Tuesday, 3 September 2013

(10.00 am)

(Delay in proceedings)

(10.08 am)

THE CHAIRMAN: Good morning. Mr Stewart?

MR STEWART: I call Dr Geoffrey Nesbitt, please.

DR GEOFFREY NESBITT (called)

Questions from MR STEWART

MR STEWART: Good morning. You've been good enough to furnish us with a number of witness statements, being WS035/1, of 20 June 2005; WS035/2, which, although, is dated 28 June 2008, I think is probably 28 June 2013. Would that be correct?

A. The second statement, it is, yes.

Q. WS035/3 of 8 May 2013, and most recently and last week, WS035/4, of 26 August. Are you content that they should be adopted by the inquiry as part of your formal evidence?

A. Subject to a couple of corrections, one of which you've just spotted. I can tell them you now if you like.

Q. If you would, thank you.

A. Some of them are factual corrections and others are just clarification. First is that the statement to the inquiry in 2005, I have recorded on page 5 that Saturday was 8 June, it should be 9 June. That error is repeated

in the police statement. My police statement was actually a repeat of the same statement. That's what they did. They added a few things but in the main it was the same statement as the inquiry, so the repetition of the error there.

In my police statement they record that I was the clinical director, whereas in fact I was medical director by that time. So that's an error, which I only spotted recently as well.

In my second statement to the inquiry, on page 30, in an answer to question 39(a), I have described No. 18 Solution as fifth normal saline in 2.5 per cent glucose, which has I can't explain because everybody knows it's 4 per cent glucose.

THE CHAIRMAN: Page 30?

A. Page 30, it's the answer to question 39(a).

THE CHAIRMAN: Let's just bring it up. Witness statement 035/2, page 30 at 39(a).

A. Yes.

THE CHAIRMAN: Yes.

MR STEWART: It's the second of the blue lines.

A. Yes. So I've got fifth normal saline in 2.5 per cent glucose, No. 18 Solution. That's incorrect, it should be 4 per cent glucose.

Then just related to that, throughout my statements

I have used dextrose and glucose interchangeably. This is a clarification for the inquiry. There's actually no meaningful difference between glucose and dextrose at a molecular level. One is the mirror image of the others. So I think the correct nomenclature now is glucose, but very often us older doctors refer to dextrose, but there's no difference.

And one final factual thing was in answer to question 21, I referenced my letter to Dr Fulton, and the reference is 021-055-134.

Q. Let's just go to the page if we may. That's at WS-035/2, page 18. Which line are you referring to?

A. I'm referring to the reference to the letter to Dr Fulton, and I've referred to it as 021-055-134, but in fact that is a letter that Dr Fulton wrote to Mrs Burnside, and it's on exactly the same subject, but what I was referring to was the letter that he was referring to, which is the one I sent to him, and I've since sent that to the Inquiry and you have a copy of that. But the one I've referred to in question 21 is actually Dr Fulton's letter to Mrs Burnside.

Q. Thank you.

A. Other than that, I think I'm happy.

Q. I'm grateful for that. You've also provided us with a copy of your CV amongst the attachments you enclosed.

That appears at 035/2, page 337. It's the first page.

Can we look at page 339 where we find in the middle of the page a matter relevant to this inquiry, and that is the paragraph starting:

"I have a special interest in paediatric anaesthesia and spent six months training in the Children's Hospital."

When was that training period you spent in Belfast?

A. It was as a registrar and then as a senior registrar, and in my CV they're actually outlined. I haven't quite got that in front of me, but on the CV it says which years I was in the Royal Victoria Hospital and the Children's Hospital.

Q. Yes.

A. So I had two episodes. Most junior doctors' training in the Children's Hospital is three months, but because I was there as a registrar and a senior registrar, I got the six months accreditation.

This was something that came out of a working party in 1999, where you had to have someone that had at least six months in the Children's Hospital to be the anaesthetist with a lead interest. That doesn't mean that they're the anaesthetist who gives all paediatric anaesthesia, but just they have -- there's someone in the department who has at least six months'

experience, and I met that criteria and was the only one in the department that did. So that was the reason that I adopted that role.

Q. Was that something that you were able to carry through into your teaching responsibilities at Altnagelvin?

A. Yes, and I would have gone to updates in Great Ormond Street and brought that back to the department and given a presentation on recent updates on paediatric anaesthesia, and the latest one that was relevant to this time would have been in 2000. I had just come back from Great Ormond Street and gave a presentation to the department on the latest thinking on paediatric anaesthesia, and that was for things like pain relief, resuscitation. There was nothing on fluids, before you ask that question. That's the sort of thing that I did.

Q. As part of --

THE CHAIRMAN: Just for the record, we don't need to bring it up, doctor, but the periods when you worked as a registrar and senior registrar are on page 341, you have set out the months and the years. Thank you.

MR STEWART: As part of a programme of continuing medical education, did you attempt to spread your learning through local groups of anaesthetists?

A. Um ...

Q. I'm referring particularly to -- go back to page 337 of

your CV, membership of learned societies. You note the Association of Anaesthetists of Great Britain and Northern Ireland, Northern Ireland Society of Anaesthetists and, more locally for you in Derry, the Western Area Association of Anaesthetists.

A. Yes. I've gone to meetings with all those associations.

Q. Were you a founder member of the Western Area Association of Anaesthetists?

A. Yes, and I was at the inaugural lecture by Tony Chisakuta in 1998.

Q. That was when he presented a paper which referenced, amongst other things, the Arieff paper and the problem of post-operative hyponatraemic encephalopathy?

A. Well, I looked at the records. I was in the audience when Dr Chisakuta gave his evidence, and he said that he had given that talk, and I can confirm that that is the case, he did give a talk and it was called "An update on paediatric anaesthesia", rather similar to what I've just described coming from Great Ormond Street. And he said that he didn't have the copy of the slides but he talked about the notes that he had made prior to the thing and these were the points he'd raised.

He said that in one of them he talked about hydro-encephalopathy associated with hyponatraemia. I have no record of that. I've looked at -- I'm not

questioning him for a moment. If he says he did that, then he did do that.

I looked at the -- all I have is a record that says there was the meeting. There's no record of who attended or what the meeting was about, just the title, a flyer for the meeting. So I can confirm -- I remember being at the meeting, but I don't remember anything specifically about the danger of No. 18 Solution or the Arieff paper actually being mentioned.

I'm not questioning it, but it wasn't a headline issue certainly. There wasn't a takeaway message from it. I remember just the meeting. That's all.

Q. That's perfectly fair. Can we, for the sake of completeness, just see what Dr Chisakuta said about it. It appears at WS283/3, page 2.

He describes the meeting on 30 September 1998 at the top of the second paragraph:

"The lecture I delivered was on recent advances in paediatric anaesthesia and on a review of the notes I had used to prepare this lecture, under item 5, (d), fluid therapy, the second topic I discussed was the problem of post-operative hyponatraemic encephalopathy discussed in an editorial by Allen I Arieff published in Paediatric Anaesthesia in 1998?

A. As I said, I'm not questioning that. I think

possibly -- it was quite a long presentation, that's possibly a very small part of it.

Q. Yes. I wonder, can I ask you to describe so we may better understand the organisational structures within which you worked in Altnagelvin in 2001, can I ask that a page from the annual report be shown, which is 321-004gj-017.

This, as you can see, is from the 1999/2000 annual report, and this is the surgery and critical care directorate within which you worked at that time. You can see at the top there are three clinical directors, Mr Paul Bateson in surgery and neurology, Mr Sharma in specialist surgery, and yourself as clinical director in critical care with responsibility for anaesthetics, theatres and the intensive care unit.

Within that directorate, how did it work with three clinical directors?

A. Well, Mr Paul Bateson was the lead clinical director, if you like. He was the top man -- I suppose you would call it that -- in the surgical directorate. Within that, the sub-directorates were the specialist surgery one.

THE CHAIRMAN: I think in order to avoid trouble down the line, could you slow down a little bit because the stenographer's going to have to keep up. I'm not

complaining about you moving through the evidence briskly, but the stenographer has to keep up. Okay?

A. There is a directorate structure, and so you have a surgical directorate, medical directorate and then you would have directorates of things like pathology and radiology and so on, service directorates, and anaesthesia is a little bit like one of those service directorates, so anaesthesia and critical care would be like radiology, like pathology in that it serves -- provides a service to surgeons and to my other colleagues.

So within the surgical directorate, you would have a general surgeon, who looks after general surgery, and he's the lead clinician and the specialist surgeons are things like ENT, orthopaedics, ophthalmology, urology, there's lots of ologies, and they're all related to surgery and they're all within the directorate, but because they each have a special interest they're represented by a lead clinician. It sounds a wee bit difficult, but it's not.

MR STEWART: So the lead clinical director here is Mr Bateson. He would report to the board, he would report to the medical director?

A. Yes.

Q. And would you report to him?

A. Yes, but it's not just as hierarchical as that. I mean, there's a little bit of common sense involved. If the thing involves intensive care, I don't necessarily have to go through him, I could go straight to the chief executive or straight to the service manager, whatever the thing was that I was trying to get changed. But I would obviously inform Mr Bateson. We all worked together in theatres, so it's not like there were silos. We all worked together, we knew each other, we were very friendly, actually.

Q. Yes. In Raychel's case, there was obvious surgical and anaesthetic involvement. Why wasn't Mr Bateson involved in the critical incident review as the lead clinical director?

A. I don't know the answer to that. I was asked to come to the clinical incident review and did so. The role that I came in was because I was directly involved with the care. I wasn't the consultant on call, but I was called in because the hospital was extremely busy that night, and I think the reason that I was called by the registrar was because I happened to be the clinical director, so she must have gone "Well, who will I call? I'll call the clinical director", and so I was the first person she called and I was able to come in, and so I did so.

Because I was called in, I obviously had to come to the clinical incident meeting, and that made sense. If I hadn't been the on-call -- if I hadn't been the anaesthetist called in and I was the clinical director, I would have wanted to have come to the clinical incident meeting.

Q. Yes.

A. So from the question you're asking is, why was the surgical clinical director not called, and I suppose looking back on it, that would have been a good idea to do that.

Q. Did you make any report to Mr Bateson of the critical incident review and its conclusions?

A. Not a written report, but I obviously engaged with him because, as I say, we worked together in theatres. So the news of what had happened spread very quickly by word of mouth, and then all the subsequent correspondence that I had with Mr Bateson, so he knew about it, but I didn't formally write to him and say, "Here's what's happened".

Q. And did he ask for any formal briefings or notes from you in writing?

A. No, he didn't. It wasn't that he wasn't interested in it, but he didn't actually ask me for those particular things.

THE CHAIRMAN: If he had wanted to become involved in the critical incident review or the fallout from that, then he certainly had the right to become involved if he wanted to?

A. He'd be most welcome. In fact, he was involved because I wrote to him, I engaged with him and all because of changes that I wanted to make in surgery, so I had to go to the head man, and that was Paul Bateson. But it wasn't so much in writing, it was a verbal communication, it was stopping him in the corridor, it was a daily thing that we did.

MR STEWART: In a sense I'm trying to pursue the structural lines of communication and accountability. In this case, the nurses had an issue with surgical staff attending upon paediatric patients. The nurses didn't seem to have a medical clinical director to whom they could take such an issue because it seems as though Dr Martin, who was dealing with women and children's care directorate, didn't really engage very much with the paediatric department.

A. I think the answer to that is that the clinical services manager played a very important role, so not only do you have a medical -- medically qualified clinical director, but you had a clinical services manager, usually who was a nurse, who worked in conjunction very

closely with the person. So working with Mr Bateson you would have had Joan Hutchinson; she was an ex-nurse. She was a nurse. So I would deal with her. If the nurses had an issue, they would go to Mrs Hutchinson.

Q. The point is that Mr Bateson was a surgeon and he was heading up the surgery directorate and, therefore, there was a direct line for medical matters to come through the nurses to him to go up to the medical director. Whereas in women and children's care any nursing issue went to Mrs Doherty, who was a nurse and reported to Ms Duddy, and it didn't get through the structural conduits communication to the medical director.

A. The only answer I can give you is that at least the clinical director of theatres and intensive care -- or anaesthesia, theatres and intensive care was there, and the nurses can go through me as well as they can through Paul Bateson. But I fully appreciate that Paul Bateson would have been a perfectly legitimate choice to have come to the clinical incident meeting.

There's a danger that the meeting becomes too big. I'm guessing, I just was asked to come to it and I did so, and I wasn't -- I was unaware of who was going to be at that meeting other than the medical director. So had when I into the meeting I just came as I was.

Q. Is there a danger for a review to become too big?

A. I'm just saying in the first instance while you're fact gathering, I think the group that we had certainly fitted the bill. The fact that Mr Bateson wasn't there I don't think materially contributed to the actions that we took afterwards. I'm agreeing with you that he could have come to the meeting and perhaps should have been at the meeting, but it wasn't for me to decide who would be at the meeting. I was asked to come to it and did so.

Q. Were you struck when you looked around that meeting at the absence of the surgical doctors who had attended upon Raychel?

A. Not particularly. I went into the meeting just having come from the weekend with the tragedy having unfolded before me, and my recollection of the meeting is the things that we discussed and the actual people that were sitting around the meeting I'm not so sure about. I know what was in my mind, I know what I was very concerned about, and I know what I talked about, and I know the issues that came out of it. So I know Mr Gilliland was there, I know Dr McCord was there. I think Dr Trainor might have been there.

Q. I don't think so. Dr Makar was there.

A. I'm making things up then. So there's some people that I know were there and I know some of the nurses were

there. Sister Millar certainly was there and Nurse Noble was there. Maybe another nurse.

So I can remember the room, but I wasn't struck particularly by the fact that the surgeons weren't there because, for me, the issue was the resuscitation and the care that she got following the collapse and the surgery, in my mind, had gone uneventfully and then there had been a collapse, and what you needed there was a consultant paediatrician, which we had, and a consultant anaesthetist, which we had, albeit that I wasn't the on-call consultant anaesthetist, but I was nevertheless a consultant anaesthetist.

So we had the expertise there to look after Raychel after the collapse, and that was, for me, the big issue for the meeting. I appreciate there's issues about surgery, looking on down the line. I've listened to what you've been talking about over the last few days so I'm aware of that.

Q. Amongst the anaesthetists, did you have morbidity or mortality meetings in the anaesthetic group?

A. Yes.

Q. Would Raychel's case have featured within such a meeting?

A. Yes.

Q. And did it?

A. Well, I gave -- I gave my presentation at such a meeting. I gave that presentation to everybody, anybody I met.

Q. Yes.

A. I mean, it was all I did.

Q. Yes.

A. So when I -- everybody in the department was told very clearly what had happened to Raychel, and then I formulated a presentation and would have presented that throughout the hospital and elsewhere.

Q. Was this anaesthetic mortality meeting, morbidity meeting, part of a clinical audit committee meeting or how was it organised?

A. It's within the department, each month you would have a meeting that was a mixture of audits that you would do within the department and morbidity/mortality where you would discuss cases where there was learning from things that had happened. It was not always about mortality.

Q. When you say department, do you mean just anaesthesia or do you mean surgery and critical care?

A. That was anaesthesia and -- critical care is intensive care, theatres and the anaesthetic department.

Q. Was this meeting minuted?

A. Very possibly. I don't have minutes of it.

Q. Where would the minutes be?

A. Minutes like that are usually held within the anaesthetic department. I've looked for minutes, it's just it's too long ago. They go back years, but they're not kept for that length of time. That was the problem. So I thought that would be useful to look at, to demonstrate that I had talked about it.
Q. How long are they kept for?
A. I think we went back to 2004. I'm not sure about that date, but --
Q. So you say before 2004 they're missing?
A. Yes. They've probably been shredded or -- it's a space issue in the anaesthetic department.
Q. When might they have been shredded?
A. Well, I don't want to be led into a corner here. I don't know the answer to that. I'm thinking that there must be some way of keeping a space in the anaesthetic department and old documents must be destroyed. I'm guessing. That's pure guesswork.
Q. Would there be any electronic copies of these documents?
A. I don't know the answer to that. I did ask.
THE CHAIRMAN: But, doctor, they wouldn't have been shredded by 2004, would they?
A. No --
THE CHAIRMAN: If Raychel died in June 2001, the documents would not have been shredded by November 2004 when the

Permanent Secretary required Altnagelvin to keep all records which related to Raychel.
A. That possibly is true.
THE CHAIRMAN: So if they were shredded in 2007 or 2008, that doesn't mean that they didn't exist at the time when the call went out from the most senior civil servant in the Department of Health to Altnagelvin to retain everything.
A. That's a very fair point. I have looked for those minutes and can't find them, and what I'm saying is that the earliest ones I can find are 2004.
THE CHAIRMAN: Thank you.
A. That's to my best recollection. I did look for them.
MR STEWART: Is there a shredding machine in the hospital?
A. Yes, there is.
Q. I wonder, can we discuss the issue of Raychel's transfer from Altnagelvin to Belfast. I know you've already described some part of this in your earlier evidence to the inquiry.
A few issues require a bit of clarification. I wonder, could we see WS035/1, page 5. This is your first witness statement, and you describe at the top how you spoke to Raychel's mother in the intensive care unit at Altnagelvin Hospital following the CT scan:
"I think around 10 am on Saturday morning,

9 June 2001."
That's following the second scan, I take it?
A. Yes. There were two scans. I can't recall when it was in relation to the scans.
Q. The second scan was at 8.30 am.
A. Well, it was after the second scan, then.
Q. "I think this was around 10 am on Saturday morning, 9 June. I explained that Raychel's condition was extremely serious and we were unsure as to the reason for her brain swelling, which this scan had revealed. I told her there was possibility that there could have been a bleed into her brain, subarachnoid haemorrhage, and that we had contacted the neurosurgeons in Belfast and were treating as requested. I explained it would be necessary to take Raychel to the Royal Belfast Hospital for Sick Children so the experts in treating her condition could take over her care. I tried to give whatever comfort I could but had to emphasise the situation was extremely serious."
The issue that I want to come to is whether or not at that time, when you spoke to the Fergusons, to Mrs Ferguson, whether you knew that nothing more could be done really for Raychel, whether in Altnagelvin or Belfast, there was no hope for surgery and that you weren't really telling them the full picture?

A. I hear what you're saying and I know that that is the line that the Ferguson family have taken from that. All I can say is that I spoke to Mrs Ferguson, who was obviously distraught, and told her, just as you've read there, that the situation was serious. There was brain swelling, we didn't know why it was, there was a possibility of a bleed. Those were things that I knew from certainly the first scan.
The second scan was to rule out the possibility of an empyema. An empyema is a collection of pus, so an abscess, if you like, and an abscess is something that you would obviously envisage surgery for. So I believe that the second scan ruled out the possibility of the abscess, but the issue of the bleed was still there, and that had not been ruled out because the report actually was not until the next day, I think maybe the 11th, on the Monday. So as far as I knew, there was a bleed.
Now, I didn't discuss surgery at all, I never did with the Ferguson family. But there is an issue that you can -- there are surgical interventions that you can do in a subarachnoid haemorrhage, so it is possible in a subarachnoid haemorrhage to do surgical interventions. One of them is to put in a subarachnoid drain, where you relieve the pressure in the brain, and you can do that through an epidural catheter or a cranial bolt, and

those are things that neurosurgeons can do, and you need an intensive care unit and a neurosurgical unit.

So those are possibilities that were always there, but all I said was it was very serious, the brain swelling we were unsure of the cause, it was possibly a subarachnoid haemorrhage and that we needed to get her to Belfast where the expert care was, and that we had been discussing her care with the neurosurgeons and they were in agreement with what we were doing.

And what we were doing was hyperventilation. Hyperventilation is where you reduce the carbon dioxide levels in the blood and you need to measure those levels, and by that doing that you can shrink the size of the brain, which is exactly what you want to do if the pressure is rising. So that's an interim measure, if you like, as to how you lower pressure, and then you transfer the patient to the neurosurgical unit.

So that's what I was saying to Mr and Mrs Ferguson. I think, listening to Mrs Ferguson's evidence, it's clear that she remembers some of the things that I said to her and doesn't remember some of the other things, and unfortunately, in my experience, this is something that is not uncommon, where you're telling somebody who's in a really bad situation some news and they're not taking on board everything that you say.

So as a medical professional I have seen it before and I have broken bad news before, and I have been in serious situations before with parents, and very often you find that the first blush, if you like, of it is that they haven't taken on board everything and you need to meet them again. And I remember that that was one of the things that was concerning me at the meeting that we held, the clinical incident meeting, that we wanted to speak to the parents. That was one of the things that was missing in this scenario because, having had a disaster, you want to meet them again, often the next day, when they've got more questions and so on.

I think the difficulty was that Raychel had been transferred to the Royal, another jurisdiction, if you like, and we didn't see the parents afterwards. So for me, that was something that was missing. And we were keen -- from the very beginning, we were keen to meet with the family to answer their questions and to help them in whatever way we could.

Q. Let's just go through some of this step-by-step. When the first CT scan was taken at about 6.00 in the morning, Dr Morrison, the radiologist, shared the imaging with the neurosurgeons in Belfast, the Royal Victoria Hospital, and you were there with him and you spoke with the surgeons in Belfast, didn't you?

A. Yes, I did, because they wanted to speak to somebody who would have some experience with intensive care, and I suppose that was the reason. It was a brief conversation with the neurosurgeon.

I have said neurosurgeons, and all I mean there is that the neurosurgeons is like a group of people, but I actually spoke probably to the senior registrar on call, I would imagine. I don't know who it was. I know I've been asked that by the inquiry and I cannot recall who it was, nor can I recall clearly the conversation. But I outlined the history to him, as far as I knew it, given that I'd come in quite late to the event, and explained what we were doing with the hyperventilation and the fluid restriction and all that type of thing.

Q. Yes. You explained it to us at WS035/1, page 2. There we are.

That second main paragraph concludes with the two sentences:

"I spoke with the neurosurgeons in Belfast who were able to view the results concurrently due to image linking. Following this conversation and at the neurosurgeon's request, it was clear that Raychel would need to be transferred ..."

So you contacted the intensive care unit, explained the situation, requested that a bed be organised so that

you could stabilise Raychel.

Then Raychel was taken to the intensive care unit:

"Following discussion of the CT findings with the neurosurgeons in Belfast, a second CT scan enhanced using contrast was performed prior to transfer to the Royal Belfast Hospital for Sick Children. I accompanied Raychel to the CT suite for this second investigation and monitored her condition to ensure her stability. We were all extremely concerned as to the cause of Raychel's brain swelling. One diagnosis suggested by the neurosurgeons had been that possibly a subdural empyema (an area infection) had developed and we hoped that surgical intervention might be possible."

So you were present for the second scan as well.

Did you speak then with the neurosurgeons after the second scan?

A. I don't believe that I did. They requested the second scan and I facilitated it by taking Raychel back to the CT room and looked after her again while that scan was done.

One of the things I did want to point out was that the paraphernalia that comes with a case like Raychel coming down to the CT room is very, very difficult to manage, and my sole responsibility is to look after the patient. So from the anaesthetist's point of view, it's

the care of the patient and particularly airway, and you need to see the CT scan room to understand it, but no one else goes into the CT room because there's radiology, and we stand behind a screen and the patient is remote from you, and there's a long piece of tubing from the ventilator to the patient, and as the patient goes into the CT scanner, there's a real danger that you're going to lose the airway. So from the anaesthetic point of view, you're concentrating 100 per cent on the patient and not on the scan.

Q. Well, you were with her at the CT scan for the second CT scan. You were extremely concerned about what it might show. You had spoken to the neurosurgeons after the earlier CT scan.

Did you not hear what the neurosurgeons said over the link?

A. I believe that I understood there was no empyema, and the empyema was a second thing that we were concerned about.

The first thing we were concerned about was the subarachnoid haemorrhage, and that had not been ruled out, that was still a possibility, and for me that was the thing in my mind that -- I mean, the whole thing about the empyema came because the neurosurgeons wanted an enhanced scan, and actually it showed nothing

compared -- nothing new from the first scan, but it ruled out the fact that it was an empyema, so we knew that that wasn't the case. But we didn't know anything about the subarachnoid haemorrhage not being there. That was actually confirmed on the 11th with Dr McKinstry when he talked to Dr Morrison, and the report was written then and he said that the area of high contrast, or whatever it was, high reflectivity, was just the cerebral oedema.

But at the time, in my mind, having been there for the first scan and hearing what it was, and there was the talk of the subarachnoid haemorrhage, in my mind that's what it was. It was a possibility. I mean, I have already said we didn't know why she had the brain swelling, but certainly a subarachnoid bleed can cause that.

Q. The neurosurgeons in Belfast were being asked specifically to comment on the subarachnoid haemorrhage, weren't they?

A. Not by me.

Q. Do you remember Dr Bhalla being in the room?

A. No. I'm not saying he wasn't in the room, don't get me wrong. For me, the concentration was on Raychel. I remember Dr McCord, and Dr Bhalla may well have been there, I don't remember him.

Q. I wonder if we can bring up Dr Bhalla's evidence to this inquiry. The transcript of 14 March 2013, pages 45 and 46, if they can be shown together.

On page 45, line 20, question to Dr Bhalla:

"Were you aware of the fact that there was a second enhanced CT scan carried out?

"Answer: Of course, yes, I was there along -- and we got the report that the second CT scan confirmed that it was cerebral oedema and there was no haematoma there."

He was there and he seems clear that the report came back there was no haematoma.

A. Well, I don't know what report he's talking about because the report was not written until the 11th. If he's talking about a verbal report --

Q. Yes.

A. -- I didn't hear that. I can't comment on his expertise. If he was there and he says all those things, I'm not saying he's wrong, but I'm telling you that I did not hear that. I was there. My concern was this was a subarachnoid haemorrhage or that was one of the possibilities.

Q. Look at page 46, line 15.

"Question: Was there any discussion, once it could be seen on the CT scan, about what they would do, what

the further treatment for Raychel would be and what her prognosis was?

"Answer: Of course. From the examination as well as the investigation results, it was quite clear that she has a very bad prognosis with dilated fixed pupils.

"Question: What did that mean to you, a very bad prognosis? What does that mean?

"Answer: That means she will not survive."

There was a discussion in that room. Do you remember a discussion?

A. No, I don't.

Q. So you were in the room, you were very concerned, you don't remember haematoma being mentioned by the neurosurgeons, you don't remember what Dr Bhalla does, and you don't remember a discussion.

A. That's correct. I think that it's easy, looking back, knowing what you know, to have that guide your memory. I'm not suggesting Dr Bhalla has done that, but he's been wise after the event here, saying, "Of course we knew, of course we knew". We didn't. I was there, I was a senior consultant and was heavily involved with the treatment. The surgeons were, in my view, in the background there.

THE CHAIRMAN: Sorry, just to get it right. Without confronting Dr Bhalla's evidence or trying to suggest

anything sinister about it, do you think, when he comes to give us his memory about what happened, he's influenced by what happened afterwards?

A. Yes.

THE CHAIRMAN: And as things do happen, perfectly innocently sometimes, people's memories of different events merge or memories are simply wrong.

A. It's a danger. A real danger. I can see it myself when you listen to other people's evidence. It almost affects what you remember yourself, and I have examples of that where I almost changed what I was thinking, but realised that, no, I was right all along.

THE CHAIRMAN: Yes.

A. I can give you that example later on, if you would like. But I do worry that people remember knowing what finally happened. I mean, when we met with the family -- I know we'll be coming to that -- we did say, "Look, looking back on it, in retrospect, you were right, the death most likely occurred in Altnagelvin", and that was an irretrievable situation. But at that time, we had not done brainstem testing, there was no question that it was irretrievable, and we were doing everything in our power to make sure -- so it's easy for someone to say, "Well, of course I knew", when you know what the final result is.

MR STEWART: He's doing something a bit different, he's remembering a discussion, which is a slightly different thing.

He goes on at page 48 of the transcript, and could we see page 48?

Line 10:

"Question: Is that something that was shared? Did other clinicians agree that there really was nothing that could be done surgically?

"Answer: Yes, I think so. As far as I recollect, all of them said she needs intensive care, conservative management."

Was there a discussion about what should be done with her?

A. I think if there was a discussion, it was about the fact that it wasn't an empyema, and the empyema is where I said that you would imagine you'd have direct surgical intervention with -- you know, you'd imagine the scene.

The intracranial bleed can also have a surgical intervention, but it's not the sort of surgery a surgeon would think of. It's the surgery where you are putting a drain in to measure pressure, something like that. So I've talked about that earlier on, so I don't want to repeat that. But there are things you can do surgically for a subarachnoid haemorrhage that are different from

the surgery you would do for an empyema.

So with his surgical hat on, he's thinking "Well, there's no surgery to be done here", but that is not the case because a subarachnoid haemorrhage can have a surgical intervention as well, and I've done that, I've been in theatre when that's been done.

Q. Was there any further discussion with the doctors in Belfast? Was there discussion with surgeons in Belfast at that time?

A. No, there wasn't.

Q. What was the advice coming back from Belfast at that time as to what you should do with Raychel?

A. Well, the advice that I got personally over the phone from the neurosurgeon was to get her to Belfast as soon as possible.

Q. Was that after the first or the second CT scan?

A. I believe the conversation was after the first scan.

Q. What advice were you getting from Belfast after the second scan?

A. I don't recall any advice, but Belfast would have been highly unlikely to have said, "Well, it's not an empyema so don't bring her here". They would not have said that, because the only regional unit in Northern Ireland is the Royal Belfast Hospital for Sick Children intensive care unit. That's the only place a child can

go, and to go there, you have to have an admitting surgeon. So the admitting surgeon would be the neurosurgeon, and the neurosurgeon would still have to take charge of that case even though they might have the view that they've got no surgical expertise to offer. But it's still their patient.

