Monday, 2 September 2013

(10.00 am)

(Delay in proceedings)

(10.10 am)

THE CHAIRMAN: Good morning. Mr Stewart?

MR STEWART: I call Mrs Therese Brown, please.

MRS THERESE BROWN (called)

Questions from MR STEWART

THE CHAIRMAN: Is your name spelt Therese but you're called Teresa?

A. Yes.

THE CHAIRMAN: Thank you.

MR STEWART: Good morning, Mrs Brown, you were good enough to give us a witness statement WS322/1 on 28 June of this year. Are you content that the inquiry should adopt that as part of your formal evidence today?

A. Indeed, I think in the statement there are one or two typos, but if you haven't picked up on them, yes, I'm content.

Q. If there are any important errors --

A. No, I don't think there are. There aren't any of importance.

Q. You have also given us a copy of your CV --

A. Yes.

Q. -- which appears at WS322/1, page 216. I wonder, could

we see that, please. This is the first page. You describe your career in the first paragraph, starting work in the Health Service in 1976, workings a clerical officer, and you remained in the employ of the Western Health and Social Services Board for 20 years in various administration posts, rising, to the time you left, to the post of head of litigation.

How many years have you been involved in litigation for?

A. Been involved in litigation probably since about 1978 in that -- as a band 3 in the department which I worked, which was called the support services department of the board, I would have been involved in receiving litigation letters. So for that long.

Q. You move on in the second paragraph to describe how you obtained a degree in 1992 from the University of Ulster at Magee College in public policy and management. You then took a law degree from the University of London in 1999, and you then achieved a master of laws degree from the University of Northumbria in 2006.

A. Yes.

Q. Moving down the page to your career history, we see again head of litigation 92 to 96, and then 1996 to 2007, which is the period we're dealing with, you were with the Altnagelvin Trust as their risk management

coordinator and subsequently risk management director.

A. Yes.

Q. Your job description is also attached to your witness statement. It appears at WS322/1, page 30. This sets out, across several pages, your principal responsibilities.

Can I take you to the bottom responsibility on that page:

"To assist and advise senior management on the formulation, maintenance and enforcement of related policies and procedures."

Can I ask what those policies and procedures are related to?

A. Well, I would believe that -- well, the job description was written before I obviously took up post, it was a new post, but I would believe that the intention was, and my understanding of it when I did take up post, that it was the formulation, maintenance and enforcement of policies and procedures regarding risk management. I would believe that I also would have been responsible, as any manager in an organisation, to ensure the enforcement of any policies that were not of my writing but were in existence within the organisation.

Q. Yes, of course. I just wondered whether it might in fact refer back to the previous responsibility, which

was in relation to achieving optimum quality of care. Was that part of your remit?

A. Well, the trust -- I'm not a clinician, but the trust in the delivering of healthcare, the optimum would be the delivery of high quality care. So yes.

Q. Right. Can we have page 31? At the top you were to be responsible for establishing systems of assessing, preventing and responding to risk, including clinical risk. To what extent did you involve yourself in assessing clinical risk?

A. Well, I wonder is it beneficial -- I believe that in 1996, when this job description was written, I took a post in, I think it was, early January 2007. Risk management, for all the reasons that have been outlined by the inquiry, was a new and developing thing, particularly in the mainland. I believe I was the first clinical risk manager appointed in Northern Ireland in an acute trust. You know, the first risk management in an acute trust.

So obviously, an acute trust is involved in delivering high clinical care. So that is where I believe my responsibilities were for establishing systems, for assessing, preventing and responding to risk within the trust.

Now, it was such a new phenomenon, there was a big

aspect of it was -- in the creation of the post was because we had become a trust in April 2006 -- or 1996, there were lots of health and safety statutory responsibilities as well, so it was -- I always believed it was to be a total risk management role path crossing clinical and non-clinical risk.

Q. Because one of the things you did after arriving at the trust was to help, I think, Ms Duddy and Dr Fulton actually produce a strategy for clinical governance.

A. Yes.

Q. So --

A. Clinical risk, I think it might have been called.

Q. Clinical risk?

A. Clinical risk, yes. Sorry, no, the strategy for clinical governance, yes. Yes, you're right. Yes.

Q. That's right. You were said to have coordinated the development of that strategy.

A. Yes.

Q. What did you do?

A. I would have been responsible for gathering -- researching the evidence that was in place in the United States. Australia was very majoring in risk management and across the world in the United Kingdom. So it was about researching all of the evidence that was around the world regarding risk management, and -- so

that was really what I saw my role in doing was, sorting together all that evidence.

