a very long haul over the next few weeks.

MR STITT: Mr Chairman, this is the one point where there's obviously been a disagreement. You made one observation earlier when you asked me not to go through every point of a long and detailed opening, and I acknowledged the merit of that immediately. But may I ask you to look, if you would, at paragraph 347 as it was originally.

THE CHAIRMAN: I don't --

MR STITT: And this is the same letter that we've just looked at that was sent to Staff Nurse Noble. The body is exactly the same, but the wording -- and this is where I'm coming from:

"... was approached to make a statement. She can have been left in little doubt as to what was expected of her by Mrs Brown who wrote ..."

And the wording is then the same as the letter that's just been referred to. That is the basis upon which my interruption --

THE CHAIRMAN: I'm sorry, is this a question for the witness? The witness is in the witness box now. We'll deal with any submissions or any issues that you want to raise again in a few minutes. Mr Stewart has finished his questions, Mr Quinn has finished his questions. Do you have any questions for Mrs Noble?

MR STITT: No.

THE CHAIRMAN: Thank you. Mrs Noble, thank you very much for coming back again. You're now free to leave.

A. Thank you very much.

(The witness withdrew)

THE CHAIRMAN: Now, Mr Stitt.

MR STITT: We had e-mailed the inquiry team and taken exception to the implication contained in the first sentence of paragraph 347 as in the original opening:

"She can have been left in little doubt as to what was expected of her by Mrs Brown."

THE CHAIRMAN: Yes.

MR STITT: And quite reasonably, the inquiry counsel altered

that and left it in entirely neutral terms.

THE CHAIRMAN: Yes.

MR STITT: It was noted and that was the end of the matter. The reason for my interjection was Mr Stewart was following up not with the same words but clearly from the same mindset and indicating and making the point, as I saw it, that this witness was effectively being coached, and that's where that came from.

I appreciate the reasonableness of the inquiry team in altering 347 after we wrote to them, and I thought the matter had been left at that, but clearly it hadn't been. That, I found, was an unusual sentence to have been included in an inquiry's opening. It's not just a question of semantics, this reflects very strongly against Mrs Brown. Very strongly.

THE CHAIRMAN: Right.

MR STITT: There is another point while I'm on my feet. It is, sir, one that you drew to my attention just after lunch. It's in relation to the Warde report and the police involvement.

You correctly pointed out that in fact there had been a meeting with representatives of various interested parties, and the Warde report and other documents were returned; that was within a few days. My instructions are that the actual meeting itself was

in December -- I beg your pardon, as I had indicated to you, the documents were sent in December, 13 December 2004, as I'd indicated originally, but in fact the meeting, my instructions tell me, was on 19 May 2005.

THE CHAIRMAN: Yes.

MR STITT: It wasn't a matter of days, it was five months later. I don't know, and I'm not in a position to draw any conclusions from that, but I just thought that --

THE CHAIRMAN: In terms of what? Because at that stage there was no police investigation.

MR STITT: No, there wasn't. It was July of the same year, whenever you were written to by the police, saying hold everything --

THE CHAIRMAN: Okay, so I was wrong about it being a few days. The correction is in fact it wasn't a few days, it was a number of months. What is the consequence of that correction?

MR STITT: I'm not sure what the consequences are. It was important for this reason. I have been asking for instructions this afternoon as to when and what steps the police took to make enquiries of the trust in relation to documentation. I don't have that answer yet, but I thought it only proper, not for any particular purpose, but just to indicate that that

meeting was five months later.

THE CHAIRMAN: Thank you. Okay. Unless there's anything more for today, ladies and gentlemen, we'll adjourn until tomorrow morning.

Mr Stewart, do we know or do you have a view about the order of tomorrow morning's witnesses? It's Mr Gilliland and Ms Millar.

MR STEWART: I assume Mr Gilliland first, but subject to their availability and your direction. I think Ms Millar is available to come back on the Thursday, so it makes sense to do Mr Gilliland first.

THE CHAIRMAN: Because Mr Gilliland is coming from his consultant's responsibilities, we'll take him first.

MR STEWART: Yes, I'm grateful.

THE CHAIRMAN: Thank you very much. 10 o'clock tomorrow morning.

(4.10 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X