So intensive care doesn't have patients -- the anaesthetists in intensive care don't have patients of their own, it's a shared care. So you never would transfer to another hospital without a surgeon or a physician taking over the overall responsibility for the child, and then the care is shared with the intensivist in that hospital.

If it's the Children's Hospital, it's the only place she can go.

Q. Just so that I'm clear, you were the transferring consultant, taking the decision to transfer her to Belfast, and you don't recall a conversation with Belfast after the second scan as to what they were suggesting you do?

A. No, I don't. I mean, the -- what they said was to hyperventilate the child, and you would do that irrespective of whether it was an empyema or whether it was a subarachnoid haemorrhage, the treatment is the same. So they weren't going to say to me "Well, you

need to alter the treatment here", because the treatment that we were doing was exactly what they wanted.

THE CHAIRMAN: Can I get it clear, doctor? If the advice after the first scan was to transfer Raychel, then was it the Royal who said, "But before you transfer Raychel, we would like to try to see if there is better imaging we can get"?

A. Yes. It was going to -- it was an enhanced scan and it would help their diagnosis. That was all. So they were saying "Well, look, before you leave", I'm putting that in parentheses.

THE CHAIRMAN: I understand.

A. The concept, in terms, if you like was "Before you leave, could you do another scan because that will help us to see if it's an empyema or not".

If it was an empyema, I don't know if I'd be any happier. I wouldn't be happy because I have had experience of that before and the outcome was the same. So a child with an empyema transferred with fixed dilated pupils from the Ulster Hospital to the Children's, I've done that before, and it was a bad outcome, and that was with surgical intervention. So irrespective of what they were saying, it wasn't -- we weren't thinking "Oh, there's great hope here". I wasn't.

THE CHAIRMAN: But we've had a number of witnesses in different cases saying this, but the fact that you had a bad outcome previously doesn't mean that you say, "Well, then, we're not going to transfer a child with the same condition" --

A. No.

THE CHAIRMAN: ?Because at this point you're clutching at any chance.

A. No, I wasn't --

THE CHAIRMAN: I'm just clarifying that. Even if the prospects look very, very poor, you don't give up; is that right?

A. No, and all I'm trying to say there was just because it wasn't an empyema didn't raise my heart in any way, I still knew that she was very seriously ill, and that's really what I tried to convey to Mrs Ferguson in the intensive care unit.

THE CHAIRMAN: Okay.

MR STEWART: Just one or two further matters on this. Can we look, please, at 020-023-049, which is part of the clinical record.

You'll see this is the noting of the CT scan and, from the second line there, you'll see:

"Taken back to the CT scan for the contrast CT scan. No new findings. Neurosurgeons contacted. Nothing

surgical seen on the scan. Not for to [crossed out] but for transfer to RBHSC when bed available."

What does that mean, "nothing surgical seen on the scan"?

A. Well, we're just repeating ourselves. I mean, what it showed was there was no empyema, and again, that's surgical speak because they're saying there's no surgical intervention.

The point I'm making is that just because it's not an empyema doesn't mean you don't transfer, and just because it's not an empyema doesn't mean you can't have a surgical intervention in what I've been talking about, about the drains and so on.

That person who wrote that note is not saying that. What they're saying is the second scan has showed that no surgical intervention is possible.

Q. Could it mean no subarachnoid haemorrhage, nothing surgical?

A. I don't see where it says that.

Q. It simply says, "nothing surgical".

A. That's correct. A lot of people who have subarachnoid haemorrhage, you don't put a drain in. I'm saying it's a possibility to do that, you don't have to do that. You sometimes ventilate them until they stabilise, and then after ten days they go back to theatre and have

a definitive operation to do that clipping of the artery that you might have heard about in subarachnoid haemorrhages.

Q. Looking back now, do you think that there's anything perhaps more you could have said to Mrs Ferguson at that time to save her perhaps the agony of hope?

A. I believe that I was honest and open and truthful with Mrs Ferguson, and it has shocked and saddened me when I read her transcript and listened to her evidence that that's what she took from it. All I can do is reiterate that I said the things that I said to her. I was as sympathetic as possible, but I said it was a very serious situation, and a lot of that goes over the head. It's not the fault of Mrs Ferguson, and it's not my fault either, because you say the thing, and I think you need to say it again, and that opportunity didn't actually come to us when they got the questions and so on afterwards.

Q. Well, after Raychel died, you must have had a number of questions, and you telephoned the hospital in Belfast again, the RBHSC, later that evening or the next day.

A. Yes, I did.

Q. And you spoke to Dr Peter Crean.

A. Yes.

Q. Did you know Dr Crean, was he a colleague or friend of

yours?
A. Yes, I've worked with Dr Crean. My six months in the Children's Hospital, they were all with Dr Crean, and I know him from meetings.
Q. Yes. It's a small, tight-knit community.
A. We're on first name terms, if that's what you're asking.
Q. And did you discuss the case generally?
A. Well, when I rang up on the Sunday, I was enquiring as to what had happened, was there any surgical intervention, was there -- you know, how was Raychel? And the consultant that I spoke to was Dr Crean on that day. Whereas on the previous day it had been, I think, Dr Chisakuta.

When I had transferred Raychel to the Children's Hospital, it was Dr Chisakuta. So when I rang on the Sunday I was half expecting to speak to Dr Chisakuta but, of course, it was a different day and it was Peter Crean.

So I said, "Hello, Peter, I'm enquiring about Raychel", and he told me what we know. And I was completely shocked. Not, you know -- I was surprised because it was so soon that they had confirmed brain death so soon, and I thought, "Well, look, it's a bad prognosis", there's no doubt that was in my mind, that it looked very bad for Raychel, but I was surprised when

he said that. I did not anticipate that he would say that. So when I say in my statement I was shocked by that, I was genuinely taken aback by what he told me and it was upsetting.
THE CHAIRMAN: I'm not quite clear, were you shocked by learning that Raychel was dead or were you shocked by learning that it had all come to an end so quickly?
A. Both, because in my mind I -- I must say, I hang my hat on the subarachnoid haemorrhage. That was what I thought it was. I thought she had a subarachnoid haemorrhage.

And my experience of those is that you ventilate the person, you may put in that dural drain I'm talking about. There are things that you can do. And then a period of time goes by and then there's surgical intervention perhaps, or -- other people do die with subarachnoid haemorrhages. Now, I know that. I'm not completely naive. I know that people die. I wasn't anticipating that Raychel would. And again, I know that the family have the view that I knew from day one, hour one, that there was no hope, and that is not the case.
MR STEWART: You knew that she had a sodium level of 118, that she had fixed and dilated pupils and that she had a cerebral oedema?
A. Yes, and all those things were being treated, so the

cerebral oedema is being treated by hyperventilation and the low sodium was being treated by fluid restriction and administration of saline. The fixed dilated pupils, as I've said in my evidence, can be due to a lot of things. There are things that can caused fixed dilated pupils and you don't say because you see fixed dilated pupils, contrary to what Dr Bhalla might think, that, well, that person is dead. That is not the case, because I have got personal experience of people with fixed dilated pupils making a full recovery or a partial recovery.
Q. We know that Dr Crean subsequently expressed misgivings about the management of Raychel. In fact, he's quoted by the coroner as having said there was mismanagement of her case.
A. Yes, I've seen that evidence.
Q. When you telephoned him on the day or the day after Raychel's death, did he express that view to you?
A. No, no, he didn't. He told me the facts and it was quite a short call, I was shocked by what I'd heard, and I said I was really sorry to hear that, you know, the usual things that you would say. There was nothing -- he didn't say, "Look, Geoff, there's been a serious problem here because ..." So that conversation didn't happen.

Q. Was there any part of the conversation that was critical of the care and treatment Raychel received at Altnagelvin?
A. No, not at that time.
Q. Because Mr Gilliland has given evidence in his witness statements that in fact there were discussions, some discussions, he couldn't positively identify them, between medical staff at Altnagelvin and the RBHSC, in which there was some criticism, some critical comment, I think.
A. This is the rumour?
Q. It's not quite the rumour. There were several different rumours going back with nurses or being picked up by the family.

This was Mr Gilliland and he said it at WS044/4, page 11. At (q):

"My recollection is that at the time of the critical incident meeting [which, of course, is the Tuesday] we were aware that there had been discussion between our own medical staff and the doctors in the RBHSC about the probable cause of Raychel's death and that some of that discussion had been critical."
A. That is under the heading of the rumour, so he is talking about the rumour, and I believe that he's just misinformed there. I think the rumour, if there was --

I know about the rumour, and the rumour said that a nurse from the intensive care unit in the Children's Hospital told a nurse from the children's ward, who had also phoned up to find out what had gone on, that we had used the wrong fluid. So there was an implied criticism there.

I don't recall any information about medical staff having conversations. I certainly had no conversation with Dr Crean along those lines, and I know that at that stage Mr Gilliland wouldn't have had those conversations either. So he may be relying on his junior staff there, and I'm unaware of any interactions that his junior staff had with the Children's Hospital.

They may have had, and again, when I'm talking about differences of recollection, I think we've discussed this before in the inquiry, it's not a criticism and I'm not saying it didn't happen, and I'm not questioning anybody's integrity. So if someone says there was a discussion with medical staff, I'm unaware of it, but I do know of the rumour he was talking about there, and that was one that came from, I believe, the nursing staff.

I did follow up on this and asked Dr Chisakuta could he shed any light. So there was a discussion between me and Dr Chisakuta, and perhaps that's what Mr Gilliland

is thinking about. But I asked Dr Chisakuta when I rang him on the 13th, although he has no recollection of the call, when I spoke to him I said, "What's this story about No. 18 Solution and the rumour?" and he was unable to shed any light on the rumour.

Q. Mr Ferguson remembered Dr Crean taking a particular interest in Raychel's vomiting and using an expression along the lines of "What are Altnagelvin trying to do, pass the buck?" When you spoke to Dr Crean, was there any discussion about the necessity to transfer her or any part of the Altnagelvin care?

A. No, absolutely not. He didn't -- he just told me the factual information that they'd done brainstem testing and that that had been confirmed. A second test had actually been done. By the time I rang the second test had been done, so it was confirmed. There was a brief conversation and I wasn't fit for much more anyway. But he certainly didn't raise any issues with me at that stage.

THE CHAIRMAN: Did Dr Crean ever raise issues with you?

A. No.

THE CHAIRMAN: Well, since you're on first name terms with him, as you've just indicated, you've known him for some years, do you think that if he was going to the coroner and being critical to the coroner about mismanagement in

Altnagelvin that you could reasonably have expected that he would have said to you, either on the Sunday or very soon afterwards "Look, Geoff, you need to sort out what you're doing in Altnagelvin because this just wasn't good enough"?

A. All I can say is that didn't happen and maybe my concept of first name terms isn't as good as I thought, but I mean, all I'm saying is I know Peter.

THE CHAIRMAN: Let's put the first name terms aside. Let's suppose you had never met Dr Crean before. If you transfer a child like Raychel or any other child to the Royal and that child is seriously affected or dies as a result of what the Royal sees to be inadequate treatment, do you expect -- sorry, would you have expected in 2001 that the Royal would be, however they phrased it, quite clear with you that there were mistakes which had been made and that Altnagelvin needed to sort this out?

A. I think, looking back on it, I'm a little surprised that that didn't happen, because I know that in the meeting on 12 June, the clinical incident meeting, where we were aware of the rumour, only that, the feeling in the room was that we were going to be criticised for having done something, used the wrong fluid. And, of course, I had done the research over the weekend from the Sunday and

had read about No. 18 Solution, had read about the Arieff paper, had obviously put two and two together and realised that the risk associated with No. 18 Solution was key to the whole thing.

So putting that together with the rumour that we'd used the wrong fluid, was attracting the idea certainly that we would be criticised by the Royal. I mean, that was the feeling in the room. We felt "Gosh, what have we done wrong?"

THE CHAIRMAN: But if you are going to be criticised by the Royal, in a sense the Royal should be ahead, shouldn't they, because it's the specialist centre? So the Royal should be -- no matter how hard and you your colleagues try to keep up with the Royal, they should have a greater range of experience and they've maybe easier access to other sources. So they should be ahead and that's why you transfer children to the regional centre.

A. I think any feelings that you might have had like that would have been after the clinical incident review meeting. The only reason I am saying this is because I noticed that during Nurse Noble's evidence, it was put to Nurse Noble that there was some finger pointing in that meeting by the Royal, and we were saying at that meeting "The Royal should have told us. The Royal's the teaching hospital, they should have known better". But

that cannot be the case because I did not find out until the next day and I rang Dr Chisakuta, that there was an issue about No. 18 Solution.

Now, I had already done some research over the weekend, but he confirmed that when I rang him. But prior to the meeting on the 12th we had no correspondence from the Royal, no communication from the Royal, saying, other than the rumour, that we had done the wrong thing, and specifically nothing about No. 18 Solution. So at that meeting, we certainly weren't saying, "But the Royal should have told us".

Mr Chairman, what you're suggesting is that afterwards we might have thought that, and I think that's -- no doubt that's true, in our minds we were thinking "Well, if this was known elsewhere why did we not know?"

THE CHAIRMAN: So you're saying the critical incident review is on Tuesday the 12th, you speak to Dr Chisakuta the next day and he tells you that there have been issues in the Royal, or there has been a change of practice in the Royal about Solution No. 18?

A. The reason this came about was at the meeting on 12 June I decided that I would call my colleagues -- we all decided it would be a good idea to call my colleagues in other hospitals where children were being anaesthetised

to warn them about what had happened in Altnagelvin and to say this was something that had happened to us and it could happen to them.

So the reason for me calling my colleagues on the 13th was twofold. It was to simply tell them of what had happened but, secondly, it was to ascertain the use of No. 18 Solution. But that wasn't the primary reason for the call. The primary reason for the call was to tell them about what had happened in Altnagelvin because I knew my colleagues in other hospitals would be doing exactly the same thing as we were doing.

I've worked in all hospitals in Northern Ireland in my long career and I know what fluids are used in children, and I thought this is going to be exactly the same everywhere else.

When I spoke to Dr Anand -- in part of this, I spoke to Dr Anand in the Tyrone County Hospital, and that's another -- there was a mention, I think the other day, it was the South Tyrone Hospital, it wasn't, it was the Tyrone County Hospital. South Tyrone is Dungannon. This is Omagh Hospital, I sometimes just call it Omagh. When I spoke to her, she said -- and I know she's no recollection of this -- but she said, "We're not using No. 18 Solution because the Royal aren't using it", and I said no more to her other than, "Well, you're very

lucky because look what's happened to us".

And on the strength of that I then rang the Royal because, if you look at it logically, there would be no reason for me to ring the Royal to tell them of the death of a child in Altnagelvin because the death had already occurred in the Royal. So I transferred her to the Royal, so they knew about Raychel. So I wasn't going to ring them and say, "Look, we've had a death in Altnagelvin".

What I did do when I rang the Royal was I said, "What's this about No. 18 Solution?" So my question was directly about the use of this solution, and it was triggered by the remark from another anaesthetist who said, "But we've stopped using it because the Royal ..."

Now, I don't know why she knew that, she might have transferred a child there, she just might have -- I don't know how she picked that up.

MR STEWART: Can I just take you back, please, to the period between Raychel's death and the critical incident review. At that stage you were aware of the rumour from the Royal that perhaps the wrong fluids had been used.

A. Yes, I think I got that rumour on the Sunday. I think that's when it --

Q. You started some research looking into Solution No. 18. Presumably you'd gone to the BMJ and found the article

by Arieff and the article by Halberthal.

A. Yes.

Q. When you spoke to Dr Crean, he may not have mentioned any critical comment. Did he mention Lucy's case?

A. No.

Q. Did he mention the fact that the Royal Belfast Hospital for Sick Children had abandoned the use of Solution No. 18?

A. The only conversation I had with Dr Crean was he conveyed the message to me that Raychel had effectively died and that was the end of that conversation. There was no more discussion about any subject.

Mr Chairman, if I could go back to what I was saying though, because the point about Dr Chisakuta was that what he said to me was that, "Yes, we have stopped using No. 18 Solution". And then he went on to talk about "There have been deaths associated with No. 18 Solution". And the only reason I'm clarifying this, and I think I do clarify it in my witness statement, number 2, is that as part of the evidence it appeared that Dr Chisakuta had said to me that there had been deaths in the Children's Hospital, and I want to make it clear that he did not say that. What he said was "There have been deaths associated with No. 18 Solution". In other words, there's problems with it, there's deaths

with it, and in retrospect I'm saying he was talking about the Arieff paper.

Q. Why do you say that?

A. Because in his evidence he said he had talked about the Arieff paper before, it was part of his presentation, so he must know about the Arieff paper, and that's what he was alluding to. I'm only guessing -- I'm second-guessing there, I don't know that for a fact.

Q. How do you know he wasn't referring to Lucy Crawford's case, which he knew about?

A. I don't know that. What I'm saying is he did not say the deaths were in the Children's Hospital. And what it looked like from my evidence was you could have read that into my sentence. And what I'm trying to do is clarify that the sentence could have been written perhaps more clearly to Dr Fulton that the deaths were -- that was exactly what he said.

Q. Yes, but the point remains that you didn't know he wasn't referring to deaths?

A. No, no. No, no. What you take out of it is up to interpretation. That's true --

Q. Yes.

A. -- but what he did not say was the deaths were in the Royal Victoria -- Royal Children's Hospital.

Q. I take that point. Let's just go back, then, to look

at the critical incident review itself in an attempt to go through these events chronologically so as to make better sense of them.

This was obviously a very rare event. Had you much experience of critical incident reviews of this type of critical incident?

A. No, it was a new experience for me.

Q. And I assume that you had, like everybody else in the hospital, copies of the policies on incident reporting and so forth?

A. Well, I wouldn't assume that. I possibly did have, but as clinical director in critical care I don't know that it was high on the agenda at that stage. That is a thing that has evolved. But I'm sure there was a policy. I don't think I ever saw that prior to that meeting.

Q. Because it's very striking how little in the way of documentation the review generated. Did you as the referring consultant to the Royal think it was appropriate for you to fill out a form or to generate documentation?

A. I didn't at the time realise I was the referring consultant. Of course, looking back on it, it obviously makes sense, you have to have a consultant's name. I just saw myself as the person who was called in to

bridge the gap because of a disaster that had happened in the hospital.

I wasn't -- as I said, I wasn't on call. So I came in, and at 9 o'clock, actually, what I should have done was go home because at 9 o'clock the consultant for the day would have come on. So the consultant -- the disaster of the night before, whatever was going on that was causing the hospital to be so busy had obviously petered out and a new consultant had come on to take over his duty for the weekend, and what I should have done was say, "Look, Raychel's here, she's stable. I'm going home now". But I didn't do that.

What I'd said was, like, "This is my case", so I continued on and transferred to the Royal at midday, whatever time it was, and didn't get back until, I'm sure, 4 o'clock, something like that. So it was a very long day.

Q. Would you have expected anything in the way of a discharge summary from Belfast to come back to Altnagelvin or a summary of the diagnosis and the treatment she received in Belfast?

A. Yes, I think that would have been a good thing. The fact that we didn't get it didn't generate anything from me. Maybe that was remiss of me as clinical director. I didn't follow up with the Royal. But I was very

caught up with how do we fix this in Altnagelvin.

I mean, rather than looking for recriminations or anything like that, I was saying, "Look, we need to change the system here", and so all my time and efforts were caught up with moving on from the clinical incident meeting.

I appreciate that there are things that we could be criticised for that we haven't followed up with the Royal. We haven't talked about where's the discharge summary. There's lots of stuff that's missing. But what I take out of this and what I -- well, what I think we did right was that we put a system in place very quickly to stop this happening again, and for me that was the most important thing. There are niceties around it that we have not done and we can be criticised for that, but I don't think we can be criticised for moving the thing on as quickly as we did.

Q. I don't seek, and please be assured that much of what was done was highly commendable --

THE CHAIRMAN: I have said it a number of times before, doctor, and I think you have probably heard me say that a number of times before, I accept that.

A. I appreciate that.

THE CHAIRMAN: I accept there was a lot done in Altnagelvin immediately after Raychel's death to start putting

things right. And in fact, I doubt very much whether we would have hyponatraemia guidelines but for some of the steps that were taken by Altnagelvin immediately after Raychel's death. So as long as you understand that I've taken that point for some time. I've accepted that point for some time. But you will also understand that there are other issues which need to be explored. Okay?

A. Yes.

MR STEWART: Could thought have been given to in some way involving the RBHSC in the critical incident review, given that it was a shared case?

A. Yes. Thought could have been given to that. Thought wasn't given to that. I think we were just caught up, as I said, in the moment of what had happened in Altnagelvin and the desperate need to change it.

I think that what you're talking about is a -- would have been later on somewhere down the line, getting together and so on. But by that time we'd started the ball rolling in Altnagelvin, and it very quickly brought other hospitals in. So the need for that probably wasn't as important. Do you follow what I'm saying?

I mean that because it went to the Chief Medical Officer at the time that it did and it started the whole review in Belfast, and Peter Crean was part of that and

Bob Taylor was part of that, so I was happy that all the hospitals in Northern Ireland were being represented in the changes that were coming forward. It wasn't just all about Altnagelvin, we wanted the changes to be everywhere, and that's why I rang all my colleagues.

So, yes, we could have had another meeting, brought the Royal in and so on, but I think we had circumvented that by the actions that we took and had all the hospitals involved, and we're talking about Daisy Hill, Craigavon, Antrim, Omagh. You name it, they were all in on what had happened, and I think that was a good thing.

Q. Quite a lot of what happened later, whether it was meeting with Mrs Ferguson on 3 September or whether it was going to inquest, or whether it was engaging with this inquiry, would all that have been assisted if a more systematic review had been undertaken and report produced?

A. I think that the value of a report, there's no question. I have listened to evidence just in recent days and it's clear that there would have been value to a report because there had been other issues that would have been explored. And looking back on it, there were maybe more issues than just the No. 18 Solution. I appreciate that.

But the main thing for me was that it was a systems

failure. Now, I appreciate that we've been talking about junior doctors and their experience and all that type of thing, and could someone be at fault. And there is -- of course, there's that part of it, but really what we're trying to do is change a system. And Dr Sumner actually agreed with that. At the end of his report to the PSNI, he said very clearly "This was a systems failure rather than individual fault".

Q. Yes.

A. And so that in a way endorsed what we were doing because what we did was we put a system in place that meant it could not happen again, no matter what doctor. You could fix Dr Devlin or you could fix Dr Curran, or you could address issues, and you could get caught up with that. But I believe what we did was we put a system in place so that no matter what doctor comes along, they cannot prescribe fluid because, number 1, I have stopped it being used, but, number 2, we've got a system in place where they've got to have a U&E, they've got to have all those things.

So I think the system fix was more important. But I appreciate that had there been a report, you could have looked in the round, if you like, in the long term there would have been other issues. And I think that's been accepted that that possibly should have been done.

Q. Because many different systems failures were identified. It was a classic multi-factorial and systematic failure, and that is exactly where an overview report should be produced in order that clarity for recommendations can be achieved.

Tell me this, there has been talk that junior doctors were asked not to go to Ward 6 in the aftermath of this. When did that change take place?

A. I'm not quite sure. It was relatively quickly after that, but it was perhaps not directly involved with that case because there was a feeling that from the postgraduate medical training board that jobs like that weren't suitable for junior doctors, JHOs and provisionally registered PRHOs. So the SHO grade was much more suitable for training in children's wards and things like that.

So it happened -- I think it coincided with Raychel's case. It certainly happened after Raychel's case, but not immediately after, but it was one of the things that changed. But I think that was in the wind anyway, it was one of the things that was going to happen.

Q. So it wasn't a consequence, it was simply coincidental?

A. That's my belief. I know that the two are related but I think that one was not following on from the other.

It was going to happen anyway.
Q. Did you feel at the time that there was a necessity, any necessity, to reconvene the review group in, I would say, two weeks later or a month afterwards, to look again in the light of reflection and in the light of what may have been done?
A. We could have reconvened the group, but -- I mean, all I can say is I met regularly with Dr McCord, who was key to changing the system in the ward. I went up to the ward regularly to meet with Sister Millar, who was key to changing the issues related to the recording of urine and vomit, all the things that we talked about, the action plan.
So I don't know that a review sitting with the same people in the room would have contributed anything more to actually what happened. I think what I'm trying to say is we changed it very quickly and we ensured that it was in place, and we monitored that on an unofficial -- we could have had everybody in the room saying, "Look, where are we with this?" and, of course, that did happen later on, that happened in April in the next year.
THE CHAIRMAN: Before you go on, when you say that Dr McCord, who was key to changing the system in the ward -- now, which change of the system are you referring to? It's separate from Sister Millar and

changes to the recording of vomit and urine?
A. Yes, the change was to the fluid that they were using.
THE CHAIRMAN: Right.
A. The debate with the -- there's a slight confusion because we decided right there, right then, on the 14th -- and I wrote to Dr Fulton -- we decided that we would no longer use No. 18 Solution in surgical children. But at the meeting on the 12th, two days prior to that, the discussion was that it would be -- that wouldn't apply to medical children. So in the children's ward you've got medical children and you have surgical children. The paediatricians look after the medical side and the surgeons look after the surgical side.
The problem seemed to be in surgery. When you look at the papers, it's all to do with antidiuretic hormone production, or too much of that production, and that's the risk in surgery, and it's not so much so in medicine at all. So there was quite a debate on the day that that did not need to change.
So when you see the bit where it says, "No change to No. 18 Solution", that refers to the children on the medical side, but the decision was very clearly that on the surgical side No. 18 Solution would not be used.
So Brian McCord's input into this was that he put up

on the ward a clear notice to say what fluids to be used in surgical children. The inquiry have all the copies of those.
MR STEWART: I can show you that. It's at 021-056-136.
A. Yes. And he also developed an easy guide so that you could read the weight of the child and the rate of fluid.
One of the things that I know, and Dr McCord knows, is that if you have an old-fashioned clinician who uses the pound rather than kilos, you're in trouble, because 20lb is 10 kilos and you meant 20 kilos. Do you know what I mean? So you have to be very clear that you're measuring in kilos and you have to be very clear that the rate you're prescribing is commensurate with that weight.
So he had a chart he developed for that, and that was put up in children's as well. That was an aid, if you like. The system was in place but this was an extra thing that you would check to make sure that the fluid you were giving was in the right ballpark, if you follow.
Q. Just before we finish perhaps this section, you probably read the transcripts and seen that I've been referring to 1999 NCEPOD recommendations, which are at 220-002-023. And you've probably read a previous

reference being made to peer review.
This is the third and the fourth bullet points here:
"The death of any child occurring within 30 days of an anaesthetic or surgical procedure should be subject to peer review irrespective of the place of death. The events surrounding the perioperative death of any child should be reviewed in the context of a multidisciplinary clinical carried."
That seemingly wasn't adopted by Altnagelvin at the time. Why was that?
A. Specifically the 30 days? I think that there was a peer review. Certainly I would contest that -- there definitely was a peer review because -- in fact, it was multi-professional review of the case, and that was discussed at the drugs and therapeutics committee and also at the hospital management team.
The point about those things is that they're not within the 30 days. I agree that within 30 days it didn't happen. But there certainly was a look from a multi-professional point of view at what happened, what should we do next.
Q. Can I stop you there. You say there was a peer review of this case in the drugs and therapeutic committee. Were any minutes taken of that?
A. Yes, and you have those minutes, and you have the --

Q. There's a discussion of the need for a multidisciplinary peer review, I think, rather than such a review.
A. Well, at the drugs and therapeutics committee, those are peers, and in that I gave a review of the case. Now, this may be semantics, if you like, but the -- in fact, I gave the presentation that I give to everybody.
Q. That's a PowerPoint presentation?
A. Yes. So they had the joy of sitting through one hour of me telling them all the things that I talk about--
Q. That's not making the case subject to peer review, with respect.
A. And following that, there was a discussion, and then following that they said that we needed a multidisciplinary look at this. And then, if you look at the consensus statement, you will see that that is exactly what that was.

So there was a meeting, which I have no minutes of. I can't find any minutes of it. But we had a meeting with all the clinicians involved, looking at this case, and how we would change the fluids, what we would do, and the steps that I put in place to date. That included the clinical service manager, the medical director, who at that time was me, the pharmacist.
Q. This was 2003. This is when a protocol is signed.
A. The drugs and therapeutics committee, I'm not quite sure

what date that was, and then there was a consensus statement.
Q. Yes.
A. I thought that was 2002. I could be totally wrong.
Q. But are you saying that those amount to the multidisciplinary clinical audit recommended by NCEPOD?
A. That is not an audit. An audit is where you look at lots and lots and lots of cases. That is a review of that one case and the things that we put in place following it. Audit to me is a much bigger thing when you take, you know, over the last year how many of these cases have we got, or whatever it was, and then you compare your results with someone else.

It's quite a cumbersome thing, and in fact today audit is certainly not discredited, it's not discredited, but the way to seek to effect change is to use a PDSA cycle, which is one of those Institute of Health learning tools where you make a very small change, you see was it effective, you monitor it, it's all done in very small numbers. Then -- so audit is a thing that's becoming a wee bit redundant.
Q. We're talking about 2001. Was it your responsibility at that time to oversee the importation of recommendations such as the NCEPOD recommendations into Altnagelvin?
A. Which time are you talking about?

Q. 2001.
A. That probably would have been the medical director at the time, who was --
Q. I'm just looking at your witness statement, WS035/2, page 9. I think it must be 9(c):

"Please describe the structures in place and the lines of accountability and responsibility for: the adoption of policy on clinical practices as a result of NCEPOD et cetera.