We had a few brainstorming sessions, if I recall correctly, and then I would have done a first draft of the paper based on all of that, trying to reference articles, which I think are referenced in the document, and then helped formulate the strategy on that basis, and the strategy then would have gone to the senior management team in the trust.

Q. You used Miriam Lugon's book, which we have referred to.

A. Yes.

Q. Presumably the NHS risk management manuals?

A. Yes. I remember on my very first day in post, I think it was the chief executive or the then director of nursing, but I remember being handed a copy of the risk management manual in the NHS because I hadn't seen it before that point.

Q. That's this booklet, isn't it?

A. Yes, I actually hadn't seen it --

Q. 1993, sir, Risk Management in the NHS.

A. I actually hadn't seen it before the interview which I got, which I had -- so how did I manage to get an interview without having seen it? But I hadn't seen it before.

Q. Yes. So obviously you read it carefully and --

A. Yes.

Q. Because you were sent off to research what other people were doing about clinical governance and risk management elsewhere, in a sense when it came to writing the strategy you were writing your own job, were you?

A. No, I wouldn't believe I was writing my own job. I thought my job was in the job description. I think whenever I was writing the strategy I was trying to inform the senior management team with the medical director and the director of nursing, I think we -- it was -- you know, we were -- although I might have physically typed it up, we were writing a strategy for the senior management in the organisation, not -- I don't see it as writing my job. We were writing what was being done elsewhere and what was being identified as being good practice.

Q. Just to go back to the screen again. The second paragraph you had responsibility to liaise with the medical director --

A. Yes.

Q. -- on medical negligence issues.

A. That's right, yes.

Q. Were you and he really the two lead individuals on medical negligence cases?

A. Well, there was a scrutiny committee that had been

established and -- well, again, there wasn't -- whenever I came to the trust that was one of the first things we did, establish a scrutiny committee. It was based very similarly on -- well, the clinical claims committee is what it was called, the scrutiny committee. I had worked in the Western Board dealing with litigation claims, so -- and I believe all trusts followed a similar process for establishing a committee where they would review new claims that were received, and the medical director, the director of nursing in the Altnagelvin Trust sat on it, which was unusual from my -- in the board, the director of nursing hadn't sat on that, and myself and the solicitor sat on the scrutiny committee.

Q. I'm not sure that Ms Duddy told us the other day that she did sit on that committee.

A. Yes, she did, yes.

Q. She did?

A. She did.

Q. I'm grateful. Can I refer to page 321-004fd-005. This is the policy for management of clinical risk 1997, which I assume was one of the documents you drafted, and we can see there a description of the trust scrutiny committee chaired by the medical director with yourself and the trust solicitor and an ad hoc member as

required.
A. Yes.
Q. So I take it the ad hoc member was in fact the director of nursing?
A. Yes, and she did say that she sat -- I'm sure she said in her evidence that she did sit on it.
THE CHAIRMAN: It was also mean in a particular case, if it was a paediatric case, a paediatrician might join for that meeting or somebody from another department, depending on what type of case it was?
A. Chairman that was always the plan that we would bring individual clinicians. Yes, there could have been a radiology or a radiography case. So, yes, that was always the option.
THE CHAIRMAN: Thank you.
MR STEWART: Indeed, you can see halfway down that list of square points, the paragraph beginning:
"Decide which cases to be settled or a defence maintained ... delegated by the trust board, taking into account the views of the consultant involved."
So there is a mechanism for taking the views of the consultant.
A. Yes. Yes. That was probably -- and particularly if the trust was considering that we should defend -- we should perhaps settle a claim or negotiate a settlement, and