"I have no recollection of involvement. If a policy relating to clinical practice had been developed, then the adoption of that policy would be disseminated to the relevant clinicians and clinical director."

That would have come from the clinical director. So the clinical director was not involved?
A. Sorry?
Q. If such a policy had been developed, it would be disseminated to the clinical directors.
A. Oh yes, yes.
Q. And presumably it would come to you.
A. No, you're asking me whose responsibility it was for disseminating them, and I'm indicating there that I thought it would have been the medical or the nursing director, but fully accept that they would have been disseminated to the clinical directors, and I was at

that time a clinical director.

Your next question probably is, did I receive that? And I have no recollection of that. That's not to say that I didn't actually receive it, but I have no recollection of it.
Q. Presumably you were aware of, for example, the 1999 working group report on paediatric surgical services in Northern Ireland?
A. Yes.
Q. And it does recommend that there be adherence to NCEPOD recommendations. It's one of the key recommendations.
A. That's correct. They are -- just as they're described, they are recommendations, and aside -- running parallel with that, are recommendations from Royal Colleges. So for example, one of the things that NCEPOD recommended was that junior doctors had to tell their consultant if they were anaesthetising a child, which we all agree with. And that would have been certainly something we would have encouraged in Altnagelvin. And then there was a rule -- not a rule, but a recommendation that competent anaesthetists who had achieved certain competencies could anaesthetise children down to five years.

So there was this unwritten rule that if you had come through the competency training and reached

a certain standard, you could anaesthetise children down to five years, albeit that you should be telling your consultant if you're taking a child to theatre. But before, below five, it should be a consultant who provides that service.

So all departments would have had that rule of thumb, and certainly in Altnagelvin our policy -- not a policy -- not a written policy, our practice was that the junior doctors be encouraged to tell the consultant, not just about children, don't get me wrong, it's about any case that's coming to theatre if they had any worry about it at all.

But if they have reached certain competencies and it's an ASA1 patient or 2, then they could -- that's a risk grading. So ASA1 means that you're fit, healthy person, no medical problems. They could anaesthetise down to five years old.

So most departments ran on that premise, and Altnagelvin would have been like that. It was a small department, the consultants knew the juniors, and there was no hesitation for juniors to call the consultant, there wasn't this hierarchy where they were scared of calling the consultant. That wasn't the case. They would call us, as Dr Date did on the night that I was called in. She just called me. And the juniors would

do that and we would come in at the drop of a hat if that was indicated. So there was no hesitation to come in.

So what I'm saying is --

THE CHAIRMAN: Yes. I have never understood, and I don't think it has ever been suggested that in Altnagelvin there was somehow a reluctance of consultants to come in, but what NCEPOD was recommending was that a child should not go into surgery or that children should not go into surgery after midnight without the consultant being advised.

A. Yes.

THE CHAIRMAN: Mr Gilliland wasn't advised. There's also recommendation against anaesthetising at certain times. Now, I just want to get this clear from you. From what you've been describing, it seems that you're suggesting that the NCEPOD recommendation was considered and it was adapted for Altnagelvin. Is that right or not?

A. I don't believe that's what I'm saying. What I'm saying is --

THE CHAIRMAN: Then I've picked you up wrong.

A. Maybe I haven't been clear enough also. Because I think NCEPOD recommendations, you might see them, but practically what you do is you run your department, and not just Altnagelvin but other departments as well where

I have worked, and if the junior anaesthetists were on and you had a low risk patient, ASA1, for an appendix, most consultants would be happy for that junior to take the -- given that it needed to be done and so on, ad that's not usually an anaesthetic decision. So from my point of view, I would never try and second-guess a surgeon because you just can't tell.

So if the surgeon wants to take the child to theatre, if it is an appendix, and the anaesthetist is happy, I would be content if I was a consultant on call, knowing it was Dr Jamison, knowing it was Dr Gund, that that would happen.

If Dr Jamison or Dr Gund had phoned me -- just pretend I was the consultant on call, if they would phoned me they'd have said, "Look, we've got a nine-year-old child. The surgeon wants to take the appendix out. It's 11 o'clock at night. I'm happy to do this, what should I do?" I'd have said, "Go ahead and if you want me to come in, I will. If you have any trouble tell me".

I wouldn't have said over the phone "Right, tell me all the things you're going to do, tell me about the post-operative fluid prescription". I would have assumed that what we normally did would have happen. Does that help?

THE CHAIRMAN: Yes, it does. I understand a bit more and I understand that the NCEPOD recommendations are just that, they don't have to be implemented. But it does seem to me, doctor, that when these recommendations come out, if they're not going to be followed in Altnagelvin or any other hospital, that that should be in the back of somebody sitting down and looking at them and saying, "Look, we can do 1 and 2, but we can't do 3 and 4, or we don't need to do it here, so let's adapt 3 and 4, let's come as close as we can to doing that so that we're as close to the recommendations".

A. I have heard you say that before, and it would be good because you could say, "Well, look, we're not actually meeting the criteria, but here's what we are doing", and there may be resource implications do that. And I've heard that and I agree that that would be a good thing to do.

All I'm saying is that NCEPOD -- well, for example, NCEPOD 1989 is quoted left, right and centre, and NCEPOD 1989 was about who operates on children. They looked at 417 children under 10 years old who had died and the majority of those children had severe cardiac abnormalities. In fact, 266 of them had cardiac surgery and they were all anaesthetised by consultants, bar two, two patients who for emergency reasons were

anaesthetised by junior doctors who were just saving the day.

The result of that was that, sort of inexplicably, they said no junior doctor should anaesthetise a patient without telling their consultant. The two patients that died that were junior doctors -- there only were two in the whole thing, it wouldn't have mattered if a consultant had been there or not, the child was not going to survive.

So for me, NCEPOD 1989 was highly unusual. It was occasional practice by anaesthetists doing cardiac anaesthesia on children that they had no right to be doing because they were occasional practitioners, and that, in my mind, did not apply to ASA1 or 2 patients who were not considered at all in 1989 NCEPOD, and yet that recommendation has been carried through ever since.

And, of course, it's a good thing. If the junior doctor tells the consultant what's happening, then you can't argue that that's a bad thing. But I think that the system that we were running in Altnagelvin and the system that I'd seen in every other hospital where I've worked in Northern Ireland was that the junior doctor would call the anaesthetist -- the consultant, sorry, if they had a concern. If the child was five years or younger, there was no question, the consultant would

come in. And that's my practice, that's what I've done. And if the junior doctor has not got the experience, then the consultant comes in. And we have experienced in Altnagelvin consultants in until midnight doing the work with the junior doctors.

So the only junior doctors that we go home, if you like, if you're on call, is when you are content that that junior doctor has reached a certain standard.

THE CHAIRMAN: So the junior doctor, on this approach, only rang the consultant if the junior doctor had a concern, and otherwise the operation or the procedure would go ahead and the consultant would learn about it the following day?

A. That's correct. Some consultants now might have taken a different view. It's very much an individual thing. Some consultants might have said, "Look, I want to be told about every single thing", and that's completely acceptable as well if we want to do that. But we did give the junior doctors some autonomy, but only if we were happy that they could do that.

THE CHAIRMAN: Okay.

A. And only if they were patients that they had no concerns about. The worry, of course, would be if you had a maverick junior who didn't know that they should have had concerns and so on. So would a consultant pick that

up on a phone call? I don't know.

THE CHAIRMAN: But you don't have to be a maverick. You might just be okay, but you might have missed something, which seems to me to be an argument for CEPOD that it protects patients from a junior doctor who's doing his best or her best but might actually have missed something, which might be picked up in a chat with the consultant, who wouldn't have to come in but would at least have some knowledge of what was happening.

A. I think in general terms, those are correct assumptions, but I'm just saying that in the case of a nine-year-old child, normal, healthy child with an appendix, I doubt whether any instruction would have been given from a consultant. Certainly a consultant anaesthetist would probably not have said, "Well, look, I don't think you should take that child to theatre", because then you're risking a perforation of an appendix, and in a child, a girl, that's really serious because you don't have the omentum, which is a large part of the bowel that protects you as an adult, and then the pus goes everywhere, and then you've got infertility and so on. I tried to explain that as well at the meeting in September.

THE CHAIRMAN: I've got the point because we heard quite a few exchanges and views and competing views about that

in February, March.

A. Okay.

MR STEWART: Just one question, and it's Professor Swainson who is an expert on governance issues to the inquiry, has made the observation that when a view is taken not to adhere to the recommendations of, for example, NCEPOD, that that should be noted and authority taken from the board. I take it that didn't --

A. No, that didn't happen, and it's a very valid point, and I wouldn't argue with it.

Q. Can I just ask this question. The 1999 report on paediatric surgical services in Northern Ireland, upon which group Mr Panasar of your own hospital sat, make a very clear recommendation that there should be adherence to the NCEPOD recommendations regarding supervision of junior anaesthetic and surgical staff. That is the 1989 NCEPOD recommendation.

A. Yes.

Q. How is it that when you have a recommendation and you've got the working group reports sent to you by the DHSS, and Mr Panasar is on that working group, that still it isn't --

A. All I can say to that is it's an imperfect world and if you produce a report that dots all the Is and crosses all the Ts, then you can't be criticised. You can say

that we should adhere to this and this and this, even though practically that's not actually what happens on the ground.

My comments about NCEPOD 89 are because I think it was probably the patients were so far removed from what you would do in a district general hospital that it didn't apply. But as it goes on through the other recommendations, the fact is they're saying, "Look, juniors should tell their consultants what they're doing", and that is a good thing, so you can't argue with that. But practically on the ground, if a consultant surgeon says, "I have every faith in the ability of my SHO "-- and remember some of those SHOs are actually really registrar level in another country, they're very experienced but they're coming into our training system at the low grade because that's the only way they can get in, so they're coming with a wealth of experience and you glean that from working with them.

And if the surgeon says, "Look, I know they've got the competencies, I'm happy that they do that", then I think common sense is what a lot of hospitals run on. It's not just Altnagelvin. I can tell you that that is the case. I've worked in lots of hospitals, and some of the anaesthetists when I was a junior would have been most reluctant to hear a call at night if I said, "I'm

taking a child to theatre, 10 o'clock/11 o'clock at night for an appendix", they'd say, "Well, why are you telling me this?"

Now, in Altnagelvin that wasn't the case because we knew the juniors very well and we were more than happy to come in. So there was never any difficulty with doing that. So I thought the system was quite reasonable.

MR STEWART: I see. It might be an appropriate moment.

THE CHAIRMAN: We'll take a break, doctor, for a few moments. Thank you.

(11.50 am)

(A short break)

(12.15 pm)

THE CHAIRMAN: Mr Stewart.

MR STEWART: Thank you, sir.

Dr Nesbitt, if I can take you back into the critical incident review again. Do you remember the discussion about the vomiting?

A. Yes.

Q. Do you remember the nurses giving their views, their opinions and their recollections?

A. Yes, I do. The feeling was that Raychel vomited on several occasions throughout the day. I would agree that the term "prolonged" might even have been used

in that it was maybe more vomiting than they normally would have seen. But the nurses were of the opinion that the amount of vomiting was not excessive, so there were multiple vomits but of small amounts, and that's a clear recollection I have of the meeting, not that it was severe or profuse. Those are not words that came out of that meeting, in my recollection. But I think certainly it was acknowledged that there was more vomiting than you might have seen, but not unusual in that you would have seen it before in appendicectomies and so on.

Q. Dr Fulton has indicated in his statement that he wasn't really able to make any final determination about the vomiting because the nurses hadn't seen it all and the nurses were telling him that the family had told them that the vomiting was repeated and so forth. Do you remember that being mentioned?

A. I haven't got a good recollection of that. I just remember the nurses saying that in their opinion the vomiting was not excessive, that -- they were totally taken aback at what had happened and they could not associate the problem with vomiting. They associated it more with the solution that we had been using and that, of course, fitted in with what I had been reading over the weekend.

THE CHAIRMAN: Do you remember any discussion along the lines that when you get to coffee-ground vomiting, that that in itself is a warning sign?

A. My recollection is -- I couldn't swear to this, but I am sure that if coffee-ground vomiting was mentioned, I would have pointed out, for it was my belief, that coffee-ground vomiting is not -- it can be, as you have rightly said, it can be interpreted as a sign of prolonged and profuse vomiting. It can also happen on the very first vomit. It can also happen without any retching or vomiting.

So if you bring up something you can have coffee grounds in it. But coffee grounds is altered blood that is in the stomach, and because of the acid environment of the stomach, the blood coagulates and it looks just likes coffee grounds. So all you can say about coffee grounds is that there's blood in it, that's all.

I have seen it on the very first episode of vomiting and I have seen it at the very end when actually there's nothing else left to vomit, and in fact what's happened is there's been a small tear at the back of the throat. That is relatively common, but most of the tears are down at the lower oesophagus, stomach junction, but you can get it at the back of your throat. That blood goes

down into the stomach and instantly becomes coffee grounds.

It's just a term that we use, and for me it doesn't actually mean that much, it's a record. You say there's blood in it. The worry is where's the blood coming from. So if that's a thing that's continuing on, then you'll be investigating. If it was another patient you'd be investigating the source of coffee grounds in the vomit because there shouldn't be blood in your vomit.

THE CHAIRMAN: When it comes after a long day of vomiting, does that not make it a stronger warning sign?

A. That would fit more with my idea that -- and I did express this at the meeting with the family -- that if you're vomiting and there's nothing left to vomit, you're retching, then because of the straining you can get a tear in the back of your throat. It doesn't have to be a big thing, and that can be the source of the coffee grounds.

So yes, it is a sign that the vomiting has gone on for so long that perhaps there's nothing left in your stomach. If my argument is to be accepted, then there's nothing left. But as I said, it can happen at any time. That coffee ground could have occurred early in the day, it just so happens to be at the end of the day, but

I appreciate that you could interpret that as a sign of certainly the prolongation of the vomiting.

THE CHAIRMAN: Thank you.

MR STEWART: And any vomiting that's been prolonged is almost by definition --

A. Severe.

Q. Mm.

A. Well, if you're the person suffering it, that's certainly true. Vomiting is very unpleasant for all concerned, and that's why the nurses were keen that anti-emetics were given, and that was discussed at the meeting, that they were very keen that Raychel get settled from her vomiting. No one wanted to see a child vomiting, and so anti-emetics were prescribed.

Q. Did the review think that perhaps they should hear from the two doctors who prescribed those medications?

A. That did not arise out of the review. That was not discussed.

Q. It might have been helpful?

A. In retrospect it might have been helpful. I think that vomiting did not take on a large part of the meeting. It was discussed, but the duration of it and the -- also we did discuss the recording of it, how difficult it is to record vomit, and a small amount goes a long way. It's like everything you know, a small amount of blood

if you have had a nose bleed it looks like a disaster, and a small amount of vomit can look dreadful, depending if it's in your clothes. It's just so hard to measure, and there was some discussion about what does one plus mean, what do two pluses mean. To me it means twice as bad as one plus, but then what does one plus mean?

So my point was: look, that's a system that doesn't actually tell you a volume. And I think the answer to that was: well, actually, you very rarely know the volume because the vomit goes everywhere, it goes on the bed clothes or it goes over the patient or something like that, and it's very hard to measure it.

So there was discussion about how it's actually measured, and there was discussion about the fact that it went on a little longer certainly than the nurses were happy with and they wanted anti-emetics given. That really was the -- as far as I can recollect, that was about the height of the discussion about the vomiting, and the main thing about the meeting was the solution and what were we to do about No. 18 Solution.

Q. There are a number of other issues I'd like to explore. In relation to Mr Gilliland, was there any discussion about whether he was on call at that time?

A. Yes, there was, and if I can refer you, I think it has been discussed, maybe I don't have to do this, but in my

statement, I do refer --

Q. WS035/2, page 15. I'm sorry to interrupt, just to get the --

A. I just knew that you would know it. If I could see it I can help you with it.

Q. "Please also confirm whether consideration was given to (b) the absence of the consultant responsible from Raychel's care."

And you have answered:

"Yes, there was discussion about the fact that the on-call consultant [presumably that's Mr Gilliland] was not necessarily the consultant under whose care Raychel had been admitted."

Well, that's Mr Gilliland:

"And there was a potential difficulty in letting that consultant know [that's Mr Gilliland] that his patient had died."

So I'm not clear I understand that. Perhaps you could explain.

A. Can I stop you right there? Because although you're reading that with the correct emphasis, the on-call consultant was not Mr Gilliland because when -- what I'm saying is when a child dies or has the collapse, the on-call consultant may not necessarily be the consultant who she was admitted under. That's exactly the point

I'm trying to make. And if that sentence isn't as clear as it should have been, then I apologise because I thought I'd made that clear. And certainly in my reading of it what I'm saying is that the on-call consultant isn't necessarily the same guy under whose care Raychel was admitted.

My point is that Mr Gilliland was the admitting consultant, but on the day of her collapse it was another on-call consultant. So all I'm saying there is -- I'm not saying there's confusion, I'm just saying that that's a fact. We discussed the fact that the on-call consultant deals with the case perhaps but the person who's actually -- the care is under may not know what's happened.

Q. Yes but --

A. That's what happened to Mr Gilliland.

Q. The question is posed about the absence of a consultant from Raychel's care, not after her collapse.

THE CHAIRMAN: Or not just at the point of collapse.

A. Then I have failed to answer the question that the inquiry has put to me because I thought what you're asking was the fact that the consultant responsible for Raychel's care wasn't actually there when she collapsed, and Mr Gilliland wasn't. That's what I was trying to answer. I was saying, "Look, I see what you're saying,

but can you not see that the admitting consultant, Mr Gilliland, isn't necessarily the on-call consultant when the collapse happens?" That's why I was answering it in that way.

MR STEWART: Well, was there any discussion about the confusion about the identity of the consultant under whom she was admitted and the on-call consultant?

A. No. The question was posed, perhaps later on there, as to where we thought and where I thought that the consultant should have been there. And my answer I think was that the relevant consultants, following the collapse, were there, and I think Mr Gilliland has attested to this as well, that from a surgical point of view there was nothing, I don't think, he could have offered at that time.

So from the resuscitation point of view, the last thing an anaesthetist wants to see is a surgeon unless it's a surgical operation you need, in which case we love them. But what we want to see is a paediatrician, we want to see expert help to resuscitate. I don't want to say anything bad about surgeons, but I don't necessarily put them in that bracket.

Q. I see. In relation to the discussion at the critical incident review as to the quantity of fluids administered to Raychel and the calculation of them and

whether or not they were excessive, do you remember that?

A. Yes, I do. I went into the meeting concerned because I had the notes, I could see that Raychel had been prescribed 80 ml per hour and that because I regularly anaesthetise children, because I know that I prescribe it on a kilogram weight basis, that her weight -- the minute I saw her weight of 25 kilograms, I knew that the rate should have been 65.

So I went in and said, "The rate has been -- the rate that's described is too high. 80 ml an hour is too high". But having said that, I then qualified what I said by saying, "But there is a deficit there, and the deficit is caused by the fact that the child is fasting from the last time they took fluids", and that is something that each hour would have been 65 ml per hour, and that's missing.

So if I'm anaesthetising a child and they are fasted, I take into account the length of time of the fasting and I calculate the amount that's missing and I give that back to the child intraoperatively, so during the operation. And in the first hour I would give one half of the amount I'd calculated that was missing, plus the maintenance -- I hope I'm making this clear -- and then in the second two hours, I would give

the remaining half. So over a total of three hours I would have replaced the deficit.

Now, if the deficit is a large deficit, in other words it's much more volume than that, then there's an argument for giving it over 24 hours, and in fact new guidance says that you should give that fluid over a longer period, even 24 to 48 hours. But normal fasting, you would just replace in theatre and that's always been my practice. So the amount you would give could be incorporated into the 80 ml per hour, and that's the argument that Mr Makar made when he gave his evidence. He said he was taking into account the deficit.

And if you were to look at that and calculate that, the deficit would not be replaced until 26 hours had gone by because the excess that you're giving is only 15 ml per hour, and with her deficit being -- I can't remember what it was I calculated, I have it down in front of me somewhere, her deficit would have been replaced in 26 hours. So in my view, that was the wrong way to replace the deficit. I said what you should do is what I've just described to you and then it should be reduced to the normal rate. So when I said reduced what I meant was that once she had replaced the deficit you would reduce the rate to what is the normal maintenance

rate, which would be 65 ml per hour.
Q. And this was discussed at the review meeting?
A. Yes, very much so.
MR STITT: I don't know if it's of help, but it does appear that there is a reduction to writing in WS035/4.
THE CHAIRMAN: Yes. Dr Nesbitt has been helpful enough to summarise this. If we bring it up on screen, briefly. WS035/4, page 2, please.
A. This goes into it in more detail than I will have gone in at the meeting. The reason I submitted this was to explain the fact that the excess amount of fluid that was given wasn't explained to the family in the meeting of September, and in fact it was suggested that two mistakes were admitted to in the meeting in June. One of them was that a U&E hadn't been done, and the second mistake was that too much fluid had been given. In my statement I do say that although technically excess fluid was given, it was by a very small margin, and I haven't expanded any more than that.
Dr McCord had submitted some evidence to the inquiry trying to explain the volumes, but I thought it would be better to -- this is purely for clarity and you don't need a calculator because it's relatively simple, but what I'm saying is that Raychel was fasting for a period of 35 hours if you take from when she last ate to when

the fluids were finally reduced in rate at 5 o'clock, say, in the morning or 4 o'clock in the morning. 35 hours.
Fluids are calculated according to weight using an hourly calculation, and this is what anaesthetists do. So I would look at a child and for the first 10 kilos of their weight, I would give 4 ml per kilo. For the next 10 kilos of their weight I would give 2 ml per kilo. So if the child is 20 kilos, that's easy, it's 60 ml per hour. For every kilo after that second 10, it's 1 ml per hour. So anaesthetists are relatively simple animals and we just calculate the fluids on an hourly basis.
Paediatricians work on a more cerebral level, and what they do is they calculate the rate over a 24-hour period and they use a slightly different formula, it's the same ratio, and they say 100 ml an hour for the first 10 kilos, 50 ml an hour for the next 10 kilos and 20 ml an hour for every kilo after that, in 24 hours. Then, because they have the mathematical capability, they divide that by 24 and they come to the hourly rate.
Now, the reason for explaining all that is that the hourly rate is 65 if you do it like a simple anaesthetist, and it's 67 if you do it like a smart paediatrician. Okay? So the calculations then are

based on, firstly, 65 ml per hour, and what was she being allowed. So she would have an allowance of 2,275 ml if you use the 65 ml per hour and 2,345 ml if you went for the 67. So there's two ways of looking at it and you get those two volumes. That's what she's allowed.
Then, if you look at the fluid balance record and simply add up what she actually got, what you find is that -- and this is where both Dr Sumner and Dr Warde, which you'll be coming to later on, I'm sure, actually made mistakes because they both failed to notice that intraoperatively Raychel was given 200 ml, and Dr Warde was even worse because he failed to notice that she got 60 ml preoperatively. So his calculations were actually that she'd got far less fluid than what I'm calculating.
So what I'm saying is if you look at her fluid balance record, you have 540 ml for day 1 and 1,680 for the following day, and then you have 200 ml in theatre. You add it all up and it comes to 2,420.
Dr Sumner came up with 2,220. If you remember Dr Sumner's evidence, his was 2,220, because he had forgotten about the 200 ml in theatre.
So if we sub-tract the two, going at 65 ml per hour, the excess is 145 ml. And if we allow the 67 ml,

a slightly more generous allowance than a paediatrician would allow, it comes to 75 ml.
So what does that actually mean? The amount, in my opinion, is a very small volume, and that volume would in itself not add to the risk of hyponatraemia by the dilution of that volume.
I think the difficulty is just trying to explain to people what a ml is. I thought it would be helpful -- this is not in the papers, this is my own -- just what I'm telling you, and that is that the ink cartridge in your pen is about 1.5 ml if you ever try to fill up one with a syringe, which I have done. An egg cup is about 50 ml, and a glass of water that I have in front of me is about 140 ml. So the volume that you were talking about is like a glass of water.
Another thing I would like to just say is that there are lots of people who give a preload to a patient for a different reason, and that is either you're resuscitating them if they're slightly shocked and you give 20 ml per kilo, or if you're trying to prevent post-operative nausea and vomiting, ironically. If you're trying to prevent post-operative nausea and vomiting you give 20 ml per kilo prior to induction of anaesthesia.
20 ml per kilo in Raychel's case would have been

500 ml. So I'm talking about 75 ml or 140, depending on which way you calculate it. But you could have given 500 with impunity because that would have been something that would actually have perhaps prevented nausea and vomiting because there's papers out there that are looking at that type of thing. Is it because someone is slightly behind on fluids? That type of thing.

So that was the reason for the calculation. So having gone into the meeting, I was concerned about the volume of fluid potentially that she'd been given. There's no doubt about that in my mind. But when we looked at it and actually measured it after the meeting, I was talking too soon because actually the volume was not the problem, the problem, in my opinion, was the solution itself and the fact that Raychel's response to surgery was unusual, it was idiosyncratic, it was rare, and I believe it was the antidiuretic hormone response that she mounted that was totally out of kilter with what's normal.

That was not meant to be a criticism of Raychel, it was never meant to be a criticism of Raychel, and yet I know that's one of the things that was taken out of the meeting with Mrs Ferguson in September when she felt that we were in some way blaming Raychel for it. But at the meeting on the 12th, I was concerned about the

volume of fluid, but we added it up, it actually didn't come to as big as volume as I thought.

I was also concerned -- sorry -- about the fact that the documentation -- we'd already discussed the vomiting, but the documentation of the fluids was, in my view, not good because the anaesthetists had written in the total box 1,000 ml of Hartmann's. So at a first glance you would say, "Look, that's 1,000 ml of Hartmann's. Then you add everything up. There's a vast overload of fluid". But I knew already that wasn't the case because the anaesthetists just put it in the total box but it wasn't. He hadn't put it in the total, it should have been written down at the bottom of the chart, and Ms Danes talked about that, that other charts chart the fluids differently, and I concur with that completely. And if you look at charts that I would have done for very small babies, I would record the fluid down at the bottom and then in the total box I would total it all up.

But for a routine appendix, Dr Gund didn't do that and he mistakenly wrote in the total box 1,000 ml, but we know that only 200 ml were given in theatre because 800 ml was discarded. So when you put that in the round, actually the volume of fluid that Raychel got was not the issue, but I contend that the fluid that she got

was the issue, the type of fluid that she got.

THE CHAIRMAN: To some degree Dr Haynes agrees with you. You'll have heard Dr Haynes' evidence or maybe you've read Dr Haynes' evidence.

A. I was here when Dr Haynes gave evidence.

THE CHAIRMAN: Dr Haynes said -- we don't need to go over all this again because we heard quite a lot about it in February and March. First of all, I don't think he would agree with you because he says Raychel shouldn't have been getting 80 ml. Most people would say she shouldn't even have got 65 ml, but nobody actually checked the rate, there was not enough thought given to the amount that she was receiving, and it wasn't checked at the ward round, the rate should have been checked and reduced.

A. The rate continued at 80 ml per hour, but I am challenging him because if you were to calculate the amount of fluid that Raychel had received by 8 o'clock in the morning, she was actually 190 ml behind. She was dehydrated in the morning because at 80 ml per hour plus 200 ml in theatre, that's not enough fluid because in theatre technically I would have given more by my method, and if you were giving it over a longer period of time, it should have been given at more than 80 ml per hour.

So by the morning time she was 190 ml behind, and throughout the day that deficit will have gradually caught up until ultimately at 3 or 4 o'clock in the morning, depending on which time you look at, she would have been in excess of 145 ml or 75 ml, depending on how you calculate it.

THE CHAIRMAN: But would you agree with Dr Haynes that if Raychel had continued to receive 80 ml of Hartmann's, it's unlikely she would have suffered any significant harm?

A. Yes, I do agree with that because that's my point.

THE CHAIRMAN: About the type of fluid?

A. The type of fluid was crucial in that the amount of sodium in it is so low.

THE CHAIRMAN: But that brings him to the point that there was no thought, active thought given all day Friday to the type of fluid that she was receiving while she was repeatedly vomiting.

A. That's correct. And the assessment of Dr Sumner is exactly that, and the coroner said that it was an inadequate replacement of electrolytes in the face of loss of electrolytes and the concomitant use of a fluid that had very small amounts of electrolytes in it.

But I have to say, and it's been stated lots of times, that No. 18 Solution was the elixir of fluids for

paediatric purposes and had been since 1957. And the reason it was so popular was because it was calculated in 1957 by Holliday-Segar that every child needed a certain amount of fluid, and for every ml of fluid they receive, they have to have a certain number of calories. And this was more important for very small babies, the smaller the baby, the more important this becomes. Small babies don't have glycogen stores and they require intravenous sugar, glucose or dextrose, as I explained at the very beginning today. So we'll call it glucose.

So children need water and they need glucose, and on top of that they need electrolytes. And the beauty of No. 18 Solution was it's exactly the same constitution from a water and a calorie and an electrolyte point of view as breast milk. So paediatricians loved it.

This was -- we all know breast milk is good for you, and No. 18 Solution was equivalent in terms of its electrolyte content, its calorie content and so on, as I just said. So it was very, very popular, and that always remained.

And I think my own opinion is that what has happened is that when surgical children were introduced into the round, the concept of antidiuretic hormone had not been considered. When Holliday and Segar had done it they

were looking at retain and replacement for small babies. And in fact, from a paediatrician's point of view, the most common abnormality seen in paediatrics was hypernatraemia, not hyponatraemia. Hypernatraemia.

Why did this happen? Because well-meaning mothers would put an extra scoop of powder into the -- when they're making up the milk. So when formula milk came in -- and this is why Holliday and Segar got really involved in this -- when formula milk came in, babies were coming into hospital with high sodium levels from well-meaning mothers who give -- if six scoops are good for you, seven's even better. So in fact to treat that, you wanted to give a solution like No. 18, which had a low sodium content. So you can see the beauty of it.

And the nurses loved it because it had sugar in it, so if you had small children, they weren't getting hypoglycaemic, everything was working beautifully, No. 18 Solution, you couldn't go wrong.

Now, in all my training, No. 18 Solution was the solution you prescribed for children, both intraoperatively and post-operatively, and in fact, despite what we've done in Altnagelvin, despite what we've done in Northern Ireland, the situation in England in 2004, despite what Dr Haynes said -- Dr Haynes said that, in his opinion, it was unique to Altnagelvin. And

the chairman, I think you'll correct me if I'm wrong, said, "And other hospitals in Northern Ireland", and Dr Haynes said, "Yes, other hospitals in Northern Ireland", but it was a unique experience.

But a paper in 2004 -- actually produced in 2006 but looking at 2004 data by Way et al, and I have given this for the inquiry's perusal, looked at the prescription of fluids in medical schools in England, and they chose Bristol and the north-west. These are two major medical schools, and they asked consultant anaesthetists their prescribing practice. This is in 2004. And in 2004, 60 per cent of consultants were prescribing No. 18 Solution intraoperatively.

Now, we were already in Altnagelvin using Hartmann's intraoperatively in 2001. But in 2004 anaesthetists in England, where Dr Haynes comes from, were actually giving No. 18 Solution.

Post-operatively, 75 per cent of anaesthetists were prescribing it post-operatively low sodium containing solutions. And of all the low sodium containing solution there are the most popular one was No. 18. So No. 18 is alive and well in England in 2004, and it still is.

NPSA 22 says: thou shalt not prescribe No. 18 Solution to children. Yet I heard from a colleague

yesterday that a medical director in England was trying to stop the use of No. 18 Solution in England in his hospital because he's the brother of one of the anaesthetists who did a study with me looking at the fluids in children here in Northern Ireland.

So the Way paper is one thing, it's 2004, but I can tell you in England and in other countries, No. 18 Solution is still being used, despite NPSA 22 telling us we shouldn't.

THE CHAIRMAN: Maybe it's been followed in the same way CEPOD's followed, it's not followed.

A. Yes, and I think --

THE CHAIRMAN: The point is, doctor, Northern Ireland guidelines say move away from that in light of deaths in Northern Ireland. The NPSA alert is specifically for the equivalent purpose.

A. Yes.

THE CHAIRMAN: So the fact that there are doctors in England who continue to ignore it, what point are you making from that --

A. Well, my point is --

THE CHAIRMAN: -- the fact that there are doctors who continue to ignore national alerts and guidelines? I'm not sure where that point takes anybody.

A. I think the point is that No. 18 Solution is still

a danger --
THE CHAIRMAN: Yes.
A. -- and what we've done in Northern Ireland is slightly ahead of the game.
THE CHAIRMAN: Absolutely, and again, as I said to you earlier this morning, that largely comes from the contact with the Chief Medical Officer from Altnagelvin, which led to the guidelines. They did put us ahead of the game. And Dr Sumner specifically at the inquest said these guidelines are ahead of anything else in the UK and they're excellent in terms.
A. My point is more about the 2004 paper by Way, in that No. 18 Solution in 2004 was still being used in England despite the fact that the Royal College had given an alert talking about it, and in fact the Way paper talks about the hyponatraemia inquiry in Northern Ireland and specifically mentions Raychel's case but not by name. It talks about a child who died in 2001. So it's very topical, and that's the situation in England.
So I think it was wrong to suggest that we in some way were doing something wrong in Northern Ireland. We were doing something that was being done elsewhere and we changed it as quickly as possible.
THE CHAIRMAN: Thank you.
Mr Stewart?

MR STEWART: If we just go back to where we were, and that is after the review it seems you carried out your calculations and in short form you came to the view that if there was additional fluid given, it was negligible in quantity; is that --
A. That's correct.
Q. But at that stage, you were also preparing your PowerPoint presentation. And I would ask for page 021-054-128 to be shown.
You delivered this PowerPoint presentation to many people, which you described in the bottom section:
"Our case. Received hypertonic fluids. Had preoperative sodium level below 140. Received excessive maintenance fluids."
A. Yes. That is correct. And I think in my presentation, depending on the audience, if it's a medical audience, then I'm talking about the study findings, and I'm saying where our case fitted in the statistics, and Raychel fits there because of all the things that you see.
In my statement to the inquiry, my second statement to the inquiry, I refer specifically to that and say that whilst our case did fit the criteria technically, the amount of excess was marginal. And that's why today I submitted that calculation to show how marginal it

was. So technically, it is true, she received excess fluids, and all I'm saying at that presentation is "Look, our case fits in with this one. This is what they were finding and Raychel does meet those criteria".
Q. Very well. After the review you also contacted several hospitals, as you mentioned, and you wrote the letter to Dr Fulton, medical director, of 14 June, which appears at 022-102-317. This is where you report back to your medical director to say that having contacted several hospitals, including the RBHSC, making enquiry about perioperative fluid management, you were informed that:
"Children's Hospital anaesthetists have recently changed their practice, have moved away from No. 18 Solution to Hartmann's solution. This change occurred six months ago and followed several deaths involving No. 18 Solution."
You say in relation to those several deaths that you refer to that you -- and this is your conversation with Dr Chisakuta -- that you didn't quiz him about what those deaths were.
A. No, I didn't. I asked him about the use of No. 18 Solution and he told me -- and I asked him about the rumour, and he told me that, and really that was the end of our rather exhausting day of calling all my colleagues that I could think of in Northern Ireland,

and I left it at that.
And my letter to Dr Fulton, that could have been written slightly more clearly. And if there's a lesson anywhere, it is that you should be clear with every word that you write because it may come and haunt you years later. Looking at that letter, I can see that that could imply that the deaths had occurred in Children's Hospital but I've been --
Q. I want to ask you this. If you didn't quiz him and you didn't know where the deaths had occurred, why didn't you quiz him? That's the question. Because after all, if you're annoyed that they've stopped Solution No. 18 in Belfast, you've had a death and he says, "We've stopped and we've had several deaths", that makes it even worse. Why didn't you say, "What? How many? When?"
A. Well, you're suggesting that I was annoyed.
Q. You must have been flabbergasted at this information.
A. Irrespective of how flabbergasted I was, I was also a bit tired, and I didn't quiz him on it, but over the weekend I had already read the Arieff paper. So for me, the idea that it was a possibility that children could have problems associated with No. 18 Solution wasn't a novel idea.
And, of course, Dr Chisakuta would say, well, he'd

already presented that at the 1998 Western Association meeting, although I have no recollection of that. But certainly over the weekend, I knew that -- this was before talking to Dr Chisakuta, I knew there was a problem with No. 18 Solution, and that's why I'm saying that at the meeting on 12 June I discussed the problem of No. 18 Solution. The discussion with Dr Chisakuta was on the 13th.

THE CHAIRMAN: I just want to get this clear. Are you telling me that it was a matter of indifference to you that the Royal had changed away from Solution No. 18 and hadn't bothered telling any of the area hospitals in Northern Ireland?

A. It's certainly not a matter of indifference to me. I'm saying --

THE CHAIRMAN: Right. That's what Mr Stewart was getting at. If it's not a matter of indifference to you, when Dr Chisakuta tells you that there have been several deaths and you now say to us "Well, I didn't know if he meant deaths in Northern Ireland or deaths anywhere around the world or deaths in the UK or wherever they were", why didn't you say to him "Well, I need to know more about that or what other deaths are you talking about?"

A. Well, I suppose -- I accept that criticism. I suppose

in my own mind, I knew that the problem was Solution No. 18. He'd simply confirmed that. I knew that we were having to change something, and I knew it was the Halberthal -- I knew it was the Arieff papers. That was the sort of thing I'd been researching over the weekend. I didn't go back and tackle them in the way that you're describing, and that could be accepted as a criticism.

THE CHAIRMAN: It's not so much a criticism, it's a concern about whether there is some effort to distance everybody from the bank of information which had built up in Northern Ireland, because at least some people in the Royal knew about Lucy's death by then. Now --

A. In retrospect that's true.

THE CHAIRMAN: -- when you said -- well, the people in the Royal didn't need retrospect. They knew. She'd only died the year before.

So when you say you rang around several hospitals, did you ring the Erne?

A. I rang -- well, when I rang Dr Anand, I don't recall ringing the Erne. That's not to say I didn't. There are hospitals I have listed that I remember distinctly because of what they said to me. And I didn't make a list of the hospital I rang, it wasn't a record in that way. I never thought it would come to this.

THE CHAIRMAN: The Erne at that time was in the same Western Board area, wasn't it?

A. It was in the same Western Board area, but a different trust though.

THE CHAIRMAN: A different trust in the same area --

A. I rang --

THE CHAIRMAN: -- with connections between the two hospitals.

A. Yes, I rang Omagh Hospital. So for me Sperrin Lakeland is two hospitals, it's the Erne Hospital and Omagh Hospital. And from the Sperrin Lakeland perspective I rang Omagh because I actually knew the anaesthetists in Omagh better than I would have done the anaesthetists in the Erne. And in fact, in the Western Association of Anaesthetists it's open to all area -- all the hospitals in that area, including Letterkenny, but very few anaesthetists from the Erne would ever have come to it.

THE CHAIRMAN: But you're now describing this as if you took a conscious decision not to ring the Erne.

A. No, I'm not describing that. I may have rung the Erne, I don't recall it, but Dr --

THE CHAIRMAN: If you'd rung the Erne, you must have received the information about Lucy, unless there's some extraordinary development, because they had a death in

which Solution No. 18 was implicated.

A. You would assume that that's the case, but if I had phoned the Erne and I wasn't told that, that would be a criticism of the Erne. I cannot say hand on heart that I rang the Erne.

I certainly rang somebody in Sperrin Lakeland Trust, and that was Dr Anand. And I think when she said, "We have stopped using it", I assumed it was the royal we, which is applying across the trust. I didn't clarify that with her, and I wish I had made a list of all the people I'd phoned, and then I could have read that out to you. I simply said that -- that's what I did, it was a gut reaction to ring colleagues to warn them about what might be ahead of them.

THE CHAIRMAN: Let me make it clear, I'm not criticising you for ringing around, I'm not criticising you for following this up. None of that is criticism. But what is very striking about Raychel's case, apart from Raychel's own circumstances, is that her case went through a critical incident review, was known about in the Royal, and went through a coroner's inquest without anybody at any time referring to Lucy, who had died the previous year in circumstances which had similarities.

A. I didn't know about Lucy's death, so I couldn't have

told the coroner.
THE CHAIRMAN: Do you understand why I'm surprised?
A. Yes.
THE CHAIRMAN: That through the various connections and through the -- and but for Stanley Millar in the Western Health Council, nobody knows when Lucy's death would have been connected --
A. Yes. I mean, I did not know --
THE CHAIRMAN: -- and that does not sound natural to me.
A. I'm not sure how I'm meant to take this.
THE CHAIRMAN: That's why Mr Stewart was quizzing you on this, and I'm asking you some questions now because I don't understand how in 2001 and 2002, when all this discussion was going on about Solution No. 18, people who should have told you about Lucy or other people who knew directly about Lucy did not raise Lucy's death as part of the developments on foot of Raychel's death.
A. I'm equally surprised by that, and I think I've said that in some parts of my statement, that had we known about previous deaths, then maybe Raychel's death would not have occurred. And in fact, I did say that to --
THE CHAIRMAN: I'm on a slightly different point. I'm on to the fact that after Raychel's death had occurred and there are investigations, there's an inquest, there are guidelines and there's a working party, Lucy's death is

not raised, and I can't understand how that happened.
A. Lucy's death wasn't raised but Adam Strain's death was.
THE CHAIRMAN: Yes, but the Royal knew about Adam Strain's death.
A. Yes, and so did the coroner.
THE CHAIRMAN: So did the coroner. In other words, the Royal raised Adam Strain's death, which had been through an inquest, and on foot of which they had advised the coroner that they were going to make a change, which would be advised to paediatric anaesthetists. Can I presume just for the record that you didn't hear anything about Claire Roberts' death?
A. No, not until the inquiry. And Lucy Crawford's death was probably -- the only time I heard that was the coroner actually told me about it following the inquest, and that was the most official notification. But prior to that --
THE CHAIRMAN: Sorry, following which inquest?
A. Lucy's in 2004. And in 2003, in the spring of 2003, which was actually after the inquest for Raychel, there was a TV programme going to be aired called When Hospitals Kill, and Trevor Birney had had -- I'd had a meeting with him so that he could understand the background of --
THE CHAIRMAN: I think that programme was actually

October 2004.
A. Yes, that's when it was aired. But in the spring of 2003, I met with Trevor Birney and he said that the child had died in the Erne. Now, whether he'd actually told me the name of Lucy Crawford, I cannot tell you, but I know that's the first time I learned that there had been another death there. But that was unofficial, completely unofficial.
MR STEWART: I want to take you back and just ask you some questions. You say that in the aftermath of your conversation with Dr Chisakuta you felt you needed to do something.
In your police statement you described urgency of the situation. You wanted to act. You'd been told that there were several deaths. Wouldn't the very fact that there had been several deaths fuel your arguments to achieve something?
A. But I was already achieving something because before I rang Dr Chisakuta, the ball was rolling. We had stopped -- well, my opinion is that we had stopped the use of No. 18 Solution in surgical children.
Q. Why did you not make reference to them ever again?
A. Make reference to?
Q. Those several deaths that appeared in your 14 June letter, you never refer to again ever after that. Why?

A. I refer to the Arieff paper because --
Q. No, I'm sorry, I'm talking about those several deaths. Why do you choose to omit them from every subsequent statement?
A. In relation to the meeting on 12 June?
Q. In relation to the whole business of what you learnt from the Royal Hospital after.
A. Dr Chisakuta told me there'd been other deaths. I later said that I believed that it was the Arieff paper he was talking about.
Q. You made that presumption --
A. It's referred to in my statement --
Q. Yes, you made that presumption some time later.
A. That's correct.
Q. I'm asking why you subsequently, before you made that presumption, chose to omit reference to them.
A. I don't think I chose to omit the reference.
Q. You did omit reference to them.
A. Yes.
Q. Why?
A. Well, because I didn't choose to, I can't give you a reason.
Q. I'm sorry, you wrote your subsequent statements, nobody else, I presume, why did you not refer to them again?
A. In my statements to the coroner or?

Q. The coroner, the police. Your statements.
A. Well, the coroner knew about the Arieff paper because --
Q. No, I'm sorry, I'm talking about the several deaths, I'm not talking about Professor Arieff's paper.
A. That is about several deaths, and the Halberthal --
Q. Are you deliberately trying to avoid the question?
A. No, absolutely not.
Q. Okay.
A. What I'm saying is I have referred to it.
Q. Because it looks as though you've heard about deaths, you choose not to make any enquiry whatever and then suddenly you're not mentioning them ever again. Why?
A. When you say I don't make any enquiry, you mean with the Children's Hospital?
Q. Yes.
A. I can't explain that except that I had already got the Arieff paper sitting on my desk and knew about it.
I can see that -- I can see your irritation, I don't seem to be answering what you're asking me. I knew about the Arieff paper. I knew that No. 18 Solution was a problem and was more widespread than I'd thought, it wasn't just a Northern Ireland thing, and I think the actions that we put in place following that addressed those things.
Q. Well, in which case --

A. And --
Q. -- I think you'd have written your letter of 14 June "This change occurred six months ago and followed several deaths reported in a number of internationally published medical articles." That's what you'd have written.
A. I can see --
Q. You wouldn't have written "Six months ago, followed several deaths".
A. I concede that completely. I have already said I think that letter could have been clearer in that sentence and it was never meant to imply it was deaths in the Royal.
I understood from talking to Dr Commission that it certainly chimed, it harmonised with what I had read over the weekend, so I assumed that's what we were talking about. In that letter that is not clearly written, and I accept that it could have been written better.
There's no deliberate policy, there was no -- nothing -- I wasn't trying to cover up anything there or omit it deliberately. I thought that's what it referred to.
THE CHAIRMAN: Okay. We'll break for lunch. 2 o'clock.
MR STITT: Mr Chairman, one point perhaps you might consider, rather than waiting until the end of this

witness's evidence, if you were to -- there will be evidence from another witness, but if you were to ask the witness could he confirm if Dr Anand was the clinical director for anaesthetics at Sperrin Lakeland, in other words, TC, Tyrone County and the Erne Hospital, I don't know if you would want to follow that up with the witness or should we leave it until the witness next week, but it's just that it was touched on this morning.
THE CHAIRMAN: So although she was based in the -- is it the Tyrone County Hospital?
MR STITT: Yes.
THE CHAIRMAN: Was she the clinical director?
MR STITT: In a question form --
THE CHAIRMAN: For the whole trust --
MR STITT: If this witness can answer that. If he can't, he can't.
A. I'm unable to -- I knew she was clinical director. Whether that was just in Omagh, I can't tell you. I can't say. I know that she did work in the Erne as well, but that perhaps was later than 2001.
THE CHAIRMAN: Okay.
A. At that stage, they might have just been in Omagh.
MR STITT: Maybe we could asterisk that and the point could be put to Mrs Burnside when she gives evidence next week.

THE CHAIRMAN: Thank you, yes.
(1.03 pm)
(The Short Adjournment)
(2.00 pm)
MR STEWART: Good afternoon, Dr Nesbitt. The first witness statement WS035/1, page 3, if I may.
At the foot of this page, you say -- this was after you'd learnt from the RBHSC that Solution No. 18 had been abandoned some six months previously.
You go on to say that you:
"... requested that any data on hyponatraemia or the incidence of this in Northern Ireland would be helpful and Dr Taylor, consultant paediatric anaesthetist, agreed to send me these details."
When did you speak with Dr Taylor?
A. I can't recall exactly, but I remember that it was -- I knew Bob Taylor and I knew he'd been doing some work on hyponatraemia, and he sent me the details, and I believe they were the same details that he forwarded to the working group. I assume that they were because very much the type of slide that was in them I have incorporated in the middle part of my presentation on hyponatraemia on the incidence in Northern Ireland.
Q. How do you know Dr Taylor was pursuing researches into hyponatraemia?

A. Well, I can assume that I'd spoken to Bob Taylor at one of the paediatric resuscitation courses that we both would have been instructors on. That might have been a possibility.
Q. Had it been before or after Raychel's death?
A. It would have been after Raychel's death, I was unaware of --
Q. How soon after Raychel's death did you receive Dr Taylor's information?
A. I don't know that exactly. I know it was incorporated into my PowerPoint presentation that I eventually compiled, and I think that it was probably around September time that that was done, and that was on the strength of a letter from Mrs Burnside, requesting that I provide some teaching on the subject of hyponatraemia.
Q. And that was in 14 August?
A. She wrote to me in August and said, "Look, here's the Arieff paper, here's the Halberthal paper. Could [I] please arrange a presentation at the hospital management team". And I -- I'm not sure if she said the hospital management team, but certainly could I arrange a little teaching, and that fitted in with what I wanted to do and making a presentation.
Where the Bob Taylor fitted in with that I can't quite recollect.

Q. Did you have conversations with Mrs Burnside about the issue of hyponatraemia?
A. No, it was almost the opposite. She had a conversation with me because she said, "Look, here's the Halberthal -- probably through Therese Brown that I got the information, but the letter from Mrs Burnside was giving me stuff, informing me about hyponatraemia, but in fact I already had that, so it wasn't adding to the sum of my knowledge. I already had those papers.
Q. Did you have any discussions with Dr Fulton about other deaths in Northern Ireland from hyponatraemia --
A. Not that --
Q. -- in the summer of 2001?
A. Not that I recall. Only in that I did speak -- relayed the Tony Chisakuta message that there had been other deaths, and I knew -- well, by the time I had the graph from Bob Taylor, I'm not sure where we are chronologically here, but when I had the graph from Bob Taylor it did mention a previous death and it was 1997.
Q. Yes.
A. In fact, that is in correct and it would have been 1995, and that's one of the examples I was quoting earlier.
Q. Leave that anomaly aside for a moment.
MR STITT: Just an intervention, hopefully in a helpful

manner. The witness has said he wasn't sure when he was written to by -- he wasn't sure if Mrs Burnside asked him to deal with the hospital management committee, and Mr Stewart knows of the letter, but would it be helpful to have a brief look at the letter just to clarify this, seeing it's been raised. WS035/2, page 90.
THE CHAIRMAN: Yes, thank you very much. The request from Mrs Burnside was to arrange some teaching at a future hospital management team meeting. Thank you.
A. So I was preparing to do that. So from August onwards I was preparing my PowerPoint presentation. The question's been asked when did I prepare it. I'm not quite sure. I guessed September.
MR STEWART: Thank you. I'd moved on to ask you about conversations you may have had with Mrs Burnside and Dr Fulton in the summer of 2001 about other deaths from hyponatraemia. Was this subject raised between you?
A. Only in that I had written to Dr Fulton telling him that the story I'd heard was there were other deaths. And at the meeting on 12 June, we discussed the fact that -- that was my concern about No. 18 Solution was that there were other deaths associated with it because that was the problem with No. 18 Solution.
Q. Sorry, you say that you discussed the other deaths at the 12 June meeting?

A. At the 12 June meeting, the concern for me was the No. 18 Solution.
Q. I thought you only learnt about the several deaths when Dr Chisakuta referred you to them on 13 June.
A. No, I think if you look back through the transcript you should see that what I said was I researched -- before speaking to Dr Chisakuta at the weekend, I researched the journals. I knew from the rumour that I'd had heard that we had given the wrong fluid, and when I looked it up No. 18 Solution there's articles on it, and that's the Halberthal paper and the Arieff paper and it talks about deaths associated with No. 18 Solution.
So that was discussed at the meeting on the 12th. That was the reason why I wanted to change No. 18 Solution.
I didn't talk about any deaths in Northern Ireland because I had no knowledge at that time there were any deaths to do with that in Northern Ireland. The first instance of that was Bob Taylor's information from the Children's Hospital.
Q. You would have been interested, would you not, in the incidence of other deaths in Northern Ireland?
A. Yes.
Q. Because they would have been in hospitals where your colleagues would have been working?

A. Yes, that would have been vital.
Q. Can we have a look at 021-056-135, please. This is an e-mail sent by Dr Carson to the CMO, but you will see that Dr Raymond Fulton, your medical director, is copied in, and you'll see at the top, he then forwards it on from Fulton, Raymond, to Burnside, Stella.

So there we are, at the end of July 2001, in the hospital, your medical director and your chief executive now know -- and we quote the beginning of the second paragraph:

"The problem today of dilutional hyponatraemia is well recognised. See the BMJ editorial. The anaesthetists ... would have approximately one referral from within the hospital per month ... previous death approx six years ago in a child from the Mid-Ulster. Bob Taylor thinks there have been five or six deaths over a ten-year period of children with seizures."

Was this mentioned to you in your conversations with your medical director and your chief executive?
A. I had many conversations with both.
Q. Was this mentioned? I'm not asking how many conversations --
A. I can't recollect, but I wouldn't doubt that it was mentioned because any concerns that there might have been about hyponatraemia were very foremost in our

minds, especially the chief executive who wanted me to provide the teaching on it.
Q. So when do you think you learned about this? So, you don't doubt or you do doubt?
A. I have no reason to doubt it was mentioned to me.
Q. Now, you are leading, spearheading the campaign to ban Solution No. 18, really. This is a mission that you have set yourself. You're part of the working group. Your medical director knows your part of the working group, your chief executive knows you're part of the working group. You know about these deaths. What do you do with the information?
A. The deaths I'm talking about are not those deaths but the deaths that Halberthal and Arieff --
Q. I'm talking about these deaths.
THE CHAIRMAN: Let me ask it to you this way. If you thought that the deaths that Arieff and Halberthal were referring to were deaths anywhere in the world, does this e-mail not make it clear that we're talking about local deaths?
A. Yes. It's not copied to me so I haven't seen that e-mail. I'm suggesting that if they had talked about other deaths, the seriousness of hyponatraemia was that other children had died before.
THE CHAIRMAN: Yes.

A. I was not aware of other children other than Bob Taylor telling me in his graph, that was the only data that I had relating to hyponatraemia. I appreciate that they're talking about the Mid-Ulster. I have no idea what that is, that doesn't appear --
MR STEWART: I'm not asking you about data that you had --
MR UBEROI: Sir, might I just raise a context in fairness. My reflection of Dr Carson's evidence was that he took these figures on balance to be referring to national figures, as opposed to local figures. I appreciate other interpretations are being probed, but that was certainly Dr Carson's evidence, as I recollect it.
MR STEWART: That was his supposition, his presumption.
MR UBEROI: It was supposition because of the specific phrase, the Cochrane review.
MR STEWART: Which is an international review which can apply anywhere across the globe.

So I want to know not about data you had in your possession, I want to know about information that had come to your attention. If this had come to your attention, and you are the person in Altnagelvin who's interested in Solution No. 18, you would have wanted to find out about these deaths, wouldn't you?
A. It would have added weight to the campaign that I was starting. I don't think it would have altered the way

things went.
Q. It would certainly have added weight to your campaign, it would have rocket fuelled your campaign. So what did you do to find out about this information?
A. I don't think I did anything to find out --
Q. Why didn't you do anything?
A. Because I was completely focused on effecting the change in Altnagelvin. I was completely focused on joining the working group. Dr Fulton had arranged that I would join that working group. So I was happy that at least I was going to voice my concerns in the Department of Health about our experience in Altnagelvin and the Halberthal paper; I keep referring to that. I did have information from Bob Taylor as I was getting the PowerPoint presentation together. It gave no details of names or where the death actually --
Q. Exactly. And that's why you have to find out, and you have to find out in order to determine whether or not there's been negligence, whether or not there's been something which ought to be referred to the coroner, whether or not there's something which might inform your research.
A. That's an interpretation you can put on it. I didn't see my role as being that. I wanted to effect a change and spread the message in the Royal.

Q. Don't you have a duty towards patients everywhere?
A. Well, I believe that I do and I believe that I have to the very best of my ability effected those changes and no matter what you say, I did go to the department with the information that I had, not this information, but the change was still effected.
Q. I'm asking not about what you did right and I think tribute should be paid to you for driving through those changes, but I'm asking you about this. Because if one of these cases had been a case which had been overlooked, which should have gone to the coroner, there might have been parents out there of a child who didn't know what had caused their child's death.
A. When I went to Belfast, I did not know of those deaths. There's no mention of the Mid-Ulster or any other deaths.
I just had the statistics that I have talked about from Bob Taylor. So I didn't know about them. Perhaps if that had been sent to me I might have acted differently to what you're suggesting.
Q. When you got Bob Taylor's statistics, his bar chart was incomplete, wasn't it?
A. It's not exactly the same as my bar chart.
Q. I know it's not the same as yours, that's not what I'm asking you. His bar chart had no entries for 1995 and

no entries for 1996. And, of course, we know that Adam Strain's death was 1995 and Claire Roberts in 1996. So when you got that information, were you not struck by the incompleteness of it?
MR UBEROI: I ask again for clarity. We obviously know that Claire Roberts' death was 1996 now, classically with the benefit of hindsight. I also add that this bar chart was a draft, and there's also further relevant evidence on it in that the PICU secretary mined the information from the PICU database, that's simply so that the full picture of this bar chart is put.
MR STEWART: Yes, the full picture, the evidence has been heard on that.
Let's have a look at Dr Taylor's bar chart.
MR STITT: Mr Chairman, just before we leave the letter, it's present on the screen. Is it not fair for me to suggest that the witness is reminded, this is a letter not to him. I know he's made the point that he wasn't copied into it, but it is actually from the Royal to the Chief Medical Officer. So I don't know if it's suggested that somehow this information was not being circulated and it's gone to the highest level.
THE CHAIRMAN: Sorry, the point was it went to Dr Fulton, and this witness, Dr Nesbitt, has said he doesn't doubt that this was then mentioned to him.

A. Can I just clarify, chair? If I've said that, what I mean to say is I don't doubt that deaths associated with hyponatraemia were not mentioned to me by Dr Fulton and --
THE CHAIRMAN: This is the point of Mr Stewart's questioning and it's an important area for Mr Stewart to probe, and he does so with my complete approval. I am very concerned about how much information was shared at the time. Dr Carson it was who came to this inquiry and said that doctors are very good at announcing their victories but not proclaiming their mistakes, and what we're exploring here is whether there was more which was known behind closed doors than has been disclosed to the inquiry or faced up to. I think you know the point of this questioning.
A. I do know the point.
THE CHAIRMAN: And it seems very curious to us that if there is a working party and this is a build-up to the working party, which is reviewing hyponatraemia, which can be fatal in children's cases, that there was not at least some discussion about the fact that apart from Adam Strain, other children had died in Northern Ireland from deaths associated with hyponatraemia. At the very least that must -- even if we say that there was some misdiagnosis of the reasons for Claire's death, which

might be a generous assumption, I don't know and can't understand how this exercise, this exchange of the people who knew most about this area of medicine and the people who discussed it most, the people who were most worried about it and the people who drew up the guidelines could possibly have done this work without revealing Lucy. And what Mr Stewart is probing is the question of whether in fact Lucy was known about, but to put it bluntly, nobody's letting on about it.
A. Well, can I, for avoidance of doubt, say that I did not know of Lucy Crawford. I did not know the details of Adam Strain. I thought the evidence was it was 1997, according to the data that I had on the graph.
When I went to the meeting in Belfast, arranged by the CMO, the issue was for me Raychel Ferguson. And I said at the meeting very clearly "We have had a death, Raychel Ferguson is the case I'm talking about".
I had no knowledge of other cases specific to Northern Ireland, and I can't be clearer than that. If other people in the room knew that they too had a case like that, it was for them to say it. I had no way of second-guessing them.
THE CHAIRMAN: Do you appreciate how -- I mean, I'll obviously weigh up all your evidence with all the other oral evidence and the documentary evidence, but do you

understand how to an outsider it seems at the very least curious that not even Lucy's death cropped up in the context of the working party?