without an admission of liability in a particular case then if a consultant or someone felt that they were not happy with that, then you would always take their views into consideration regarding what their views were on the litigation.
Q. So the individual consultant could block your view in relation to --
A. No, no --
Q. -- whether to defend a case or settle?
A. -- I'm not saying -- but you would want to take their views into consideration as to how you may well discuss the settlement and feed back to them. You wouldn't want them just to hear in the press that a claim had been settled if they had said they'd always wanted to defend it.
Q. I see. Let's go back to your responsibilities at WS322/1, page 31. Your responsibilities continue, it's almost like a counsel of perfection.
To about the fifth paragraph down:
"To develop a systematic process for the identification, assessment and control of actual and potential risks and losses throughout the trust. That sounds like a fairly broad undertaking. What did that mean?
A. Well, the whole terminology of risk management is all

those terms. It is identification -- and this job description was written before I went into post so I didn't write it. But that is the term of risk management, identify, assess. Once you've assessed you see what the controls are for the risk and see how then you will manage that risk in the future.
So it really is just using risk management terms, that's what I would understand it meant and that's what I understood my job was to do. So when you became aware that a risk existed you assessed the severity of the risk and then you assessed what the current control measures were and whether they were appropriate or not appropriate.
Q. So if, in other words, by whatever means, audit or review or benchmarking, you became aware of an issue to be addressed or problem area, potential risk, then your responsibility was to do something about it, was it?
A. Well, I would believe that my responsibility was not always to -- that the individuals if they were aware of a risk, it was their responsibility to try to do something about it. I think my responsibility would be to let the trust know if I felt that the risk was not being managed appropriately. I don't know that I could physically always do something about the individual risk, but perhaps make proposals to improve how it could

be resolved.
Q. You're aware of this extraordinary clinical governance phrase of "closing the loop"?
A. Yes. Absolutely, yes.
Q. In other words, making sure that if you're alerted to a problem --
A. Yes.
Q. -- that you put into place some sort of method of fixing it and you make sure that's in place and working properly. Was that part of your remit?
A. Yes.
Q. Over the page, finally, to page 32. We find you responsible, I think the fifth paragraph down:
"To secure the monitoring and effective management of risk across the trust."
The postholder is required to comply with all trust policies. I take it that was an important part of your job?
A. Yes. I think that is something that goes into every job description at a management level, that you must comply with all trust policies -- that's existing policies -- and standing financial instructions.
Q. It'd be fairly strange if it was otherwise, wouldn't it?
A. Yes.
Q. Your witness statement, which is at 322/1, page 1,

advises as to the various committees and panels that you sat upon at the time. 2001 is the period we're interested in, which starts off at the top there, internal trust committees was the health and safety committee, which doesn't concern us. Also you sat in 2001 on the clinical incident, clinical audit and, as we mentioned the scrutiny committee.

A. Mm-hm.

Q. How often did these committees meet in 2001?

A. Um. Now, I -- sorry, do you want to talk about the health and safety committee?

Q. Let's move on to the clinical incident committee. How often would it have met?

A. Well, the clinical incident committee in actual fact I know there was some discussion regarding that on Thursday --

Q. Yes.

A. -- and there was a suggestion that it met every month, and I know in my statement I've said it met every month. I believe it did meet every month, but time goes on because through -- I went back to the clinical incident files in the trust on Friday morning and I discovered in the files with -- because incidents were -- incident forms were received, clinical incidents were received, and they were filed in a file, and then we met and

discussed them; I believed it was every month, but that was -- as the numbers increased it was quarterly, it appeared to have been quarterly, because I've got -- so ever three months, so you looked at the incidents that have come in over the last --

Q. Would it have been at the end of March, end of June, end of September?

A. That was the plan, yes. But then -- yes, but as it moved on, and there was too many incidents to discuss, then it became a monthly meeting. It's currently a monthly meeting. Well, medicines governance is.

Q. Was it minuted?

A. No, it wasn't minuted. I've actually -- excuse me, chair, but maybe just to clarify. In 2001, the department of nursing and risk management -- the risk management department was basically me. I mean, there was no admin support. I'm not a secretary, you know, I'm not a typist, but I can type, but -- so in 2001, there weren't minutes done, the minute wasn't minuted, but there were agendas, which I developed, and there were action notes, and the incidents would all have been summarised in a spreadsheet and they would come along to the meeting.

Those have managed to be -- those minutes or those action notes and agendas have been provided to DLS to

provide on to the inquiry. I found them on Friday morning, just to clarify.

Q. I'm sorry; you found them on Friday morning?

A. Yes.

Q. And they will be forwarded in due course after your evidence is complete; is that right?

A. Yes.

THE CHAIRMAN: No. I want to see them before then. When are they available, Mr Stitt?