A. It would appear curious, but from my own -- I'm sounding very defensive, but from my own personal contribution to the meeting I did not know about Lucy Crawford.

THE CHAIRMAN: But if you --

A. Others might.

THE CHAIRMAN: That isn't quite the question. And I accept that you have said that a number of times. The question is, if you're sitting round a table with people who are concerned about deaths which are related to fluid maintenance, there were people round that table who were aware of the death of Lucy Crawford.

A. I don't doubt that.

THE CHAIRMAN: And the notion that they kept quiet about that and did not put it -- did not add it to the discussions which took place seems to me hard to understand.

A. If I could just say one more thing. I think the remit of the meeting was to get consensus on intravenous fluids in children, not to investigate the deaths of any particular children. I've answered that question in my second statement.

MR STEWART: Can I ask you where you got that answer from?

A. Pardon?

Q. Can I ask you where you got that answer from?

A. It was my recollection of the reason for having the meeting and that would be the -- that would be the letter from Paul Darragh. I'm thinking --

Q. Can we get this out of sequence -- in fact, we'll come back to it if I may because I want to establish some groundwork first, please, with you. Can I ask you, for the avoidance of doubt, when you answered this question a moment ago, you employed a most curious double negative, "I don't doubt I would not". I want for the avoidance to get a completely straight answer from you, Dr Nesbitt.

A. Okay, that was not intentional.

Q. Did you in 2001 have any part of the content of this e-mail brought to your attention in any way whatsoever?

A. No, I don't believe I've seen that e-mail until --

Q. No, I didn't ask you that. I said was any part of the information contained in it brought to your attention?

A. There are parts of it that are familiar to me, but not from that particular e-mail. I mean, there's things there that I know about, like formula milk and risk of hypernatraemia. Those are things I've alluded to, those are things I know. The BMJ editorial, I know about that, but it wasn't from this e-mail. I haven't seen

this e-mail until I have seen the evidence from the inquiry.

Q. And are you saying that Dr Fulton didn't discuss the content of this with you?

A. Not to my knowledge.

Q. Are you saying that Mrs Burnside didn't discuss any part of the content with you?

A. I don't believe this particular e-mail was discussed with me.

Q. Did she discuss any other deaths from hyponatraemia with you?

A. No, only that the Halberthal and the Arieff paper was the thing she was asking me to talk about, and that was about deaths from hyponatraemia.

Q. Did Dr Bob Taylor discuss any part of the content of this e-mail with you?

A. No.

Q. Tell me this. Did you discuss any other deaths locally with Dr Fulton?

A. I don't believe I did.

Q. Did he tell you about any other deaths?

A. Not at that time. Not to my knowledge.

Q. When he went off to Belfast on 18 June 2001 to attend a meeting of his fellow medical directors, did he come back and tell you but a conversation he'd had with

Dr Kelly from just down the road in the Erne?

A. I believe he told me that Dr Kelly said they'd had a problem with No. 18 Solution or intravenous fluids. I don't believe any name was mentioned or death.

Q. So you think you came back from that with the absolutely astounding news that there had been another death and in which Solution No. 18 was implicated, and again that the Royal had stopped their use and hadn't told you, but just referred to it as a problem?

A. Are we talking about Dr Kelly now or --

Q. I'm talking about what Dr Fulton said to you.

A. I believe Dr Fulton said that at the meeting Dr Kelly had said to him that they too had had a problem with intravenous fluids in the Erne, but no more than detail than that, as far as I can recollect. I certainly wasn't told about Lucy Crawford from Dr Fulton.

Q. And does it surprise you now to hear or read what Dr Kelly said about that meeting and feel that Dr Fulton didn't come back and tell you what he knew?

A. It does seem surprising because if Dr Kelly's talking about the problem -- and the timing of this must be Lucy Crawford, that he's referring to, but there was no name mentioned, nor was a death mentioned --

Q. Yes.

A. -- as far as I know.

THE CHAIRMAN: I can understand the name not being mentioned. I can't understand how there's reference to a problem when in fact the problem was a death, and it's exactly the same sort of disastrous problem that you had a year later in Altnagelvin.

A. It seems incredulous. All I can relate is what Dr Fulton would be relaying to me would be that when he went to the meeting, there was concern in the room and Dr Kelly had a concern about a fluid experience they'd had. But there was no more than that, as far as I know. And Dr Fulton can maybe shed more light on that.

THE CHAIRMAN: Yes.

MR STEWART: Well, it was more than that because Dr Kelly's given a statement in which he said he and Dr Fulton took a vox pop on the room and the anaesthetists said, yes, there'd been near misses, and the medical director said there's been problems. So it was something that seemed to be known about at that meeting, there were very few people there but known to them nonetheless.

A. I wasn't at the meeting so I can't comment.

Q. No, but you are a consultant anaesthetist with a particular interest in paediatric matters. Are you saying you had heard nothing at that time of problems or near misses?

A. At that time I had no other information about

hyponatraemia or incidences of it, and when Raychel Ferguson, the tragedy occurred, that was the first experienced I'd had in 34 years of medical practice of seeing a child develop hyponatraemia of that nature, and it is an extremely rare situation. I think if you have a room of anaesthetists, it may be that then you get a more global feel for it, and it's more like the Cochrane database because then you might get a better feel for how many instances there were.

Dr Fulton said that in the room there was a disquiet about No. 18 Solution and some people said they would go back to their own trusts and look at was it being prescribed and so on. But there were no other mentions of deaths to my knowledge.

Q. So Dr Fulton did come back and did describe the meeting and did tell you what was said, and left out the one extraordinary piece of information, that drove him into that meeting in the first place, that there had been another death with Solution No. 18?

A. What drove him into the meeting in the first place was the Raychel Ferguson tragedy. When he came back and said -- he did not say of any other deaths. He said that -- there was a discussion in the room and it was towards the end of the meeting. This is second-hand. This is conversations I've had with him.

My recollection is that he said that towards the end of the meeting some people had left, there were a few anaesthetists left because quite a few medical directors are anaesthetists, and there was a discussion about "We'll have to look in our trust to see if that's happening", and some anaesthetists said, yes, they had heard there were problems with Solution No. 18 as well. But that's anecdotal, it wasn't said to me, and no other deaths were mentioned, I'm fairly sure about that.

Q. You see, the trouble is that all the individual players, many of the individual players across Northern Ireland on this, all individually know these deaths, and suddenly people can't remember. Suddenly there was no communication. Suddenly when several deaths are mentioned, as you did, they don't reappear again. Could there be a sort of a sense that you're all not rocking the boat and that nobody's mentioning these deaths?

A. Can I go back to the fact that you suggest it never appeared again. But the other deaths became -- not deaths in Northern Ireland, the other deaths associated with No. 18 Solution became central to the PowerPoint presentation that I gave to the world and his wife. Everybody I met I gave that presentation to. So it wasn't like I mentioned it once and never, ever again. I mentioned it every time I met somebody.

Q. Yes, and central and remarkable for its inaccuracy.

A. My presentation?

Q. Yes. For your bar chart, which leaves out two years which contain two deaths that we know about and which Dr Taylor knew about.

A. I took the bar chart in good faith. It was sent to me. I did not make that bar chart. That's what I was given. So I incorporated that in my teaching, and part of it was the incidence of hyponatraemia in Northern Ireland, background, and I said, "Well, here's the incidence from the Royal Belfast Hospital for Sick Children".

Q. But you'd had several deaths referred to you which you hadn't bothered to find out about.

A. There were two deaths on it, one was Raychel Ferguson, because that was 2001, and the other one was 1997, which I had no details of. That's quite correct. And I did not research that any further, and so that error, if you like, 1997, it was actually 1995, and obviously Adam Strain, but that error was then promulgated through all my presentations because I kept using that bar chart.

Q. When did you first learn of Adam Strain?

A. I believe ... When Hospitals Kill, 2004.

Q. Did nobody in the trust tell you about it? Because Mrs Brown told us the other day that the coroner rang

her and told her about it in December 2001.
A. Yes. He did not say it was Adam Strain, he said that he had investigated -- and he'd used Dr Sumner as an expert in a previous case in Northern Ireland and it was a similar case. That was all. And in fact, in the coroner's inquest, he said more, he said that it had been just exactly the same. I don't believe the name Adam Strain -- I can't recall that. But I did not know of Adam Strain's name.
Q. That's the only case in which Dr Sumner also give evidence which the coroner heard, isn't it? It was Adam Strain's case you were discussing by name or not.
A. In Northern Ireland?
Q. Mm.
A. But Dr Sumner also produced all the stuff that I'm talking about, Arieff, Halberthal, and he --
Q. Did Mrs Brown tell you about what she knew of this other death that the coroner had investigated in which Solution No. 18 was implicated? Did she tell you about that?
A. She -- there are no details of that. It didn't say Adam Strain, just that the coroner had investigated a death before.
Q. She told you about that?
MR STITT: I'm sorry, this is the third or fourth time and

the transcript will bear this out that the witness has been in the process of answering when he has been cut off. Now, I appreciate that counsel is enthusiastically following the line of questioning, and I'm sorry for appearing to break that up, but it's only fair that the witness is allowed to finish a sentence or finish his answer, and there are at least two recent examples within the last five lines or so when that has happened.
MR STEWART: I do apologise. I don't mean to be rude. However, I would appreciate it if Dr Nesbitt could attempt as best he can to give a succinct and clear answer to the questions, and that will preclude any further harassing of him by me, and I apologise for that.
Is your evidence that Mrs Brown did tell you in December 2001 that she had heard of the death of another child, a death investigated by the coroner in which Solution No. 18 was implicated?
A. I don't believe in 2001 I was told that by Therese Brown.
Q. When do you believe you first came by that information?
A. It was after that and it was -- I was asking, well, when did -- when did I first find out that there had been another death in Northern Ireland. And I asked Teresa and she said the coroner had phoned her on 5 December

and that's why that information came to her, but --
Q. When did it come to you?
A. Well, I can't remember exactly, to be as succinct as I can --
Q. It was before the inquest, wasn't it, before Raychel's inquest, wasn't it?
A. Yes, it was, because I knew in May -- in May 2002, I knew that the coroner had previously investigated a death and I assume that was from the information that Therese would have had from December 2001, but in May 2002 I was then medical director and would have worked more closely with Therese. As a clinical director in anaesthesia in 2001 I wouldn't have.
Q. How did you get the information in May 2002?
A. I'm not sure. The information for Henrietta Campbell, when I wrote my letter to her and said, "Look, the coroner had investigated a death before, I could see it on the graph. I thought it was 1997", and the fact that's why when I wrote to Henrietta Campbell I said investigated the death of a child five years ago, if you look chronologically, that puts it at 1997, in fact it was longer than that, it was 1995.
Q. But you see, you've previously told people, correct me if I'm wrong, that that death that you referred to the CMO was the death you saw on the bar chart.

A. I assumed it was.
Q. But that bar chart didn't tell you that that death had been referred to the coroner, did it?
A. No, it didn't.
Q. So how would you know to write to the coroner if that was your only information?
A. I didn't write to the coroner.
Q. I beg your pardon, write to the CMO.
A. Because obviously, at some point between December 2001 and me writing to Henrietta Campbell, I'm assuming Therese Brown told me that the coroner had phoned her, I'm sure it wasn't a secret, that previous death had been investigated.
Q. Why do you presume it was Mrs Brown as opposed to many of the other people with whom you were having conversations who would also have known?
A. Well, I don't know. I can't tell you who it was told me that. But I know that factually it's correct. So the letter that I wrote to Henrietta Campbell, as far as I was concerned, was factually correct, but I was going on the bar graph, and the coroner did not say in which year it was that he'd investigated a child, just that there'd been a previous case, very, very similar to it.
So I just put two and two together and assumed it was the same one. That may be incorrect for me to have

done that.
Q. Before we leap forward, let's just stick with the basic chronology. That was your attendance with others to meet with Mrs Ferguson on 3 September. And you have given an account of that at WS035/1, page 5.
The bottom paragraph deals with that meeting and how you expressed your sincere condolences and so forth:
"During the meeting I remember answering why I thought Raychel had died."
Can I take you a few lines down to a sentence beginning:
"The fluid therapy [about five lines down] which Raychel received was the same as that used in other hospitals, and the standards of care were the same as in other units treating children."
Did you tell Mrs Ferguson that the fluid therapy was not the same as being used to your knowledge in the Royal Belfast Hospital for Sick Children or in the Tyrone County Hospital?
A. No, I don't believe that I did.
Q. Well, why not?
A. For no particular reason. What I was trying to say was that in as sympathetic a way as possible, that the care and treatment that Raychel got, in my opinion, and of course it's my opinion, was the same as she would

have got in Craigavon or the Ulster, any other hospital.
I appreciate that that there says in other hospitals, it doesn't say in all other hospitals. But I understand that the context -- you could take out of that that everywhere was doing exactly the same, but I knew that the Royal was slightly different.
I don't think it would have contributed to helping Mrs Ferguson at the time, and also, it was not proved to me that that was the case. That was something that Dr Chisakuta had told me and it was something that I was incorporating into my teaching on it, but I had no concrete evidence --
Q. But you'd had corroboration from Dr Anand, is what you tell us.
A. Dr Anand told me that the Royal had stopped using it. I have not ever tried to actually get to the root of that and prove it.
Q. Tell me this, did you attempt to find out if that was so? When you went along to the working group and there was Dr Taylor, did you not say to him "Well, did you or didn't you stop using Solution No. 18?" Surely by 3 September you'd have known?
A. I can't recall and it would seem amazing if I didn't because I was very caught up with the fact that Raychel had died and I remember at that meeting --

THE CHAIRMAN: It would seem amazing --
A. It just sounded like a broken record.
THE CHAIRMAN: It would seem amazing if you didn't at the working group say "Well, is this information I'm getting right that the Royal stopped using Solution No. 18 because that's what I hear from South Tyrone?"
A. I don't believe that conversation took place.
THE CHAIRMAN: Because on the working group, that is undoubtedly information which should have been shared. I mean, if the Royal had -- Arieff and Halberthal and so on are very important, but on the information which we understand Dr Taylor had already been researching for some time, unfortunately you didn't need to look outside Northern Ireland for information about the dangers of Solution No. 18.
A. And my only defence I can think of was that for me it was an opinion that I had, it wasn't concrete evidence, and it would certainly have been finger pointing if I'd done it. And I don't know that in the context of that meeting it was about the deaths of particular children, it was about coming to some sort of acceptance of what the proper solution for children should be. And for me to start pointing fixers and saying, "But you should have told us" I think would probably have been counterproductive.

THE CHAIRMAN: We'll come back to that later. I think you want to deal with 3 September first, Mr Stewart.
MR STEWART: Well, moving on here, thank you, sir, the standards of care, this is what you tell the inquiry. You told them:
"The standards of care were the same as in other units treating children."
Well, the critical incident review looked at the standards of care and found some of them to be wanting. So unless care is wanting in all the units treating children in Northern Ireland, and we don't know that isn't so, this statement appears to be untrue.
A. It's my opinion that the care and treatment that Raychel got in Altnagelvin Hospital would have been the same or very similar to another hospital. For example, the problem that we discussed about with recording vomiting is the same in all hospitals, and I've always seen that two plus, three plus system being used.
The fact that the policy of who prescribes the fluid was unclear would be the same in other hospitals as well because in all the hospitals I worked in, I've never seen a clear policy about who would prescribe the fluid.
Q. But other hospitals might check the U&Es, other hospitals might make fluid balance chart records, other hospitals might not administer excess quantities of

fluids, other hospitals might have proper protocols for ensuring there was supervision of patients. Other hospitals might have nurses who would have got hold of surgeons when needed on the paediatric ward. There was a raft of deficiencies identified at the review and you think that the standard of care was adequate? Liability's now been admitted in this case.

A. Well, at that time I did think the care was as good as you'll see anywhere. I had a lot of respect for the nurses on the ward. I dealt with them on a weekly basis, certainly, and was very familiar with their care and attention they would give. And the view that I had got from the nurses was that the vomiting, although prolonged, was not severe.

So I was working, if you like, on good faith because that's clearly what they told me. I knew that the problems with, as I said, recording plus systems are notoriously difficult everywhere, I knew that prescription of fluids is -- it's just common sense where the anaesthetist prescribes fluid in theatre and it continues on in the ward. But the anaesthetist isn't there and the surgeon takes over.

Q. How useful is a review that takes on good faith what it is told?

A. Well, we asked the nurses. I mean, I don't know how you

would come to anything other than say, well, I believe what you're saying.

Q. Tell me this, did you tell Mrs Ferguson at that meeting that in fact you'd had a review and that you were putting in train changes? Did you tell her that?

A. Not specifically.

Q. Why not?

A. Because --

Q. Useful information?

A. Yes, that is useful. And if we had known the way the meeting was going to go now, we could have played it differently.

Mrs Burnside, when she organised the meeting, said, "Look, those who want to come along and speak to the family are going to come along and we want to be gentle, we want to be sympathetic, we want to answer questions they might have". So the meeting started in that vein and very quickly changed to an agenda where questions were being fired at us.

And in retrospect, you could have gone into the meeting and said, "Look, this is what's happened, we have had a clinical incident meeting and here's the action points from it", and we'd have delivered that to Mrs Ferguson and the family members that were there. That would have been one way of doing that, and in

retrospect that would have been a better way of doing it.

What we went into the room initially thinking was, we were going to discuss to help Mrs Ferguson with questions that she might have.

And I have dealt with -- I mean, Dr McCord touched on this in his evidence. I've dealt with this type of thing before where you meet with distraught parents and you comfort them, you support them, and you help with questions that they have. The meeting did not evolve that way. So as the meeting progressed, the answers that I gave, I believe, addressed many of the issues that came out of the clinical incident meeting. But we did not address each action point in order, I fully accept that.

THE CHAIRMAN: Sorry, you can't say on the one hand that you were there to answer the questions that they asked and then refer to the way in which questions were asked as "the meeting started in that vein and very quickly changed to an agenda where questions were being fired at us". A question's being fired at us is, I'm afraid, a rather inappropriate term to use for the Ferguson family coming to that meeting and asking questions.

As I understand it, these questions were asked after they had effectively been told that the treatment which

Raychel received was the same treatment as she would have received in any other hospital. So they were being told there's nothing wrong with what Altnagelvin -- and they were being told in terms: there's nothing wrong with the way that Raychel was treated in Altnagelvin.

A. It was -- the comment was wrong. I mean, it's wrong to say it like that. It just meant -- it meant that the meeting --

THE CHAIRMAN: But that's --

A. The way the meeting went was not the way I envisaged it would unfold.

THE CHAIRMAN: Yes, but maybe the Fergusons didn't envisage that the meeting would unfold by them being told that their daughter had received the same type and standard of treatment that she would have received anywhere else.

A. Yes, that was said, but also what was said was "Look, what happened here is a tragedy" -- I mean, the meeting -- we said it was a tragedy and we said that what had happened was --

THE CHAIRMAN: And I think they acknowledge that. They acknowledge there was a degree of sympathy, they acknowledge that there was a degree of sympathy and the tragedy was addressed. But the vein in which the meeting then continued was the defensiveness, which is how I would describe it, of the people in Altnagelvin

telling them how Raychel was treated, not telling them even in general terms -- I'm not sure and Mrs Ferguson and her sister and family were then expecting to have precise details and technical terms used, but if even somebody had said to them, "We've learnt some lessons from this and we are improving our procedures in an effort to make sure this doesn't happen again", but of course, it's difficult to say that when you're simultaneously telling them that she received the same level and standard of care as she'd have got anywhere else.

A. But I said that to them. I did say, "Look, we have learned lessons from this. I have changed practices. I have introduced changes in the fluids. I have introduced -- I will be introducing teaching to my colleagues and this will go much further than this. This will be something that will go across Northern Ireland and the UK", and at that meeting I gave Mrs Ferguson a commitment that I would do everything that I could to make sure that that change was effected and that there was learning from it. So I've a very clear memory of that part of the meeting.

MR STEWART: Can I refer to 022-084-223, because sadly the minute of the meeting doesn't really accord with your recollection.

Down the bottom it says:

"Dr Nesbitt said we all feel the same. If it was my child ... [he said] the fluids used are the standard across the country. We may have to change these if children are getting too much sodium. There has to be a middle ground. Nothing we were doing was unusual."

A. Can I -- without wishing to make too much of this, can I make a comment, chair? And that is that this is not a minute of the meeting in that at this tribunal we have a transcript, which is a verbatim account, syllable by syllable, every "um" and "ah" is recorded, and I wish that's what we had for this meeting because --

THE CHAIRMAN: I am sorry, doctor, I don't need that because when this document was raised last February when the clinical hearings started, we asked if this account was -- if this record of the meeting prepared by somebody involved by the trust was accepted as accurate. And this record, of course, had gone back to Mrs Burnside very soon afterwards by the person who took the minute, Anne Doherty. And the information we were given is, yes, it is an accurate minute, save that it didn't quite capture the expressions of sympathy which were given at the start.

A. It's my recollection, yes, that that is true, I fully agree with that, but that particular sentence that you

read out there, "Dr Nesbitt said we all feel the same, it was my child", and so on:

"He said the fluids used are the standards across the country, we may have to change these if children are getting too much sodium."

That doesn't make sense because there was much more said there. So I've said that it doesn't encompass everything that was said.

What is said is a better minute than I have of the meeting. I only have my recollection of the meeting, I have no minutes. So I am very grateful for what we have here, but that sentence does not explain exactly what I was saying.

What I was saying was, we are changing fluids, for example we're using normal saline, but normal saline may have too much sodium in it so we may have to change that again. In fact, that is exactly what happened. So we went to half strength saline, then we went to full strength saline, then we went to Hartmann's solution with 3 per cent.

Mrs Ferguson couldn't have been told that at that time, but I was saying, "Look, we may have to change our fluids", and that's exactly what we did. And in fact, the fluid that we have now arrived at is one that is a unique fluid, it has been manufactured for us and it's

Hartmann's solution with 3 per cent glucose.

THE CHAIRMAN: Thank you.

MR STEWART: Given what you knew about some of the shortcomings of the care and treatment given to Raychel as identified at a review, do you believe that the reasons for Raychel's death and the circumstances of her death were properly explained to Mrs Ferguson on that day?

A. One of the omissions from this is a part that I remember extremely well from the meeting, and that is where I explained what I thought to be the cause of death. And I said to Mrs Ferguson that I was sure it was the low sodium, that part is recorded, and that it was -- I don't think we used the term "hyponatraemia", but certainly I said it was the low sodium.

I then went on to explain how that actually causes the problem, and there was cellular swelling, that you would get that across the body, that it doesn't matter elsewhere but in the brain, in the skull it does matter, and I remember discussing that.

The reason I remember it is because I was going out on a limb because we had not got the coroner's post-mortem results. I said to Mrs Ferguson "Look, we do not have the coroner's results, but I can tell you categorically that I accept it's the low sodium and

here's the mechanism of it". So I am content that I explained to the very best of my ability how Raychel had died. I also -- sorry.

Q. Do you believe that Mr Gilliland should have been there?

A. I think Mr Gilliland should have been there. And I was a little surprised that he wasn't. I went into the meeting not knowing who else would be there, and I was asked questions about the surgery, which was -- I wasn't anticipating because I thought it wasn't about why she had the surgery, I thought that was a given. So I had to answer questions about surgery, which was fine because I have some knowledge about that. But Mr Gilliland would have been better placed to explain that than I would.

Q. Yes, she was after all his patient.

A. That's correct and, I mean, if you're asking me should he have been there, yes, I believe that he should. Mr Gilliland has given his reasons why he felt he shouldn't.

Q. Yes. That was 3 September. You had received from Mrs Burnside over two weeks before her request that put together some teaching, and we looked at that letter earlier.

How far had you got in the researches for your PowerPoint presentation by 3 September?

A. Well, my best guess was it was September. I wouldn't have had it done by that time. It was suggested in the opening that that would have been an opportunity for me to share that with --

Q. I don't think that was quite suggested. It was suggested it was a shame that it couldn't have happened, which is perhaps a different thing.

A. I accept that it would have been a useful thing, and I would also say that I would have been very happy -- "happy" is the wrong word. I would have been content to give that presentation to the Ferguson family at a later date, and in fact at the end of the meeting I did offer to go through the notes with them to help them in whatever way I could, and if they'd any more questions, that they would come back to us.

And I thought the way the meeting was going was that we were being seen as being helpful. In fact, Mrs Ferguson's view is that we were being dishonest and defensive, and I'm afraid I can't reconcile the two.

Q. Let's have a flick through your PowerPoint presentation. We saw one page from it earlier on and that was 021-054-128. There we see in the bottom half the note that Raychel received excessive maintenance fluids.

Let's go on quickly to 021-054-124. There we see in the top a note that there were no notes and there was

no U&E requested.

Let's move on to 021-054-120. We find from the bottom part of this that just about every surgical patient is at risk of SIADH or ADH. That would include Raychel.

And then let's go to 021-054-121. We see at the bottom that:

"IV fluids changed to No. 18 Solution."

This was the default position.

And then going back to 021-054-129, we see at the top reference to Halberthal. That's the lesson of the week in the British Medical Journal, although it's here referenced as BML.

And we can go and see that at 070-023b-217. We can see there the lesson of the week. On the left-hand side in the heavy emboldened type:

"Do not infuse a hypotonic solution if the plasma sodium concentration is less than 138."

And, of course, Raychel's was less, it was 137.

So there we have a pretty complete view of some of the deficiencies in Raychel's case that you emphasised in your PowerPoint presentation, and you did give that, as Mr Stitt reminded us yesterday afternoon, to the hospital management team. In fact, you gave it to the board, to the CMO, to the council, to nurses and

doctors, but you gave it to the hospital management team on 9 October 2001, and we can find that at 316-006j-001.

There we are. It's 9 October 2001, hospital management meeting, and we can go to page 004, we find specific reference to it:

"Dr Nesbitt informed next that he had been requested by Mrs Burnside to give members a report on the importance of fluid balance. He advised that he would give a presentation on IV fluids and had separated the presentation into three sections. Renal physiology made easy, a case report of hyponatraemia [that's Raychel]. Recommendations."

And you go on to describe -- it gives a brief rundown of what you set out in the presentation.

Now, that's all very straightforward and very clear. But then we come to the statement you made for the coroner on 14 November 2001. That we can find -- it's the same statement that goes into your deposition, which is at 012-037-173.

It's a short statement made after you presented your PowerPoint presentation. Correct me if I'm wrong, but there's nothing in this short statement about the critical incident review, what you've done, or those deficiencies that, the deficiencies which you highlighted in your PowerPoint presentation, being

brought to the attention of the coroner. Is that correct?
A. That is correct. That was a statement of my involvement with Raychel's clinical care, it was my understanding as to what the statement should include. So that was the statement given to the coroner.
Q. Yes. You had identified as a matter of scientific fact that there had been an excess of maintenance fluids given, hadn't you? So why didn't, as a matter of fact, that find expression in your statement to the coroner?
A. I think possibly because the matter of fact is a technicality, as I've said in my statement.
Q. What about the matter of fact that you highlighted that her U&Es, her sodium levels had not been checked? Why didn't that find expression in your statement to the coroner?
A. They hadn't been checked earlier than 3 o'clock and I didn't say that, that is correct, I'm simply saying what was my involvement with Raychel, and I said that her sodium was very low and that she was -- and I did then discuss with the coroner the issues of No. 18 Solution.
Q. Your involvement was also to take part in the critical incident review. Your involvement was to discuss what went wrong with your fellow clinicians.

A. Well, in my submission, I discussed that with the coroner because we said that we were looking at No. 18 Solution, we had stopped its use in Altnagelvin, we had instituted changes and so that came out with the evidence. What you're pointing out is my statement doesn't say, "And we had a clinical ..." But then I wasn't being an expert opinion, I was simply saying this is an synopsis of my involvement, and then I go to the coroner's inquest and I remember doing that and being asked questions by the coroner and others, and answering those questions to the best of my ability.
Q. It's very all well presenting your PowerPoint presentation to everyone who'll listen, but not if you don't tell the coroner that information.
A. That I had prepared a PowerPoint presentation?
THE CHAIRMAN: No, sorry, please, that wasn't the question. The question was about the contents of the PowerPoint. If you're telling the coroner all that -- I mean, what happens -- there's a very simple way of making this point -- eventually the trust put a statement by Dr Fulton before the coroner all about the critical incident review, isn't that right, and all of the actions which were taken on foot of the critical incident review?
A. Yes.

THE CHAIRMAN: That statement is dated 12 November 2002. Now, what was it that within the trust that prompted that information being provided to the coroner in November 2002, but not being included in the statement which you made to the coroner much, much earlier?
A. I assume that Dr Fulton had been asked for his involvement and, of course --
THE CHAIRMAN: But his involvement -- if you're going to restrict your evidence to the coroner about Raychel's death, then Dr Fulton wasn't involved in Raychel's death; isn't that right? He didn't treat her.
A. I thought the question I was asked was my involvement about her clinical care. I thought the question Dr Fulton was asked was his involvement after that.
THE CHAIRMAN: Let me spell out to you my concern. In Claire's case we had a doctor who volunteered in his draft statement that he'd made a mistake and it was suggested to him that he should remove that because that's for the coroner to decide and not for him, and he took that advice and removed that reference to a mistake.
We're coming now into Raychel's case in which the trust starts its position to the coroner by only giving information about what actually happened and not admitting mistakes, but at a much later stage it decides

on the change of tack by saying, "Well, maybe now we will give the coroner information about mistakes because it will show that at least we've learnt lessons and we at least have faced up to what we did wrong".
So I'm not sure as between trusts and even within Altnagelvin Trust what the view is about the information which should be fed to a coroner. Because the coroner, as you will have gleaned from his evidence, is now concerned about the information he receives from trusts in Northern Ireland.
A. All I can say is that I did not withhold anything from the coroner. I was not instructed to withhold anything from the coroner.
The statement that I gave was one that I wrote myself. I got no advice on it, I just -- I assumed it was my clinical involvement on the night of coming in, taking her to the CT scan and so on, and then under questioning I was very happy to answer any question that I was asked, and I didn't withhold anything, there was no ulterior motive, and I can say that absolutely with assurance.
THE CHAIRMAN: I'm concerned, doctor, about the inconsistency with which trusts -- on the evidence of this inquiry the inconsistency with the trust's approach to the coroner.

A. I think ...
MR STITT: Mr Chairman, might I just engage with you on that point? The point you make is clear and you seem to be comparing and contrasting the November 2001 statement from Dr Nesbitt with the statement the following year from Dr Fulton.
THE CHAIRMAN: Yes.
MR STITT: It's only fair to say that, as you've already pointed out, Dr Fulton did not have any responsibility for or direct contact with Raychel or her family when she was a patient. That's obvious. But clearly, when he was asked to make a statement and he made a statement, all he could deal with was the critical incident review, which he set up. And that was his remit, that's what his statement was about. And I think it's perhaps a little unfair to suggest to this witness, who has made a categoric statement about his involvement with the treatment with Raychel from the early hours of the morning until his last involvement with her, to imply from that that he is somehow holding something back. It just goes against the flow of, in my respectful submission, the witness's evidence thus far.
THE CHAIRMAN: Thank you.
MR STEWART: Your evidence was a moment ago, Dr Nesbitt, that you did not withhold anything from the coroner.

Did you not consider your duty in 2001 to proffer information to the coroner?
A. Perhaps today I would be more outspoken. When I went to that coroner's inquest, it was a -- an experience.
Q. I suggest when you made your statement in November 2001 you should have been more outspoken in your statement.
Can we go, please, to the General Medical Council's Good Medical Practice guidance for doctors at 314-014-002. That's the cover, I'm sure you recognise it. It was freshly delivered to you in 2001.
Can we go to 314-014-014 where at paragraph 32 the obligation is imposed to you by duty.
Paragraph 32:
"You must assist the coroner by responding to inquiries and by offering all relevant information to an inquest or inquiry into a patient's death."
That was your obligation as a doctor then. Do you think you fulfilled it?
A. When I was in the coroner's inquest I was content to answer any question that he asked me and did so, and he asked me --
THE CHAIRMAN: But people knew to ask you about the critical incident review and what was being done because that information had eventually come to the coroner through Dr Fulton's statement.

Let's go back. What's the purpose of an inquest? It's to investigate how somebody has died, and if necessary for the coroner to make recommendations to try to avoid repetitions in the future; is that right?
A. I agree with that, and I said to the coroner that there was a problem with No. 18 Solution that we had researched that -- I mean, it's in the deposition -- and I said that we had stopped its use.
Other hospitals were also using it. They did not realise the risk with it. We had put systems in place. We had new fluid policies. Those are all things that I volunteered to the coroner.
If you're asking should I have said more to the coroner, if I'd been asked it, I would have.
MR STEWART: Now, at the time you made that statement, you were already part of the Chief Medical Officer's working group on hyponatraemia. Can we go to 007-048-094.
26 September 2001. This is three weeks after you met with Mrs Ferguson, and there you are in Castle Buildings with a group of distinguished clinicians to discuss hyponatraemia and listen to Dr Taylor making his presentation.
We see who was present at the top. Dr Darragh is the CMO's deputy, I think. There's Dr Bob Taylor.

Dr Lowry from Craigavon. Was he an anaesthetist? What was his --
A. Yeah. There seemed to be some confusion there. That's obviously Darryl Lowry, who is an anaesthetist, but I have seen in transcripts someone talking about, I can't remember, is it Dennis Lowry, another name, who was an obstetrician. And I can see no reason why an obstetrician should be there so I think there's an error in the mention of his name. David Lowry is mentioned and it has to be Darryl Lowry because he worked in Craigavon and in fact he was one of the anaesthetists I telephoned.
Q. Yes, that's right. And was he having his doubts about Solution No. 18 in June 2001 as well?
A. He was, because he told me, when I phoned him, that that was precisely the situation in Craigavon in that in theatre they were using Hartmann's as we were, but in the ward it was reverting to No. 18 Solution because that was the solution of choice in their ward, and he was trying to effect a change there.
Q. Why was he trying to effect that change at that time?
A. I think because he -- I don't know. You would need to ask him. I didn't ask him particularly, he just said to me "Gosh, we're trying to change, it's very difficult, isn't it?" That's the way that discussion went.

Q. And then we have yourself and Mr Marshall from the Erne Hospital. What is Mr Marshall's specialty? Is he a surgeon?
A. I think it's Glen Marshall. I think he's a surgeon.
Q. Yes. So he might have known about Lucy?
A. There are people there who might have known about Lucy, this is the point, and I -- Lucy was not mentioned at that meeting. I know Raychel Ferguson was mentioned at the meeting because I kept on and on and on about it. It's not in the minutes but it's within the bit where there was a discussion. I remember it clearly.
Q. Now, the working group, I don't know how often it met, but it certainly e-mailed -- there was e-mail flowing between members of the working group, wasn't there?
A. Yes.
Q. How often did it actually meet as a group?
A. I believe I only attended the opening meeting and thereafter there was a small working group planned, and I was not part of that working group.
Q. And then we have got Dr Clodagh Loughrey, I assume, who is the chemical pathologist who gave a report in this case?
A. That's correct.
Q. Who is Ms McElkerney?
A. She may be -- I don't know, I'm making it up, she might

be a pharmacist from the Ulster. I don't know her personally.
Q. Then we have Dr Crean.
THE CHAIRMAN: I don't think you're making it up, doctor, I think you are guessing. Making it up is something different.
A. I'm guessing. She is not an anaesthetist that I know of, and she's not the anaesthetist that I telephoned when I spoke to someone in the Ulster. So I'm assuming there were pharmacists, there were chemical pathologists, so that was a bit of careful deduction there. I made it up slightly.
MR STEWART: Then we've got Dr Crean, who, as we know, knew about Adam's case, Lucy's case, and Raychel's case.
Then we've got apology from Dr Jenkins, who we know knew during the course of the working group's deliberations not only about Raychel but also about Lucy, and we know from e-mails that during the course of the working group Dr McCarthy and Dr Loughrey knew about Adam Strain's case.
So at this group in this room there are people who have got a -- they've got the threads that can be drawn together.
And you're there to discuss hyponatraemia.
Paragraph 2:

"Dr Taylor informed the meeting about the background, instance of cases seen in RBHSC ..."
What did he tell you, what did he tell that meeting about cases seen in the Royal Belfast Hospital for Sick Children?
A. I don't recall. I know that he's talking about the slides that I incorporated, one of which was the bar graph. I don't recall any discussion other than what is written there about Adam Strain, for example. In fact, the only -- if my recollection is right, the only child that was mentioned was Raychel Ferguson, and it wasn't part of the agenda, it was to talk about fluids. But I kept bringing it up because it was a raw thing in my mind. I really had to emphasise to everybody why it was so important, in my view, that we made the changes that I wanted.
Q. But why wasn't this committee discussing the deaths in Northern Ireland that it knew about collectively?
A. I don't know. I was asked to join the working group on -- at the behest of Paul Darragh, and Raymond Fulton had encouraged that through the Chief Medical Officer that I should be part of that working group.
Q. I didn't ask why you were part of the working group --
A. I wasn't given a remit.
Q. -- I asked why was the working group not discussing

these deaths.
A. I discussed Raychel Ferguson's death and can testify to that.
Q. I know that, I'm asking you a different question. Why was the group not discussing the deaths?
A. I didn't organise the group.
THE CHAIRMAN: Okay. Can I ask you, when the minute says that Dr Taylor informed the meeting about the incidence of cases seen in the RBHSC, what cases which had been seen in the RBHSC did Dr Taylor inform the meeting about?
A. He's talking about how many cases of hyponatraemia there are per year and the bar graph indicates that. There's a couple of years where there are no incidences of hyponatraemia, some years there's six cases, some years there's seven. So he's saying, "Look, there is an incidence of hyponatraemia, how do we address that?"
MR STEWART: Did he tell you --
MR UBEROI: Might I just add for completeness here, if we can be clear about what the witness actually recollects or why he might be understandably supposing. I don't wish to muddy the waters further, but it's Dr Taylor's recollection that his bar chart and his slides weren't actually used at this meeting and weren't taken forward after the e-mail which he sends to

Paul Darragh on the morning of this e-mail, which describes them as a draft.

THE CHAIRMAN: Thank you.

MR STEWART: Right, and indeed that is what Dr Taylor has maintained throughout, that he didn't go through with his presentation. So what did he tell the meeting?

MR UBEROI: I'm sorry, it's a different point. He didn't use the PowerPoint slides which we've been discussing. He obviously engaged in a discussion as is minuted here.

MR STEWART: That's my point, that's my question, what did he tell you?

A. I can't recall.

Q. What you said a moment ago was that there were a couple of years when there were no cases of hyponatraemia.

A. That is my recollection from memory of the bar graph. I believe that 1994 and 95 there's no incidence.

Q. 95/96.

A. Right.

Q. How do you feel now knowing that those were two years that contained deaths and that Dr Taylor knew about those deaths?

MR UBEROI: That's not right. That's not right. The Claire Roberts death was 1996. The inquiry's taken a great deal of evidence about the complexity of the aftermath of that case, and it's certainly not clear

that Dr Taylor knew about it.

MR STEWART: Sorry, about which case?

THE CHAIRMAN: Claire Roberts.

MR STEWART: He examined Claire in PICU.

MR UBEROI: Yes, and as you well know, he examined her for a specific purpose at a specific stage in her life and that is very different from the suggestion that he recognised that hyponatraemia had caused her death.

MR STEWART: And he also chaired, if I'm correct in my recollection, the clinical audit committee.

MR UBEROI: Well, this is what I mean about the complexity of the evidence and it being rather simplistically summarised by my learned friend. There's a great deal of evidence on that as to whether or not it actually took place, for a start.

MR STEWART: And he's been researching the incidence of hyponatraemia at the RBHSC and had access both to the PICU internal audit and to the clinical coding system.

THE CHAIRMAN: I think the point is that if the witness doesn't recall what -- if Dr Nesbitt doesn't recall the detail of what Dr Taylor said, we'll have to refer to Dr Taylor on that.

MR UBEROI: Thank you sir.

MR STEWART: The meeting continues, and at page 096, at 007-048-096, at point 10, it's noted:

"Dr Taylor undertook to inform CSM [that's the committee of safety of medicines, I think] ..."

A. Yes, that's correct.

Q. " ... of a recent death in Altnagelvin [that's Raychel] associated with hyponatraemia."

Of course, he did do that and he subsequently sent that correspondence to you, didn't he?

A. Yes, that's correct. He informed them of the risks of No. 18 Solution and they felt that the evidence was not sufficient to withdraw No. 18 Solution and suggested that all fluids carried a risk.

Q. We'll just go to part of that correspondence, which he has, which is at 012-071e-412. This is his letter to Medical Controls Agency of 23 October.

Can I take you down to the last three lines where he informs them:

"I am also conducting an audit of all infants and children admitted to the PICU with hyponatraemia. My initial results indicate at least two other deaths [that is other than Raychel] attributable to the use of Solution No. 18."

When you saw that, what did you think?

A. I didn't think anything particularly. I didn't go to my bar graph and try and reconcile it. It was clear to me that the bar graph was wrong because 1997 was always

wrong. It should have been 1995 if it was Adam Strain. And that appears as a no incidence on the bar graph.

So the inquiry have asked me, did I try and reconcile the instances of the hyponatraemia that you're talking about with the bar graph, and I have tried to do that and cannot do so. But when I gave the presentation, when I learned of Lucy Crawford -- the presentation is just an aid to telling people -- the presentation is what I tell them, and when it comes to the bar graph I always point out that we know that Lucy Crawford died in the year that she died and doesn't appear. So I have drawn attention to the fact that the bar graph is wrong. It may be wrong of me to have used the bar graph if Bob Taylor said it was only a draft and he then didn't use it, but I didn't know that.

Q. You are serving on the Chief Medical Officer's working group looking into drafting guidelines for the prevention of hyponatraemia in children in Northern Ireland. You are with a group of fellow experts. You tell us that you haven't pursued with them the fact that the Royal Belfast Hospital for Sick Children discontinued its use of Solution No. 18 and didn't tell you.

Are you now saying that you didn't pursue with Dr Taylor by e-mail or otherwise this extraordinary

piece of information that there were three deaths then?
A. I don't recollect doing that.
THE CHAIRMAN: Can we agree with this, can we agree that that last sentence in all probability does not refer to two other deaths outside Northern Ireland, it refers to two other deaths inside Northern Ireland?
A. He's talking about children admitted to PICU, would be my interpretation of it.
THE CHAIRMAN: Right. But he doesn't just say two other deaths, he says at least two other deaths attributable to Solution No. 18. So he seems to be saying: this was work that was ongoing, but I can tell you that apart from the girl, known as RF in this letter, who is Raychel, there are on his initial results at least two other deaths attributable to the use of Solution No. 18?
A. And one of those would be Adam Strain, and would the other be Lucy Crawford? I'm only proposing that.
THE CHAIRMAN: You see, if that's what was being investigated, if that was what was being analysed and revealed, somebody forgot to tell Mr and Mrs Crawford.
A. I was unaware of Lucy Crawford, as I've said. I didn't follow up on that. That may be remiss of me to have done that.
THE CHAIRMAN: And I haven't forgotten Mr and Mrs Roberts.
MR STEWART: Did Dr Jenkins contribute anything to the

working group about his knowledge of Lucy?
A. He may have done because he attended the smaller working group, I believe. He was not at the meeting that I was at. So in the meeting where I was on that day, he was unable to contribute and he sent his apologies.
Q. Who served on the smaller working group and how was it chosen?
A. I can't recall. It's -- I saw it in the papers, so it should be on the papers related to the -- perhaps on an e-mail or something. I've seen it. I haven't got it to hand.
THE CHAIRMAN: Just from your own perspective, do you know why you weren't on the smaller working group?
A. No. I don't think it was because I caused a row at the meeting. I think it was -- they wanted a smaller group. Bob Taylor was already researching it and I was happy that -- I mean, I knew Bob Taylor very well and respect him greatly, and I believe he's doing a lot of good work in paediatrics, and so I was happy that he would take on that role and I was happy that he would represent the Altnagelvin case. I knew I wasn't going to be on the working group. I don't know the reason for it.
THE CHAIRMAN: Okay.
MR STEWART: Later on, you were taxed about this very issue by Mr Trevor Birney in September 2004, and a response to

his questioning is drafted by you, and it's 023-046-108.
This, I think, is a first draft. 22 September 2004:
"The meeting to which Trevor Birney was, as agreed by him, off the record. I am not aware of the death of a child named Adam Strain."
Are you taking a very technical point there, that you were aware of a death of a child but not one who happened to be named Adam Strain?
A. Yes, he asked me when did I become aware of the death of Adam Strain. I said I'd never heard of Adam Strain but I did know that -- I think I say it there -- I was informed there had been a death in the Children's Hospital in 1997. No name was ever mentioned that I can recall.
So when he was asking me, "Did I know of Adam Strain?" I said "Not by name but I do know that it was 1997". Of course, we now know that it wasn't 1997, but acting on the information I had that was what I was saying, and I was very clear. The reason it looks a little -- that looks odd, but the reason it's laid out like that is because Trevor Birney asked questions in sort of bullet form, and so I'm actually answering each one. So it doesn't actually follow. He then asked "When did you know about Lucy Crawford?" So I'm simply saying I was not aware --

Q. Why didn't you say "As a matter in of fact in 2001 I received a copy of Dr Taylor's e-mail where he identified at least two other deaths apart from Raychel"? Why didn't you mention that?
A. Because he asked me specifically -- he asked me "When did you know about Adam Strain?" And the answer is "I never knew the name Adam Strain".
"When did you know about Lucy Crawford?" And I said "I was not aware of the death of Lucy Crawford until it was reported in the media".
And then he asked me "What other cases were discussed" -- as you're asking me, "What other cases were discussed at the working group meeting?" And I'm clearly saying, "As far as I am aware, the working group only considered the case of Raychel Ferguson".
And the only reason it was considered was because I brought it up. I don't say that there, I'm repeating myself slightly, but that's why I know that to be the case.
Q. And your response was forwarded to the communications department for its approval before release.
If we go to 023-047-109, we can see a trail of e-mails leading up from the bottom to the top, going between Altnagelvin and -- we can just see all of them. Up to the top.

And, finally, the answer comes down from Colm Shannon, who is, I think, communications officer at the Department.

He thinks that the final paragraph might be changed:

"We would suggest the following amendment to the last line. The Chief Medical Officer's working group was established to prepare guidance on the prevention of hyponatraemia and not to consider the case of any specific child."

Now, we go back to -- can we put it side by side, 023-046-108? You see your last line there:

"As far as I am aware, the working group only considered the case of Raychel Ferguson."

He suggests that be changed to:

"The Chief Medical Officers working group was established to prepare guidance on the prevention ... not to consider the case of any specific child."

And you took that advice and changed, didn't you?

A. I took the advice? I don't recall --

Q. Here we are, 023-049-115. And we find the final paragraph there takes up Mr Colm Shannon's advice and you now respond 27 September 2004:

"The CMO's working group was established to prepare guidance ... And not to consider the case of any specific child."

That was an answer you attempted to give earlier today to a question I asked you, and it's in fact a response that you recycle more or less in one of the witness statements.

To what extent do you normally rely upon a press department to draft your responses?

A. Well, we very often use the press department to draft a response because they're usually a little bit more careful with words than I am, and I would take their advice. I'm quite happy to tell Trevor Birney that the only case discussed was Raychel Ferguson, but it is true that that was not the agenda, that was not the reason for the meeting. So actually, that press release is correct, the reason that the working group was formed was to look at guidance on prevention of hyponatraemia, not to look at specific children.

THE CHAIRMAN: Yes. What strikes me at the moment as being a little strange about that is if you're going to draw up guidelines as a result of deaths, the people who are drawing up the guidelines need to know something about the circumstances in which each child dies to ensure that the guidelines will cover the circumstances of those deaths. And if there's no discussion about Adam, if there's no discussion about Claire and there's no discussion about Lucy, and the only child who's

discussed is Raychel, then how does the working party know that the guidelines which it has drawn up will actually cover the deaths which have occurred in Northern Ireland?

A. Well, when they produced the guidelines, there was a lot of e-mail correspondence back and forward. And I was unhappy about the guidelines and I never really signed up to them because I felt that they had not addressed the issue that I was concerned about with Raychel, that it was No. 18 Solution.

It was very clear that that was implicated. And a little bit like what Bob Taylor was saying with the Medicines Control Agency, the feeling was there was no evidence to show that that was the case.

The evidence for me was that we had a child who died and I don't think you can have anything worse. So with the reading that I had and the information that I had about No. 18, I was extremely agitated that No. 18 Solution should be named and shamed.

Of course, if I was a manufacturer I'd be upset to hear that, but in itself it's not poison, No. 18.

THE CHAIRMAN: No.

A. But if it's used incorrectly, it can be dangerous, and I think the best thing to do is what we did in Altnagelvin, or I did in Altnagelvin, and that is remove

it.

THE CHAIRMAN: Which is exactly why, when the working party is drawing up the guidelines, it should be considering what has happened in the instances of these deaths to ensure that its guidelines will actually capture the problem and solve it.

A. Yes.

THE CHAIRMAN: But you can't do that if the people around the table are not talking about the deaths or the circumstances in which the children died.

A. If you're asking me should they have discussed those deaths, then I think, yes, they should, because I was very happy to be -- I mean, I really emphasised Raychel Ferguson, and if somebody had said, "Well, that's exactly the same as Lucy Crawford" -- I have to get my dates right here, but if they knew about other deaths, then they should have said so. I would not object to that and it would have added weight, I think, to --

THE CHAIRMAN: Because you might need to know how broadly to draw the guidelines or how far they extend, because the circumstances of each of the deaths with which the inquiry is concerned aren't identical, there are differences between them, and if you want the guidelines to solve the problem, then you need to make sure that

the guidelines know what the problem is.
A. It has to be a catch-all.
THE CHAIRMAN: Exactly.
A. I think that -- you know, to be fair to the working group and the department, the amount of work that went into this was extraordinary, they really did a lot of work, and I understand that --
THE CHAIRMAN: I understand that, doctor. Let me repeat again, I have no difficulty with admin. People who know far more about it, people like Dr Sumner, and virtually everybody else says the eventual guidelines were very good. I'm more than happy to take that and to acknowledge that is -- if there's anything to be salvaged from these disasters it's the fact that the guidelines were drawn up and introduced.
A. I'm actually being critical of myself because what happened was they did all this work, tremendous work, they produced the guidelines, but I was completely unhappy with the guidelines, and it was because at the meeting that I was at, we had arranged that No. 18 Solution would at least be mentioned as a potential risk, and that was one of the items on the learning list, if you like, on the document that we were going to produce.
But when I got e-mails from Miriam McCarthy

indicating that the reference to No. 18 Solution was being removed because there was no evidence to implicate it, there was a few more e-mail responses where I felt that really the evidence that we had was a death, that No. 18 Solution was very clearly implicated and that as far as I was concerned -- now, I wasn't walking off in a huff, but what I was saying was, as far as I was concerned, No. 18 Solution would be high on the agenda in Altnagelvin and would not be used, and we would make sure that was the case. So we would develop our own policy.
MR STEWART: In other words, you're using a death to emphasise your point?
A. Yes, I concede that that is, of course, the ultimate worst tragedy that can happen. So the death of Raychel Ferguson is why I have undertaken all the work that I have done on fluids, and if somebody else had a death, they would have done the same, I'd have thought.
THE CHAIRMAN: And your point is supported by the fact that Dr Taylor is saying there were at least two other deaths attributable to the use of Solution No. 18, so draft guidelines which come out which don't deal with Solution No. 18 don't seem to you to quite capture the problem.

A. Yes. I accept that if you follow the guidelines to the letter, you'll not go wrong. But by not naming No. 18 Solution, there's a chance that someone will use it. That's why we deviated from -- we observed the guidelines, but when it came to No. 18 Solution we developed our own policy that you could not use it, you cannot use it in Altnagelvin, and the reason you cannot use it is it does not exist anymore. So we removed it from the pharmacy. It took until about 2006 before that happened, but that was a rather draconian way of doing it, but it certainly worked.
But I fully appreciate that there's more to it than that, there's more to it than No. 18 Solution, it's to do with electrolyte checks, it's to do with all the things that we know.
MR STEWART: Sir, might this be a convenient time?
THE CHAIRMAN: Yes. We're going to finish your evidence this afternoon, Dr Nesbitt. We'll take a short break now.
Thank you.
(3.38 pm)
(A short break)
(3.55 pm)
THE CHAIRMAN: Dr Nesbitt, if you can live with this, we'll sit on and get you finished this afternoon. Mr Stewart

said it will be an hour, so we can see how accurate he is.
MR STEWART: I said I hoped it would be an hour.
THE CHAIRMAN: I'll help him.
MR STEWART: Thank you, sir.
Time moves on, Dr Nesbitt, and by the time of the inquest you're medical director at the trust and you have a new job description, which appears at 321-004gh-005.
We find that amongst your principal responsibilities, the penultimate paragraph on the page:
"To advise on medico-legal matters."
So were you the lead adviser to the board at board meetings on medico-legal matters?
A. I have no legal qualification, but at what we would call the scrutiny committee meeting where we would discuss cases of litigation, I would be often -- I think I was the chair of that and I would give medical opinion to the lawyers present so I could assist in terminology and that sort of thing. So I was no medico-legal expert, it was more that from a legal perspective I gave the medical input.
Q. And did you find yourself giving medical input on this case at those scrutiny committee meetings?
A. I don't have a strong recollection of that, but I would

be surprised if from time to time that didn't come up and I would be giving feedback and so on. I remember, for example, things like liability and negligence being talked about, that sort of thing, and the distinction between the two and so on.

Q. In the lead-up to and the preparation for the inquest, you were a key member of the group preparing for that, weren't you?

A. I was, but my recollection of it is extremely poor. Where I've tried to recall things for the tribunal or the inquest, I have tried my very best to do that. In fact, my statements go to 15,000 words, one of them. So where I've tried to recall things, I have tried to do that.

When it comes to this part, I cannot recall the detail of medico-legal consultations that we had. I don't doubt that we had them, in fact I saw the other day, I saw my name on a list, so I was there.

I have no recollection of it. I believe that I was very anxious about the coroner's inquest and that was probably distracting me, I'm guessing. I don't know why I don't have a strong recall of these things, so you'll bear with me, I'm sure you'll help me through it.

Q. Well, there isn't a great deal to ask you, but I do know that a copy of the post-mortem report was forwarded to

you when it came into the trust on 7 December 2001. We can see that at 026-017-032.

It comes in to Mrs Brown and she sends it off to you, and it perhaps comes in to Dr Fulton, but in any event it's circulated to Dr Fulton, Mr Gilliland, Dr McCord and yourself. And that, of course, is the post-mortem report that concludes amongst other things that Raychel suffered from profuse vomiting.

Did you, when you received that post-mortem report, make any objection or cavil at his conclusion of profuse vomiting?

A. No, I didn't. I thought it -- I didn't know it was my place to even do that, I just thought, "Well, there's the result of the post-mortem. Who am I to question it?"

Q. Very well.

A. It's an opinion that's been stated. My own opinion was based on the evidence -- the discussions I'd had with the nurses that, in my opinion, it wasn't that, but if someone else had come to that conclusion, it wasn't for me to argue with them.

Q. We know, as you mentioned a moment ago, that you attended consultations in preparation for the inquest on 20 March 2002, in April 2002, on 31 October 2002 and, separate to those, you received an invitation to attend

at a pre-inquest meeting with Dr Fulton on 9 April 2002, and in that regard can we look please at page 022-029-073.

There we are. A small group is being put together of the doctors Fulton, Nesbitt, McCord, with Mr Gilliland and Mr Makar, and:

"Dr Fulton, who was medical director at the time of Raychel's death has agreed to convene a pre-inquest meeting on Tuesday 9t April."

This is not one of the larger medico-legal consultations, this is a small group, as you can see, listed there. Do you remember this consultation?

A. I don't. That's one of the things I don't remember. I know that on 9 April there was the other meeting, which was the feedback on the -- not the feedback, but the group that had looked at the clinical incident.

Q. Yes.

A. And I'm wondering, was it the same, but again that's speculation. I don't recall a separate meeting. I assumed when I answered the question for the tribunal, I said, "Look, I can't remember this, but I would assume it was in preparation for the coroner's inquest", which would make sense. But I do not recall it.

Q. The next thing that seems to happen is -- or rather, the same time, the report from Dr Sumner arrives. Just

before that, Dr Sumner's report arrives, and -- in February 2002, and that's circulated to you.

You make reference to that in your witness statement 035/2, at page 28.

At 35 (c):

"State whether you were asked to comment on the content of Dr Sumner's report, and whether you took any issue with the accuracy of the same.

"I was asked to comment [you respond] and overall I took no major issue with the report but noted some factual inaccuracies. Dr Sumner reached a conclusion that Raychel had profound and sustained vomiting. He concluded that Raychel was in a negative fluid balance ..."

And so forth.

I'm not quite sure I understand that, are you saying there that you formed the view that Dr Sumner's conclusion in respect of profound and sustained vomiting was something that you disagreed with?

A. No, what I'm saying is that that is an opinion that he came to, which I wasn't going to have an issue with. But the factual inaccuracies that I referred to were, number 1 the weight of the child --

Q. Yes.

A. -- and he assumed 26 kilograms. And when -- looking at

Raychel's post-mortem, it was 25 kilograms, which is 1,000 ml equivalent of water less. I'm simply saying that actually he probably estimated the weight using a formula which is well-known to anaesthetists doing paediatrics like me, so if you don't know the weight of a child, if it hasn't been weighed, you can calculate it by adding 4 on to the age and multiplying by 2, and it's as simple as that. And if you do that with Raychel it comes to 26, and I believe that's how he came to the 26 kilograms, because all other references are 25.

So I was only drawing attention to that to say that if he had assumed she was 25 kilograms, he wouldn't have said she was in deficit of 1 litre because her post-mortem weight was exactly the same as the weight on admission.

THE CHAIRMAN: Okay.

MR STEWART: Indeed, you and Dr McCord brought various inaccuracies to the attention of Mrs Brown, who asked that they be brought in due course to the attention of the coroner, and those are listed at 160-183-001.

A. I actually go on in that statement to say what the inaccuracies were and the times.

THE CHAIRMAN: Yes.

MR STEWART: That's correct. Now, I'd like to ask at what stage did you decide or did you ever agree with the

proposition that Dr Sumner was wrong in concluding that Raychel had suffered severe and prolonged vomiting?

A. I'm agreeing that that is his opinion.

Q. Yes.

A. In my heart, I feel that there was something very unusual that had happened, and so I think it was much more related to the retention of water, and that would be the ADH thing. I mean, I have seen -- I've done 30 years of anaesthesia and I have seen lots of children with vomiting, and I have never seen this. And I think it had to be something -- yes, there was vomiting, but with the nurses' evidence, the nurses' testimony at the meeting, they were saying, "It wasn't as bad as that". So for me, I felt there must be something else there. But nevertheless that is Dr Sumner's opinion.

The factual inaccuracies I was happy to point out because it was wrong to say the times were totally wrong and he had failed to grasp the meaning of the 150 ml that appeared in every column. But in fact, as we discussed with Dr Haynes, that was because of a burette that was used, so each hour the worst that could happen would be 150 ml, that was a protective thing, and then from that 150 ml you calculated the 80 ml an hour, and that's in the next column.

Q. I'm interested in the vomiting and its extent and the

length of time. It was decided subsequently to make a concerted effort to counteract Dr Sumner's conclusions in respect of the vomiting.

Can we look please at 022-017-052. We'll see here, this is the day after you attend at a consultation, and Mrs Brown writes to Staff Nurse Rice and identifies the date of inquest and tells her and you and she met with a barrister yesterday:

"The barrister feels it is important that we counteract the comments made by Dr Sumner the independent expert in relation to the allegation of excessive vomiting."

And it sets out the method by which it is proposed to do that with nursing evidence.

Did you agree with that approach?

A. I think that the vomiting, according to the nurses, was not excessive. Dr Sumner had used, as I alluded to in my statement there, the weight of 26 kilograms, and on the basis of that I felt he was coming to a conclusion that the fluid loss was of 1 litre, but if you take her as 25 kilograms, that wouldn't be so.

Then the point was that the plus plus system is so hard to determine what the actual vomit was, so there was a question in my mind about was it actually to do with the vomiting or was it to do with something else.

But I wasn't -- I didn't question Dr Sumner's conclusion in that he had his opinion and he stated it.

Q. Well, did you agree that it was important to counteract his conclusion?

A. I think when you're trying to show that what you were doing was the normal course of events -- I mean, the nurses were very, very clear that the course of events that Raychel followed initially was normal. You do see -- in fact, she was very well in the morning and then there were some episodes of vomiting. But it did not amount to the amount of vomiting that Dr Sumner was suggesting.

Q. But how did you know what Staff Nurse Rice was going to say?

A. I had no idea what the staff nurse was going to say.

Q. Exactly.

A. I think is that not indicating that, from the coroner's point of view, it would be very useful if he could learn from the nurses what they meant by --

Q. No, it's from the barrister's point of view that's the best way of putting forward a case. It's nothing to do with the coroner.

A. I'm not a barrister, but --

MR STITT: With the greatest respect, it's everything to do with the coroner, because the coroner has got to find

out, among other things, the cause of death, et cetera. Any barrister worth his salt is going to be saying, "The coroner's got this report and it concludes there was profuse vomiting, et cetera". If that's not in accordance with the instructions or the beliefs of nurses and there is a plus plus system, surely you've got to at least have that matter ventilated. It's not great theory, every barrister in the land would do that.

MR STEWART: Very well.

You were content to go along with his approach?

A. Yes, I was, I didn't object to that. I felt it certainly needed to be -- it was a fairer thing for the coroner to hear what the nurses were going to say about the amount of vomiting that there was.

Q. Did you know at that time that the coroner had received a letter on behalf of the trust, saying that the nurses had been interviewed when they hadn't, and they had all agreed to a man, which they didn't, that the vomiting was neither excessive nor prolonged? Did you know that?

A. I didn't know that. I saw that yesterday. I don't know, perhaps nurses were interviewed at a solicitor level. I don't know. That's just something that came to my mind.

I don't recall anything in the hospital happening that way, but I wouldn't have known anyway. As

a clinical director in anaesthesia I wouldn't have been part of it. But from my discussions with Therese Brown I don't think there were specific interviews, and the only thing I can think of was at the meeting, it wasn't an interview but it was certainly a discussion where nurses said what their opinion was.

Now, I do remember that very clearly from that meeting.

Q. Yes, but we know that this nurse, Staff Nurse Rice, or McAuley, wasn't at that meeting. Were you told about Dr Warde's report?

A. I am sure that I was. I have no recollection of Dr Warde's report. I have seen Dr Warde's report, of course, now, and when I saw it, I thought it was the most unusual report in the way it was formatted.

So I don't understand why I don't remember it, but if someone says they discussed the Warde report with me I'm prepared to accept that that might have been the case. But it did seem so unusual in that it was almost redacted before you got it, it was like a -- lots of little dots and things. I've never seen anything like that so it was most unusual.

Q. Can I suggest to you that you're proceeding towards the inquest as one of the principal members of the inquest group and your agreed approach to the inquest is to

counteract Dr Sumner's reports, and to that end a report is commissioned from Dr Warde to comment on Dr Sumner, and Dr Warde comes back and says "In my opinion Raychel suffered severe and protracted post-operative vomiting". Isn't that something you would have discussed?

A. It seems extremely likely that's the case. I can only reiterate that I have no recollection of anything to do with the Warde report and absolutely nothing to do with any notion that we should withhold the Warde report, and in fact if I had got the Warde report and it said the same as Dr Sumner, I wouldn't have objected to it going in to the coroner. There'd be nothing to be gained. It didn't add to it.

Q. We know it didn't go to the coroner and we know that no reference to it was made to the coroner. Now, at the group of people --

THE CHAIRMAN: Sorry, there is something to be gained. There's something to be gained, doctor. I can't let that go.

A. Two experts agree --

THE CHAIRMAN: Two experts agree, which might make it more difficult when two experts agree to accept -- sorry, it might make it more difficult to accept an alternative recounting of events coming from nurses.

A. My point was just that Dr Warde's report was almost

identical to Dr Sumner's in every way.

THE CHAIRMAN: That's the point, and he was engaged to advise the trust and comment on the issues upon which Dr Sumner had given his expert opinion. Dr Warde's expert opinion was almost identical. So there is -- I just can't let it go that you say there was nothing to be gained by that report not going before the coroner, because there was.

A. Perhaps I should have said there was nothing to be lost, because, I mean, Sumner's report was going in, and in fact we have accepted Dr Sumner's report. But --

THE CHAIRMAN: I'm sorry, again, that's not right. Because if the nurses gave evidence, the nurses could be cross-examined on behalf of the family on the basis that if they're right it means that two experts are wrong, and that might make it more difficult for the coroner to accept the nursing evidence about the vomiting.

A. Um, I don't know what to say to that except that I know I didn't have any input to any decision to withhold the Warde report, and as Therese Brown said yesterday, she would have anticipated the Warde report would have gone to the coroner. And I never, ever considered privilege.

THE CHAIRMAN: Okay. That helps because that means that I now know two of the people who were not involved in the decision to withhold the Warde report from the

coroner.
MR STEWART: Who was the most senior person there that day at the coroner's court?
THE CHAIRMAN: From the trust.
MR STEWART: From the trust.
A. That's a good question. Um, I was medical director, so that's quite a lofty position, even if I say so myself.
Q. Indeed, you're an executive director sitting on the board. Any other executive directors there?
A. It was held over three days. I was only interested in my own -- I have a very poor recollection of the coroner's inquest and I'm really sorry that that's the case. I cannot remember who else gave evidence.
Q. It must have been obvious to those present that given the letter written to the coroner stating "This is the trust's case because this is the trust's evidence", it couldn't then run the contradictory evidence. It was perfectly obvious to everybody there. Somebody decided that Dr Warde should sit at home in Dublin and the coroner should be none the wiser. Who was that person?
A. Well, I can tell you who it wasn't and it wasn't me because I would not have made --
THE CHAIRMAN: Okay. Can you tell us who it was?
A. No, I did not make that decision.
THE CHAIRMAN: Thank you.

MR STEWART: Just to go back, one of the things you did after one of the consultations, it was a consultation in April 2002, and on 1 May 2002 you wrote to the Chief Medical Officer, and that appears at 022-091-298.
This is the letter:
"Dr Campbell.
"Following the death of a child in Altnagelvin, which is thought to have followed severe hyponatraemia..."
Well, you knew it was severe hyponatraemia, you had the assay of the sodium:
"... many steps have been taken to ensure that such an event does not occur again. We are all anxious to learn from what was a dreadful experience and to share vital information with others. Guidance issued from your department will help in this regard and we are grateful for the recent posters on the subject.
"I am interested to know if any guidance was issued by the Department of Health following the death of a child in the RBHSC which occurred some five years ago."
Now, why did you have to write to the CMO asking about whether there was guidance from the Department of Health when you'd served on her own working group?
A. I don't recall any discussion about previous guidance at

the working group.
Q. You had spent time researching the literature on this letter from within hours of Raychel's death. You knew perfectly well, did you not, that there was no guidance issued by the Department of Health here?
A. Why would I have known that?
Q. Because you made it your business to change the use of Solution 18, you researched it, you drove the campaign, you sat on the CMO's working group and now you're saying, "Please tell me, was there any guidance?"
A. No, can I suggest that's completely unfair, it's totally unjustified, and why would I have known as a clinical director about guidance that had come out from the Department or not?
The suggestion yesterday was that the reason that I did that was following a consultation prior to the inquest, and the inquest was then delayed and so on, and I can tell you categorically that is not the reason that letter was written.
Dr Campbell wrote to all -- I'm trying to think who it was addressed to, but it was to all doctors, and it was to do with the recent guidance from the Department and that there was a forwarding letter, this was probably the end of March, I think, 25 March, something like that.

Q. 25th.
A. She sent a letter to me saying there's guidelines and we're going to forward a chart to you and it's very important that we learn from this type of thing, and so on. And she was writing that and I was having to -- well, I thought I should respond to that.
So my response was I wrote on the same day as I wrote to Dr Campbell, I wrote to all the medical staff in Altnagelvin, so this was later on from 25 March, and I said, "We have now received the chart, we have now received the guidance, and please start doing this". And I suggested the change to half-strength saline and you've seen all that correspondence.
I wrote it first, so I wrote to all the doctors and said, "Look, here's the guidance from the Department, I want you to act on it because that's what it says".
Then I thought, what guidance was issued from the Department before, and I completely reject the notion that I would have known about any guidance from the Department. So I simply asked her, but I was giving her a heads up and I said, "Look, the reason I think this is a problem is because if there was a death before, then we're going to get asked questions", and you can't argue that I was wrong when I said that because we are being asked questions, but it was not a subterfuge, it was not

a way of diverting attention, it was not any of the things I've heard suggested, and I object in the strongest possible terms to that.

Q. Let's put beside it 022-017-052, please. As you quite rightly say, the inquest was adjourned from April through to November, and here we are, we're back to this letter again we were looking at a moment ago, and the second part of it is the positive aspects of the case:

"... are the actions following the death and again it is hoped that Dr Fulton will be able to give evidence in relation to his actions following the tragic incident. The other positive note is the letter dated May of this year from Dr Campbell to Dr Nesbitt and the barrister is keen to exploit this issue."

Now, it looks as though it's going to be exploited for the purposes of damage limitation, essentially.

A. It does look like that.

Q. So I'm asking, was it in fact drafted for the purposes of damage limitation?

A. But I've already said that it wasn't, so to ask that question is implying that I made that up. I'm telling you that the letter to Dr Campbell was in reaction to the letter that she sent to me about the impending wall chart and the letter that came with it talked about No. 18 Solution, as I'd asked her to.

And was it a knee-jerk reaction from me? I don't know what was in my mind. But what was not in my mind was anything to do with the suggestion that I was covering up or dissipating or any of those things that you are suggesting.

The barrister, of course, then can take that and use it, and I can't help that. I mean, it did -- it does look like it adds weight to our case. But that was not the reason for it. And in fact Dr Campbell could have come back and said, "Well, here's the guidance I issued back in 1995".

Q. I suggest you knew perfectly well there was no guidance. Can I ask you this question, why did you wait --

A. Can I object -- sorry, can I object to you saying that --

THE CHAIRMAN: The doctor has to respond, Mr Stewart.

A. You've suggested I knew perfectly well. On what basis would I have known perfectly well?

MR STEWART: We've been through that before. Here's the second part of it.

MR STITT: Is Mr Stewart resiling from the proposition he has put more than once that this was a deliberate subterfuge letter? Does he have some evidence apart from stating it. The witness has denied it. If there's some other backup evidence, please put it at this point.

MR STEWART: With respect, I did not state this was a subterfuge letter, I said I was asking him whether it was drafted for the purposes of damage limitation, which is a wholly separate thing --

A. And I think I answered the question.

MR STEWART: -- what I have stated is that an individual who served on the CMO's working group and who had researched hyponatraemia and Solution No. 18 from within hours of Raychel's death would be better placed than anybody else to know that there had been no Department of Health guidelines issued in the mid-90s.

MR STITT: That's not a question. That's a statement of opinion.

THE CHAIRMAN: It explains where the question's coming from.

Let me follow it up with you. Looking at the left-hand side of the screen for a moment, do I understand the middle paragraph to be a reference to Adam's death in the Royal?

A. I didn't -- I'm not sure if I knew it was Adam table. I knew it was the case -- and I'd counted back five years because I thought it was 1997, in fact if I had known it was Adam's case really it should have been seven years.

THE CHAIRMAN: Okay. You had exchanged communications with Dr Taylor as part of the build-up to the working party,

and he had sent you some information.

A. He'd sent me the bar graph.

THE CHAIRMAN: Right. And he's a man for whom you have a lot of respect, and the inquiry has heard on a number of occasions that he has done a lot of good work for which he deserves respect. Right?

Why not lift the phone to Bob Taylor and ask him something about the death in the Children's Hospital?

A. I didn't do that.

THE CHAIRMAN: That's not the question.

A. Why not?

THE CHAIRMAN: Why not?

A. No reason.

THE CHAIRMAN: It's the quickest way to find out what happened after the death some five years ago, isn't it?

A. It's one way of finding out. The other way would be if anything came out of the Department, and that is -- the Department -- when we told the Department about Raychel, then everything was set in motion and the guidance came our way and a wall chart. I said, "Look, this happened before, was there any learning from it, because I believe we'll be asked questions as to why there wasn't?" So that's really what I said to -- remember, I don't envisage this ever being -- this was a letter to Henrietta Campbell from me, and now, of course,

everything, you're right, is public. But I wasn't anticipating this was going to be used in evidence, I didn't think anything along those lines, that was a completely innocent letter giving her a heads up of my concern.

THE CHAIRMAN: Can I ask you this, at the end of the second paragraph there's a sentence:

"I was unaware of this case and I am somewhat at a loss to explain why."

Do you remain at a loss to explain why you were unaware of Adam's case --

A. No.

THE CHAIRMAN: -- after he died?

A. I'm not at a loss to explain that there was no guidance from the Department because she wrote back --

THE CHAIRMAN: That's not the point. That's not what you're at a loss. The loss that you were at is that you were unaware of this case. In effect you're saying in that sentence "I should have known about this case".

A. Yes, I was surprised.

THE CHAIRMAN: And if you're saying that in Altnagelvin, you're really saying that every comparable or equivalent doctor in Northern Ireland should have been aware of Adam's case.

A. And I believe that Dr Campbell was also surprised

because she wrote back to me and said, "Look, the first inkling I had of hyponatraemia was actually when you raised it", but that wasn't to cover myself in glory and --

THE CHAIRMAN: No, sorry, that's not the angle I'm coming on that at. What you're saying in that letter in terms is that every equivalent doctor in Northern Ireland should have been made aware of Adam's case.

A. I believe that they should have done.

THE CHAIRMAN: Because there were lessons to be learnt from the circumstances in which Adam died, which could have helped other doctors in the Royal and beyond, beyond that.

A. In terms, yes, but in Adam's case I don't know that that's actually true because Adam's case, I still would contend, is a different case in that it was an extremely difficult -- and in fact I was asked three hypothetical questions towards the end of my statement, one of them was: what would I have done if I'd been told of the death of Adam Strain. And my response to that was, I doubt that it would have had any effect because most doctors would have thought, "That's a most unusual case, it's in extreme circumstances, a child with polyuria, very experienced doctors looking after him in the Children's Hospital. That's not for me".

The second question I was --

THE CHAIRMAN: Sorry, does that mean without reciting what's in your written statement, without reciting that, does that mean that now that you do know the circumstances of Adam's case, you now understand and accept that you were not made aware of it? So you now understand and accept the reasons why you were not made aware of it?

A. Yes, because --

THE CHAIRMAN: So although this letter appears on the face of it to be critical of the fact that you and your colleagues were not made aware of the circumstances of Adam's death or any lessons to be learned, your position now is "I now know about Adam's death. I entirely accept why I wasn't made aware of Adam's case"; is that your position?

A. I accept the reason I wasn't made aware was because there was no guidance came out from the Department and Henrietta Campbell said that. But would guidance from the Department -- you know, hypothetically, that's why I'm saying it's --

THE CHAIRMAN: Sorry, doctor, I have to say, with respect, that the question I'm asking you is relatively straightforward.

A. Sorry.

THE CHAIRMAN: At the time you wrote this letter, you say

you didn't know it was Adam and you didn't know the circumstances in which he died, you just knew that a child had died in the Royal.

A. Yes.

THE CHAIRMAN: And you say to the CMO, "I was unaware of this case and I'm somewhat at a loss to explain why".

Now that you are aware of the circumstances of Adam's death, do you say," I accept that there was no reason for me and my colleagues in other hospitals in Northern Ireland to be told about Adam's case because there was unlikely to be anything learnt from it which was of use to us"?

A. No, I'm pushed to give a one-word answer, but the reason I replied to the hypothetical question was in my opinion had we been told specifics about Adam's case, then we might not have done anything because we wouldn't have thought it applied to us. But if we'd been given guidance on hyponatraemia as a result of Adam's case, then it might have been a learning thing for others.

But I'm not sure that Adam's care would have generated that. That's looking back on it now with what I know. Does that -- I mean, I'm not trying to be obfuscating or anything like that.

THE CHAIRMAN: I'll take your answer and we'll move on.

MR STEWART: The coroner gave his verdict and it was that

the hyponatraemia was caused by a combination of inadequate electrolyte replacement on the basis of severe post-operative vomiting and water retention, and you said that you agreed with that verdict.

A. Yes, that is correct, because the electrolyte level dropped and was not brought up to the level quickly enough. So there was inadequate electrolyte replacement.

Q. Yes. The next thing is you, along with your chief executive, Mrs Burnside, and the director of nursing, Ms Duddy, meet with the Western Health and Social Services Council on 19 February 2003 and that's minuted at 014-016-028.

The full attendees are listed. We learn that the meeting was arranged at the request of the council to learn of the Altnagelvin Trust's perspective on the death of Raychel Ferguson. The Altnagelvin have fielded a high level team to meet with the council. The chief executive, director of nursing and medical director:

"The trust provided a copy of a press statement."

And that's the statement which appears at 023-003-003.

This says in the second paragraph:

"While it is of little comfort to her parents and

family, it is important to emphasise that the clinical practices used during Raychel's care, following her operation, were at that time accepted practice in all other area hospitals in Northern Ireland."

That's not entirely accurate, is it?

A. I was in the audience listening to the debate about that yesterday, and I'm not going to contend that it was area hospitals we were talking about either. I think that in truth that should have said the majority rather than all. That would have been -- it's semantics, I know, but what I said --

THE CHAIRMAN: Sorry, it's not semantics, it's sending out a would-be reassuring but misleading message to the public. The reason that you issue a press release is to get a message out to the public, and the message that Altnagelvin sent out to the public was that Raychel was treated in the same way she would have been treated in any other hospital in Northern Ireland. If that's right --

A. Well, the message --

THE CHAIRMAN: -- that's something to be very, very worried about.

A. The message that we wanted to convey in a press statement was that the treatment that Raychel received was the same as she would have received in other

hospitals in Northern Ireland. By putting "all", then it puts me in the position of but I knew that the Royal weren't using No. 18 Solution, because the thing about that was it was really -- the message was that the solution that we were giving to Raychel was commonly used, not only in Northern Ireland but everywhere. That was the solution. And that was what we were trying to say was: look -- that was the thing.

Then, of course, we were talking about the practices, and I accept that there are practices, but many of the practices were also the same. The care that she got, it could have been in Craigavon, it could have been in the Antrim Hospital, it could have been the Ulster Hospital.

THE CHAIRMAN: Is there a hint in that press statement that anything was done wrong in Altnagelvin?

A. No, I think that press statement is giving assurance to the public that they should bring their children to us and we would look after them. I think that was the purpose of the press statement.

MR STEWART: Can I suggest to you that it misleads as to what the Altnagelvin Trust had delivered to Raychel Ferguson.

A. If it did mislead --

Q. And it is defensive. And did either you or your fellow

executive directors think for one moment to read and to check that before you issued it to the council?

A. I'm sure it was read, but as I was trying to say, if it did mislead, it was not to intentionally mislead because to mislead is deceitful and that was not the intention.

Q. That's exactly my point.

THE CHAIRMAN: Does it ever occur, doctor, that sometimes public confidence in Altnagelvin or other hospitals might be increased by an acknowledgment that mistakes have been made? Does that ever occur?

A. I think if a mistake has been made, you should be open and honest about it, and that would be my ethos in medicine. So if I make a mistake --

THE CHAIRMAN: Well, that's not reflected in that press statement.

MR STITT: With respect, sir, last Friday -- now, I know it's 2013.

THE CHAIRMAN: No, I'm sorry, Mr Stitt, the idea that in February 2003 it wasn't recognised in Altnagelvin that mistakes had been made in Raychel's care is unacceptable.

MR STITT: I'm not going to argue that point, sir. That's clear.

THE CHAIRMAN: And my point to the doctor is that he says he wants to -- the purpose of this press release is to

encourage public confidence or reassure the public in the greater Derry area to bring their children to Altnagelvin. And my question is: does it ever occur that public confidence might be increased if Altnagelvin or any other hospital sometimes says, "We made mistakes but we are sorry we made mistakes, we are learning from them and the fact that we are learning from them is a reassurance for the public".

MR STITT: Maybe I misheard. I thought you said had they ever said they had made mistakes and were learning from them.

THE CHAIRMAN: Okay, I'm sorry, if I did, I didn't mean to put it in quite those terms. That's my concern, because I have been told about doctors' defensiveness and I've heard it from Ian Carson and other, and I've heard about nurses' defensiveness. This is institutional defensiveness.

A. I can see --

THE CHAIRMAN: It doesn't work. If there's one thing that this inquiry shows it's that that doesn't work. If you want to reassure the public, doctor, just be open with the public.

MR STITT: May I take you, sir -- if I may come back to that and I don't want to make a mountain out of this particular issue. If you could go back to 201, line 7?

THE CHAIRMAN: Yes. The last part where I said "Does it ever occur"?

MR STITT: Yes, "Does it ever occur, doctor, that sometimes public confidence in Altnagelvin or other hospitals might be increased by an acknowledgment that mistakes have been made? Does that ever occur?"

And that was the reason why I --

THE CHAIRMAN: Your point is that it occurred last Friday.

MR STITT: It occurred last Friday, but the position -- and I know I'm jumping to litigation. The position had been stated in a letter of 2005, which I've already dealt with, which is now -- which you're aware of.

THE CHAIRMAN: Yes.

MR STITT: But, of course, in 2005, no one, not even yourself, sir, was aware of the fact or would have been shocked by the fact that in 2013 we were sitting here in the middle of this inquiry. I remember the Presbyterian Assembly Rooms in 2005 because I was involved, and I think it's fair to say that we were all surprised by what happened.

THE CHAIRMAN: Yes. Thank you.

MR STITT: And we anticipated, or you probably anticipated, sir, if I may be so bold, that the inquiry would have been conducted and finished and reported upon very many years ago, through no fault of yours.

THE CHAIRMAN: Exactly.

MR STEWART: Dr Nesbitt, can I ask as an executive director, were you asked ever to proofread press statements, look at drafts, suggest amendments, to approve them in effect?

A. I don't recall that happening.

Q. Who would have approved this statement for release at that meeting?

A. I'm not sure. Marie Dunne would have talked possibly to the chief executive office, I'm not sure. I don't know that I actually saw that one. I appreciate what the meaning of it was. I can also see that it can be misconstrued that it was, you know, misleading.

Q. In order that we may more properly understand the meaning, let's have a look at an earlier draft of it at 172-002-043. If we could have it alongside it, please.

This is an earlier draft. I don't know how many versions this went through. This bears at the top of it what looks like a fax transmission date of March 2002. So it's quite a bit earlier. It's well before the inquest, and in fact it probably was prepared for the inquest when it was first listed on 10 April 2002.

You can see the second paragraph there in fact relays back to the second paragraph of the press statement as issued:

"While it is of little comfort to Raychel's parents, it is important to be aware and the procedures and practices put into effect in the care of Raychel following her operation were the same as those used in all other area hospitals in Northern Ireland."

So that was even more broad in its application, procedures and practices. And in fact, the press department released a document explaining the meaning of all those terms, and I read from that document the other day when we were debating the meaning of it.

You see there that there is a correction put in there?:

"The hospital immediately made changes."

Is that your writing?

A. No.

Q. Whose writing is that, do you know?

A. I don't know.

Q. Okay. Do you remember draft press statements ever coming to you as medical director for your approbation?

A. It has happened that I've seen a press statement before it went out. I don't recall seeing this press statement or the previous one to the final one. But I have as medical director seen press statements.

Q. Can we go back to those minutes of the meeting at 014-016-028. And there, because we're on the second

paragraph there with the press statement, the third paragraph continues:

"Mrs Burnside explained the outcome of the coroner's inquest which did not apportion blame to the trust."

Well, did you tell the council that in fact the coroner had decided that the electrolyte replacement was inadequate?

A. Yes. I mean, the -- that's what it said. It meant -- that to me meant that it was inadequate, the replacement that she got was not a big enough amount for what was needed. It's not that the trust were -- you know, I think that's what I'm taking out of it. Everyone looking at me if that's amazing but --

THE CHAIRMAN: Sorry, I'm on a slightly different point. Is it not the case that coroner's inquests in Northern Ireland do not apportion blame as to why somebody died?

A. No, the coroner --

THE CHAIRMAN: They are specifically not supposed to be the equivalent of a court deciding whether somebody is negligent; isn't that right?

A. That's correct, they rule on the cause of death.

THE CHAIRMAN: Right. So if that's the case, then the coroner was never going to apportion blame for Raychel's death; isn't that right?

A. That's true.

THE CHAIRMAN: So what was Mrs Burnside doing saying that the outcome of the coroner's inquest did not apportion blame to the trust if it wasn't the role of the coroner to apportion blame to anybody?

A. I don't know the answer to that.

THE CHAIRMAN: It could be understood by the members of the Western Health and Social Services Council that the coroner had somehow decided that the trust was not in any way to blame for Raychel's death, and that's not what the coroner decided, sure it isn't.

A. No, it was rather factual what he said.

THE CHAIRMAN: Well, that's what he's supposed to do. He doesn't say at the end of an inquest "and I blame Mr A, Mr B and Mr C for the death".

A. I have never thought of it in those terms. It never crossed my mind. Yes, quite right.

MR STEWART: You went on then to deliver your PowerPoint presentation yet again, but this time you augmented it with a few additional --

MR STITT: I do sincerely apologise and I'll be very brief. Perhaps on balance, though, if I refer to the last sentence in the -- last paragraph on that document:

"Mrs Burnside said in hindsight the trust accepted the death could have been avoidable."

It's not the other side, it's not the exact flip side of the point, but it is a recognition that clearly it was avoidable.

A. That was the first point I made in my presentation. This was a death that could have been avoidable.

MR QUINN: Sorry to interrupt, Mr Chairman, but I have to get up and ask then, if Mrs Burnside was saying this in 2003, why didn't everyone else come out and say it to the parents?

THE CHAIRMAN: Why did nobody say to the parents that Raychel's death might be avoidable?

MR QUINN: Yes. When the litigation was issued, and we've been waiting now for seven years to get an admission of liability -- it's actually 10 years.

A. I remember saying to Mrs Ferguson on 3 September that had we known -- well, first of all, we said that she had died under our care and that it should not have happened, that's the very, very beginning of the meeting, and there was a profound apology given to Mrs Ferguson and the other members of the family that were there. Then -- so I recall that being discussed at that meeting.

So we said: look, this shouldn't have happened, we accept this should not have happened. So that's why I believe that we were liable because she was in our

care and it should not have happened and we said that from the very beginning. It didn't take it to be 2003, there was no epiphany here, this was -- we knew already and we discussed with the family that it should not have happened. And we also said that had we known now what -- if we knew then what we now know, it might not have happened because we might have had things in place. So we were saying: look, these things have happened, it could have been avoided. So I can't be more clear than that.

THE CHAIRMAN: Okay.

MR STEWART: I wonder, can we just look quickly at two pages from your PowerPoint presentation delivered that day, which are 077-005-006 and 007. I wonder if they can be both put side by side, but they're both in landscape format. Is that possible?

A. These were by way of an introduction to the actual PowerPoint presentation I would have given to anyone else, and because it was a lay audience, this was just headlines, if you like.

Q. All right. On the left-hand side we go to the third bullet point down, we are talking about the cause of death being brain swelling brought about by a condition called hyponatraemia:

"This was caused by [and this is your emphasis]

a very rare idiosyncratic reaction to surgery."

I assume you mean the hyponatraemia was caused by SIADH, which was a reaction to surgery, do you?

A. And concomitant therapy with fluid having a low sodium content.

Q. Yes, but the very rare idiosyncratic, emphasised, reaction. It's just SIADH, it's not very rare.

A. It's not just SIADH. I have never seen a child die for this cause in 34 years. It is extremely rare. Evidence given to the inquiry by experts for the inquiry have said the very same thing.

Q. But you -- I'm sorry to interrupt -- in the course of your discussions with Dr Taylor, your correspondence with Dr Taylor, revealed his audit, which had two deaths apart from Raychel. You have given evidence of how you heard from Mrs Brown of Adam's case. We're not talking vanishingly rare.

A. Well, Harvey Marcovitch is saying it's vanishingly rare, and he's an expert.

Q. Leave aside what Dr Marcovitch may have said, from your own knowledge at the time you wrote this document.

A. From my knowledge I would say it's extremely rare. I have never seen it before and I was, in my opinion, quite experienced.

Q. Moving on then:

"Such a case has happened before in Northern Ireland."

Which case was that?

A. I assume I'm talking about the case that's on the bar graph that I'm now going to show them in the thing, so they're going to see that a case has happened before, and I thought it was 1990 -- whatever it was -- 7.

Q. Can I just read Dr Jenkins' report, which was his evidence at Raychel's inquest and, of course, this meeting with the council is to discuss Raychel's inquest.

On the second page of Dr Jenkins' report of 30 January 2003 he writes:

"Until further concerns were raised in Northern Ireland in September 2001 as a result of two deaths ... Steps were taken to convene a working group which were subsequently prepared and distributed guidance."

He's highlighting there there were two deaths and it was those concerns caused by those two deaths which gave rise to the working group.

He returns to the theme in his final concluding words:

"In the circumstances relating to this incident it was only the tragic death of two children in

Northern Ireland."

Which were those two children you understood Dr Jenkins to mean?

A. I assumed he was talking about -- well, one of them I assumed was Adam Strain, and the other, I don't know who that was.

Q. Why do you assume, then, when you're talking about the previous death in Northern Ireland in your PowerPoint presentation that that was a 1997 death, then?

A. Because if you look at the bar graph that I was sent from the Children's Hospital, the bar graph that you've got in the inquiry is not the colour version that I have and you may not see that the blue part is the number of cases, and where it's in red or orange at the top, that's where there's a death. So when you look at the bar chart, you can see not only the incidences but where a death had occurred.

So in 2001, if you look at the top of that bar graph, you'll see there's a different colour there and that's one death, which I know obviously to be Raychel Ferguson, and in 1997 there is another one. I assumed that was the death that the coroner had investigated previously.

Q. How do you know that death was post-surgery?

A. Well, I don't.

Q. Exactly. So you couldn't have been referring to it.

A. Why could I not have been? I was referring to it.

Q. You couldn't possibly have known it was a reaction to surgery. You see:

"This was caused by a very rare, idiosyncratic reaction to surgery. Such a case has happened before in Northern Ireland."

A. That was an assumption on my part. I believed that that was a reaction to surgery. Most of the cases of hyponatraemia in children have been in reaction to surgery. It's post-surgical that it happens, it's not --

THE CHAIRMAN: Sorry, not in Adam's case. Adam's case isn't post-surgical.

A. It's intra --

THE CHAIRMAN: Yes, exactly.

A. Or post --

THE CHAIRMAN: No, that's quite separate. Adam didn't die post-surgery. Adam died on the operating table.

A. I do think Adam's case is different, but I'm saying that such a case -- in the presentation -- I'm giving them a heads up of what's coming in this presentation, I'm saying that if you look at the presentation, there's a previous case. I didn't update Bob Taylor's presentation.

THE CHAIRMAN: And to be complete, two of the four deaths that we are interested in are not post-surgery. Lucy's death is not post-surgery and Claire's death isn't post-surgery.
A. I agree that the hyponatraemia that I'm talking about is post-surgical, I think that's the most common cause. But fluid mismanagement can to it, especially if you're using No. 18 Solution.
MR STEWART: Let's move on. That bullet point you go on to the same sort of line that the press department are taking, that the practices in Altnagelvin were the same in the majority of other hospitals treating children.
THE CHAIRMAN: We've been through this, Mr Stewart. Let's move on.
MR STEWART: At the time you met with the council were you still having difficulty ensuring that electrolytes were being checked on a regular basis?
A. I know that I've sent letters out to staff suggesting that they have to do that. So --
Q. You send a letter on 25 March of that year, which is at 012-064c-328 and 329. I'm sorry, I have given you the wrong reference there. At that stage there was still an unresolved issue of responsibility for the management of surgical paediatric patients. Was that brought to the attention of the council?

A. No, that wasn't part of my presentation to them.
Q. And also, as late as September 2004, you were issuing reminders that Solution No. 18 should not be used in the hospital. Was that something that you would have brought to their attention?
A. The fact that I did that just is good practice, because you're simply reminding people of a practice that you put in place. It wasn't -- that's not in relation to another disaster that's occurred or some clinical incident, it's just -- it's probably to do with the fact we got guidance from the Department and I'm reminding them that they've got to do U&Es, they've got to do 12-hourly electrolyte checks, they've got to do more fluids. All that sort of thing.
So you're just reminding staff of something you've already put in place. It doesn't mean there's been another incident. That's just good practice, in my view.
Q. Very well, thank you. You referred earlier to the letter from the Chief Medical Officer of 25 March 2002 which heralded the publication of the guidelines, and it appears at 012-064c-328 and 329.
Just two questions here. The second paragraph, the Chief Medical Officer writes to advice:
"Hyponatraemia can be extremely serious and has

in the past few years been responsible for two deaths among children in Northern Ireland."
When you first saw that in March 2002, which deaths did you take that to be referring to?
A. Well, one of them is Raychel Ferguson, so the question always is what is the other one? And I assume it's the one I've talked about all along, which is the one that's in my PowerPoint presentation.
Q. Okay. The letter goes on to, at the top of the second page, say in relation to the guidelines that were published:
"It will be important to audit compliance with the guidance and locally developed protocols and to learn from clinical experiences."
Can I ask, what measures were put in place to audit compliance with this?
A. The only place where fluids would be given to children was the children's ward at that time. And we knew that it was in place, and there were no exceptions to that because the way we designed the system, it wasn't -- there was no choice for practitioners, it was rather draconian and they had to choose fluid A or fluid B. There was no other alternative. So we knew -- and it was based on electrolytes and, later on, it was based on electrolytes at 12 hours, and we were the only trust in

Northern Ireland to do that.
When the guidance came out from the Department, it was that you had to assess the need for fluids at 12 hours and senior help should be sought if you were going to do more fluids. But we took a different view and we had already instigated a situation where, if you were going to -- anaesthetists would provide fluids for 12 hours, that was the agreement, the consensus agreement, and after that period of time, if you wanted more fluids, you had to start again and start with the U&E.
So we then at 12 hours were actually demanding a U&E be done, and as a result of that the data that we collected -- this was not a research project, but we collected far more data of U&Es in children than any other hospital, and we were then able to look at when we changed fluids, and we changed fluids from time to time because of responses from the nurses.
So when we changed to Hartmann's, we anaesthetists were very happy. I was happy. The nurses were very concerned because No. 18 Solution, the beauty of it was it had sugar in it, and they said to me "But Hartmann's has no sugar". So we had to do six-hourly blood tests on children to make sure their sugar was all right.
So in 2002 we changed to half-strength saline and

I wrote to everybody reminding them again of the need to do U&Es, and then later on we changed to normal saline because in collecting the data we realised that half-strength saline does not bring up a low sodium. So if a child has got a low sodium, and I don't mean dangerously low, it just mean below 138, when you give half-strength saline that remains low throughout the child's stay in hospital, which may not be serious at all.

If you change to normal saline, it brings it up to normal. So we're very happy with that. But then we discovered that the chloride levels get very high, and we don't know if that's important or not, but we were concerned about that.

So at the end of the day we decided to go back to the beloved Hartmann's solution and to add some sugar to it to keep everybody happy. So that's the solution we finally arrived at, and the reason we arrived at that is because of the continual audit of fluids and electrolytes.

Q. So the answer to my question is that you did put in place a system to audit compliance?

A. It was rather a long answer.

THE CHAIRMAN: But it is important. In fairness, doctor, particularly over the last hour it's important to put on

the record that you implemented the guidelines, plus you added in effect your local twist to them, because you think that improves on them.

A. Yes.

THE CHAIRMAN: And does the record of what has happened since then show that having experimented or tested different approaches, you now have a well-established system which is working well?

A. We have, and it's been internationally recognised from as far away as Australia that actually this is possibly the ideal solution. At the moment, it costs us an arm and a leg because it's ú10 a bag, because it's manufactured. But if we could get -- you know, trying to promote the idea of Hartmann's with 3 per cent glucose, there may be an alternative that's already out there but we're very content with the results we've had.

MR STEWART: In March 2004 you received a further letter, the chief executive did, from the Department at 021-043-089. It refers both to the guidelines for the prevention of hyponatraemia in children and guidelines relating to adults.

And the purpose of this letter is expressed four lines from the end:

"The purpose of this letter is to ask you to assure me that both of these guidelines have been incorporated

into clinical practice in your trust and that their implementation has been monitored. I welcome your assurance and ask you to respond in writing by 16 April."

And you respond practically immediately at 021-041-086 to say in the final paragraph:

"Implementation of the guidance is monitored through the trust's incident reporting mechanism."

Implementation is monitored through the incident reporting mechanism. That doesn't seem to be audit, that just seems to pick it up when it goes wrong.

A. No, it's -- you can audit trigger lists that show if there's a potential for something to happen. So it is gathering data and audit isn't much more than that.

Q. I see. And again, one has to ask why -- 021-039-082 -- was written. This is September 2004 after this. This is to remind all medical staff treating children that No. 18 Solution is not to be prescribed.

So it seems that possibly there was some prescription.

A. That refers to the fact that we had now agreed in the paediatric ward -- and I'm talking about medical children here, chairman, where previously they had been very, very loath to move away from No. 18. When we moved to half-strength saline and the consensus

statement was issued, they were very happy with that. So the change was that nobody in the children's ward should be getting No. 18 Solution.

So just after 2001, when I made the change to Hartmann's for surgical children, there obviously was still a use of No. 18, and you will see that in the statistics on those bar graphs, the line graphs that we've seen.

And after 2004, you should see that there is no more No. 18 Solution being used, it was potentially still being used in the paediatric side, although they'd agreed to go to the half-strength saline. So I'm simply reminding everybody that, look, we've all agreed in the consensus statement -- and, of course, the next step, the next step was, look, what about I get rid of No. 18 Solution completely and throw it out, and that's exactly what I did.

So the way to fix the thing is to get rid of the problem. And, of course, as you know, some clinicians objected to that and there was a little bit of argy-bargy, but I achieved what I wanted and I get rid of No. 18 Solution.

THE CHAIRMAN: 2006?

A. 2006 was the -- as long as it took me to do that.

THE CHAIRMAN: Okay.

A. And there are applications where some physicians wanted to use it, and I understood that, but once they agreed that there were other fluids that they were prepared to use, they allowed me to get rid of it. There are other solutions out there that are even more dangerous, but that's another whole --

THE CHAIRMAN: Yes. We'll leave that to someone else.

A. -- can of worms.

MR STEWART: I have no further questions.

THE CHAIRMAN: Mr Quinn?

Questions from MR QUINN

MR QUINN: One question I do want to ask, which has been asked already by the family: doctor, when did you realise that the fluid calculation that you were relying on in the first meeting after the death was not correct? And I put it into these terms: when you went to the meeting a few days after -- that's the critical incident meeting, a few days after the death, you said one of the points you made in the notes was that you thought that the fluid level, the fluid input was wrong, IV fluid was wrong, when did you realise that what you're saying now is correct?

A. The rate was wrong and immediately after the meeting people sat down and actually totted it up. So I came in a bit hot and heavy with the -- I mean, it was an

emotional moment for me because I was really raw. I could not believe what had happened. I came into the meeting and I just looked and I saw the rate 80 ml a hour and I thought, "Look, that's wrong, the litre, that's wrong. Everything is wrong", but when you look at it that was probably an overreaction and in fact at the very end of the meeting people sat down and looked at the amounts.

So immediately after the meeting -- and, of course, I was still right, I wanted to stop No. 18 solution, but it no longer became a problem of the amount that was given rather than the solution itself. So it was the solution itself plus the fact that there had been a surgical insult, and then the ADH, and in my mind that is how that was happening.

Q. So to encapsulate, you're saying that immediately after the meeting --

A. Very soon after, yes.

Q. Was it days after, or hours after?

A. I believe it was in the next day.

Q. So the issue of volume became a non-issue with you, a day or so after the critical incident meeting?

A. That's why at the meeting with the family there was never -- I mean, it was raised why, mistakes made were that we had not done U&E, and we did discuss all that,

and the other mistake made was that we'd given far too much fluid. But immediately after the clinical incident meeting we knew that actually it wasn't an issue of too much fluid, just the type of fluid.

Q. Forgive me for saying, was it not raised with the family that one of the issues was that Raychel did get too much fluid?

A. The amount of fluid -- as I've explained at length, the amount of fluid in excess that she got over 35 hours amounted to, at worst, 145 ml, which is a very small amount, or 75 ml, which is even less. Like an egg cup full. And you could have given far more fluid and still have been within accepted guidelines.

THE CHAIRMAN: That would take account of the argument that, as Dr Haynes said, conceded, it's not universal that the rate of fluid would be reduced post-operatively.

A. The rate of fluid reduction post-operatively, as a matter of course, is not followed by 90 per cent of anaesthetists, and that is also in the Way report. So they asked people: what fluid do you prescribe? Do you reduce it post-operatively? And -- sorry, 87 per cent said they did not reduce it post-operatively. 2 per cent actually increased it post-operatively. And the remainder said it just depends.

So the notion that it was a widely accepted policy

of reduction is wrong. What I said was I anticipated that if you were using 80 ml per hour to replace the deficit, it would have to reduce, but only to the 65 ml that would be normal.

MR QUINN: But in your mind at that time at that meeting you had two issues in relation to fluid. One was volume of fluid, which you've now told us you've later rethought. The second one was that you'd given the wrong fluid, solution No. 18. Is that correct?

A. At the time we thought it was the right fluid --

Q. Yes.

A. -- but my concern was that the fluid was implicated in the problem.

Q. So would you agree that that would be -- what could be defined as a shortcoming in Raychel's treatment?

A. Only if you knew that you shouldn't be giving that fluid to children and you willingly did so, but we did not know that and we said that on the day to the family --

Q. Apologies, apologies, you're not answering the question, you've already discounted --

MR STITT: Mr Chairman, this witness has been going for seven hours.

THE CHAIRMAN: Where are we going?

MR QUINN: What I'm asking is, he was aware at the meeting, that is a critical incident meeting, that there was

a shortcoming in relation to the fluid volume, because he only corrected that view the day or so afterwards.

THE CHAIRMAN: Yes, he went into that meeting on the basis that there was an excess of fluid given and having -- on leaving the meeting, there's some debate about it, he recalculated it and thought there is a excess but it may not be a significant excess.

MR QUINN: Yes. And where I'm going to with this is that I know Mrs Burnside is coming up in the next few days and in relation to what she said at the end of the meeting that was held at the board level in relation to the coroner suggesting there may be no liability on behalf of the trust, I want to then get to the issue as to whether or not shortcomings in any of the treatment or care was discussed at the critical incident meeting a few days after Raychel died. And I'm saying that -- because just hold on, I'll get to the matter immediately. If WS032/2, page 15, could be brought up I'll explain my point.

WS035/2, page 15. You'll see at (h) at the bottom of the page, this question is a series of questions relating to the critical incident review meeting and whether or not consideration was given to various issues listed below.

At paragraph (h) they've asked:

"Possible shortcomings in the nursing care provided to Raychel Ferguson."

You have said:

"I don't believe we mentioned shortcomings, but documentation problem were discussed."

A. Yes.

Q. Why were no shortcomings mentioned when you were aware of shortcomings?

A. The shortcoming was not a shortcoming because the fluid that was used was accepted practice, it was used widely in, as I've said earlier at length, in the UK and in other hospitals in Northern Ireland. So the actual solution we were using we believed to be perfectly good. After the meeting, I was saying, "Look, this solution's got a problem associated with it --

Q. Sorry, you've misunderstood again. What about the volume that you knew was incorrect when you entered that meeting?

A. But I didn't know it was incorrect.

MR STITT: Sorry to interrupt for one second. This question has got to do with nursing. The fluid balance issue is a doctor's issue.

MR QUINN: I realise that. I'm coming to the next point. I'll leave that point.

MR STITT: I insist at this point, Mr Chairman, that

Mr Quinn put his points to you and if you would be so kind to put them to the witness rather than berating the witness after seven hours.

MR QUINN: I'm not berating the witness, Mr Stitt.

MR STITT: All right, I'm sorry. I retract that.

THE CHAIRMAN: Leave it, it's getting late. I understand to a degree your frustration because it's not entirely clear to me, having heard a number of witnesses, about what exactly was faced up to at the critical incident review, whereas I thought it had been established at the clinical hearings in February and March that at the critical incident review there were a number of shortcomings faced up to, and that's now clouded, let me put it that way.

MR QUINN: That's the point I'm making. Thank you, Mr Chairman, you've got the point.

A. Mr Chairman, I do not accept that it's been clouded. I do not intend to cloud it.

THE CHAIRMAN: Let me put it this way. I had a clearer impression in February and March that various failings had been recognised at the critical incident review.

A. The nurses admitted that the documentation was not of the standard they might have expected, they could have done better with the documentation. The recording of the amounts of vomit.

THE CHAIRMAN: But I thought you said that that was the standard recording system of plus or plus plus. So if that's the standard system, that's not --

A. And if I might finish then. The U&E that should have been done that wasn't done. That was something that potentially could have shown the U&E problem. We don't know if that's the case. If you'd done one in the morning time you'd have had a normal U&E.

THE CHAIRMAN: So that may or may not be a shortcoming.

A. Well, it wasn't done and it should have been done, and I think the admission in that meeting was that a U&E should have been done.

THE CHAIRMAN: Sorry, but that wouldn't be a nursing issue because the nurses don't do the U&E.

A. That's correct.

THE CHAIRMAN: So if that's a shortcoming, on whose part was it a shortcoming?

A. It'd be on the medical staff or it'd be on the nurses saying, "Look, if Dr Zafar had said he thought the fluids were coming down and there was no need to do a U&E in the morning because she was so well", and then that wasn't the case, then the nurses would have told the doctors "Look, we're continuing the fluids", and then perhaps someone might have said at 6 o'clock "Well, look, that's 24 hours or roughly that, maybe we should

do another U&E". One wasn't done and I think the feeling was that it was always going to be discontinued. That was the reason why it wasn't done. And I've explained the doing of a blood test on a child is unpleasant for everyone.

THE CHAIRMAN: Yes, but let me be more precise. In essence, if I picked you up correctly, that's a shortcoming by Dr Devlin at 6 o'clock-ish when he comes in and administers the anti-emetic because Raychel hasn't made the expected recovery and is vomiting to the extent that she needs an anti-emetic. So the criticism that was agreed in the absence of Dr Devlin at the critical incident review was that Dr Devlin should have organised a U&E.

A. Or the surgeons in charge of her case should have done. He's not a surgeon, he was just a doctor on the ward who was helping out, and he probably didn't look at the fluid balance chart but the surgeons should have known.

THE CHAIRMAN: Yes, but for the surgeon to know that he surgeon would have to attend her.

A. Yes, I believe that they should have contacted the surgeons saying "Look, this is not going as we thought, we should do a U&E here", and that wasn't done, and that was discussed at the meeting, and also at the meeting with the family, and we talked about the fact that U&Es

are very difficult, no one wants to do them and for all the best reasons it wasn't done. Eventually one was done, which showed the very low sodium, but by that time, as we now know, it was too late. But not at the time, we didn't know that.

THE CHAIRMAN: Okay.

MR QUINN: My second point is this, and the family have asked me specifically to raise this point, and it is a rather emotive point. Mr Chairman, the witness used the term that the family were firing questions at the people assembled in the meeting in September 2001, and I want the witness to confirm that one of the questions that they were firing at him was that Raychel was vomiting in a severe and prolonged fashion. That's point number 1.

And I then want you to ask, Mr Chairman, through you, that when he got the report from the expert witness, Dr Warde, did he not feel that the parents had a point -- or Mrs Ferguson and her sister had a point in raising this issue about severe and prolonged vomiting, and if he did think they had a point that that was correct after seeing both Dr Sumner's report and Dr Warde's report why did he not go back to the parents and confirm that in fact Raychel did suffer from severe and prolonged vomiting and that it might be a very

relevant point in her care and treatment?

THE CHAIRMAN: Let's start, we were discussing the 3rd September 2001 meeting with Mrs Ferguson and her sister. I was concerned about your use of the phrase "firing questions", which you then moved away from, but was one of those questions or issues which was raised by the family about what they believed to have been Raychel's severe and prolonged vomiting?

A. Yes, it was. They said -- well, for a start it's a statement they said, but Raychel was vomiting profusely and there was blood in her vomit. And then there was an explanation that vomiting does occur after surgery, and I then explained how blood can get into the vomit, and there was a lot of -- when I said the firing of questions, what I meant was it was the -- it wasn't the way the meeting --

THE CHAIRMAN: You don't need to -- don't worry about the firing of questions, because we've already covered that. Let's move on. When Dr Sumner's report comes in, he appears to agree with the family's analysis of the vomiting.

A. He does.

THE CHAIRMAN: Then Dr Warde's report comes in and he too seems to agree with the analysis. Now, at that point how come it doesn't occur to somebody "Look, actually

the family's right. The family's right about the severe and prolonged vomiting". So insofar as the recollections of the critical incident review end with Dr Fulton being unable to reconcile or you being unable to reconcile the views of the family on the one hand and the nurses on the other, there are then two experts' reports which come in, which are pretty much in the family's camp. So why wasn't that recognised and faced up to?

A. For me, it was a matter of regret that we did not meet again after that meeting. And I did say that I was -- I would go through the chart, I would feed back to them about the fluid meeting on the 26th. I would do everything in my power to make changes, all those things. And the family didn't -- the meeting was -- there was no success from that meeting because they left the meeting with a completely different view than I had.

I thought that we had been open and honest and helpful, and I would have looked forward to helping them with other questions that they might have had. And that would have been an opportunity to say, "Look, it does look like the vomiting was worse than we thought". But that did not arise.

THE CHAIRMAN: No it didn't happen, and next time in fact that the family saw the trust in any substantive way was

at the inquest when the nurses were giving the evidence that this was normal post-operative vomiting.

A. That was their contention and that was the basis upon which I did everything --

THE CHAIRMAN: I don't want to go over it again. But I've made the point more than once before about if the nurses are being unrealistic or not facing up to what went wrong, and their records aren't reliable, does somebody not say to the nurses, however sympathetically you do it, "This just isn't the way it reads", rather than simply adopt their line, which is not supported by expert evidence. We've all been with people who make mistakes and sometimes you have to say to them, "That's just not right".

A. I accept your point you're making.

THE CHAIRMAN: And the fact that the nurses were holding to this view, notwithstanding the fact that the records were incomplete -- I mean, forget about the vomiting plus or plus plus because I don't think that's the family's big point, it's a way of measuring, and there's always a degree of subjectivity in it. But the family's big point is that the number of vomits wasn't accurately recorded. And, of course, if the number of vomits isn't accurately recorded it throws off any argument or it certainly damages any argument that the nurses are

making about how severe the vomiting was, because the more that Raychel is vomiting, the more one is driven to conclude that this is prolonged and severe.

A. I agree. I think the documentation has to show more clearly the volumes, estimated volumes, because the point you made before was that different nurses are recording at different times.

THE CHAIRMAN: Yes.

A. And if one nurse had observed the whole thing, then maybe it would have been a different view that they took. Each nurse had a smaller --

THE CHAIRMAN: Yes, but it's more than that, doctor, I'm afraid, because some of the vomits simply were not recorded. It's quite clear to me on the evidence that we heard in February that a number of vomits were missed.

MR STITT: Mr Chairman, may I respectfully suggest you have summed it up well by saying, "It's perfectly clear to me -- you've summed up your opinion well by saying "It's perfectly clear to me on the evidence which we heard in February". Now, those words are important "on the evidence we heard in February".

You found yourself in a position to make a value judgment, you heard the family on the one hand, you heard other people who had been in the ward and you

heard the nursing staff and you heard doctors, and you formed a view.

The whole point of having witnesses turn up before a coroner is so that he can be in the same position as you are and form a view as to how much vomiting there was.

THE CHAIRMAN: That's right up to a point.

MR STITT: But the two experts can't do that.

THE CHAIRMAN: No, but --

MR STITT: They're in a room somewhere doing their report.

THE CHAIRMAN: No, Mr Stitt, that's right up to a point. But what happened here was that the trust went along with the nurses' position without a proper investigation of whether the nurses were right or not because they weren't interviewed in the way that was asserted to the coroner. And you don't just go in front of the coroner and say, "This is the line that our nurses want to take so we're putting it out to the coroner". Surely a public body has a responsibility to say to itself internally, "This is a line or a view which is held", even if it's held honestly by the nurses, "But before we advance that on behalf of the trust, let's examine it closely and see if it actually stands up to scrutiny". Now, I don't see any evidence that it was examined before the inquest.

MR STITT: I don't. I know the letter to which you refer. We're all familiar with that.

THE CHAIRMAN: Yes.

MR STITT: But the fact of the matter is, nonetheless, the nurses obviously had a view on the thing. They gave their evidence and, on top of that, there's other evidence, which may not be worth a candle -- I'm not going to comment --

THE CHAIRMAN: Okay.

MR STITT: -- or it may be that parts of it are very solid about the general condition about the child throughout the day. I'm not here to make a case at this stage in 2013, especially in the light of last Friday. But what I am saying is that if we go back in real time to the coroner's inquest, I respectfully submit it was not unreasonable of the trust to suggest to the coroner that he might like to hear from the nursing staff, and he accepted that invitation.

THE CHAIRMAN: Yes, but he accepted the -- well, we're going over the ground. He accepted that invitation on the basis that it was asserted to him that the nurses had been interviewed and this was their evidence.

MR STITT: We haven't seen the basis for that, I accept that.

THE CHAIRMAN: Okay.

Mr Quinn, does that cover your points?
MR QUINN: Thank you.
MS GOLLOP: Sir, may I ask just one question?
Questions from MS GOLLOP
MS GOLLOP: Very briefly, I'm here representing Dr Jenkins, so you know what I'm doing here.
Can you tell us, in June 2001, when Raychel was an inpatient at the hospital, did the hospital have a protocol or a policy on fluid balance management?
A. Not that I'm aware of. A specific policy saying who should prescribe it or ...
Q. I wouldn't know what the contents might be, but did it have any sort of a protocol, practice, for the management of fluid balance?
A. Not that I'm aware of. It may have had, I wasn't aware of it.
Q. Did you see Dr Jenkins' report and letter?
A. I saw his report. I'm not sure which letter you're referring to.
THE CHAIRMAN: Well, there were three exchanges with Dr Jenkins: an initial report, a response to Dr Warde, and then the report which went to the coroner. Did you see all of those?
A. In the course of the gathering information for this, I have. At the time I was -- to be honest, I was

unaware of the Jenkins report, I was unaware of the Warde report, I was only aware of the Sumner report. My recollection --
THE CHAIRMAN: Sorry, I thought you said to me earlier on that you must have been aware of Dr Warde's report --
A. I --
THE CHAIRMAN: But you can't remember it now.
A. Well, I accept that, because I was the medical director, and I would be very surprised if they hadn't told me. It's just I have no recollection. I have never met Dr Jenkins and didn't know much about him, and I don't remember his being asked to do a report. I have a very poor recollection about that, but I've seen them since, so I have seen his report.
MS GOLLOP: And last question. He produced his first report in November 2002. One of the things he said in that report was that he would like further information about whether the nurses had acted in accordance with proper practices at the hospital for fluid balance observation, management and so on, and asking if there was practice or a protocol. If you had been asked whether there was such a protocol and whether you could provide -- or, through you, further information could be provided to Dr Jenkins, you would presumably have assisted with that request, wouldn't you?

A. I would have, and I suppose I would have gone to the nursing side to see, "What documentation do you have for that type of thing?" I don't recall having done that if that's an answer to your question.
MS GOLLOP: Thank you.
THE CHAIRMAN: Anything else from the floor before I come to Mr Stitt? No?
Mr Stitt, do you have anything for the doctor?
MR STITT: No.
THE CHAIRMAN: Doctor, thank you very much. It's been a little bit longer than we'd hoped for, but unless there's anything more that you want to say at the end --
A. Only to say that I've had a long experience of 34 years in anaesthesia, and I consider myself to be very experienced, and I have seen desperate situations, disasters, bombings, shootings, awful situations where you're dealing with relatives. So you never get used to it, and it's always awful, but for me the story of Raychel Ferguson is on a par with the worst thing that I've ever seen.
And secondly, I did give a commitment to Mrs Ferguson -- I don't know if she remembers it or not -- but I did say that I would do my very best to ensure that changes were made and I believe that I've tried to do that and I'm hoping that she understands

that that's been my intention all along.
THE CHAIRMAN: Thank you very much, doctor. Thank you.
Tomorrow morning, ladies and gentlemen, at 10 o'clock, with Dr Fulton. Thank you.
(5.30 pm)
(The hearing adjourned until 10.00 am the following day)

I N D E X