A. Well, the originals are here.

MR STITT: We thought we had forwarded them.

MR STEWART: I haven't seen them.

MR STITT: The witness no doubt can explain why it was Friday morning, but that's not the point. The point is that the documents are with the DLS, they've got to be looked at purely from a confidential -- I mean, a patient --

THE CHAIRMAN: To delete references to all the patients?

MR STITT: That's it, and that's being done.

THE CHAIRMAN: Okay. Do I take it from that, then, that there are references in the records that you found from 2001 to Raychel?

A. No.

THE CHAIRMAN: So although other incidents, incident forms were received in 2001 about other patients, there are no

references to Raychel?

A. No.

THE CHAIRMAN: If you delete the references to other patients in the agendas and in the action notes, what's left if you delete the references to other patients? What's left for us to see?

A. You can see the agenda and you can see the action notes. There were some general issues being discussed.

THE CHAIRMAN: Okay.

MR STEWART: We'll just go through this bit by bit. Were there minutes?

A. No.

Q. Ms Duddy gave evidence the other day that all clinical incident committee meetings were minuted.

A. I think she changed that and she recalled it later -- she --

THE CHAIRMAN: She did change that and said --

A. That is why I knew they weren't minuted. And, chair, if I can apologise, I didn't believe -- I never believed there were minutes of those meetings, so that's why they were never provided before because I knew they weren't minuted.

MR STEWART: Have you located, then, the agendas of the meetings of 2001?

A. Yes, that's what I've located.

Q. Have you located the action notes?
A. Yes, as crude as they are, because, I mean, they really are a one-page, you know, it's about the general issues. Because each incident was put on to a spreadsheet and the action against each one of those incidents is documented on the spreadsheet, so it's really -- it's really as crude as they are.
Q. All right. Was dilutional hyponatraemia discussed even if Raychel Ferguson's was not?
A. No, not at those meetings. There's no record of it being discussed at those meetings.
Q. Well, if her case wasn't discussed at this committee, why wasn't it discussed at this committee?
A. Because it's very -- Raychel Ferguson case has been discussed at length. You know, it's not -- it hasn't -- it isn't documented as being discussed at those meetings. I'm not saying it wasn't discussed, it doesn't appear on the agenda. It -- there was a critical incident meeting for this incident. So it was -- this wasn't a clinical incident, this was a serious critical incident. So it didn't fall into the routine clinical incident summaries where we were discussing other incidents. That was the purpose of that meeting, to look at the incidents that had come in in the previous three months and look at those and take

action regarding those. That was the purpose of the meeting.
THE CHAIRMAN: Does that mean that the incidents which were reported on the incident forms and discussed by the clinical incident committee were incidents which were typically a lot less serious than Raychel's case?
A. Absolutely.
THE CHAIRMAN: So if Raychel's case is the subject of a critical incident review, in effect it doesn't end up before the clinical incident committee; is that the distinction you're making?
A. Well, the thing is because the clinical incidents were the summary of incident forms that had come in. If something had been -- we had developed the critical incident protocol, as you know --
THE CHAIRMAN: Yes.
A. -- later on in November. The clinical policy was in February 2000 and then, later in 2000, we developed the critical incident protocol. This was a serious -- this was the most serious incident you could get.
THE CHAIRMAN: Okay. Well, then, just by way of illustration, Mrs Brown, the sorts of incidents that are referred to on the clinical incident forms might be what?
A. Well -- and the summaries, I have lifted them out. The

summaries are there, they would be some, perhaps, the wrong patient's name on the patient, you know, a sticker in their chart, a medication error, a patient almost getting the medication for another patient. And why -- those, I know those -- and someone getting maybe infusion running in too quickly, it's meant for four hours and it runs in over an hour. I'm not saying they're not serious incidents, they are serious incidents, but the outcome would not have been serious for the individual patient, and that's what makes them not a critical incident.
THE CHAIRMAN: Right.
MR STEWART: So in other words, if a form had been filled in, it would have come before the clinical incident committee?
A. If a form had been filled in, it would have been on the summary of the sheets, but that would have been probably reviewing the summary of those sheets at the end of three months. This had happened in June, it potentially could have been discussed in July if you were waiting on that process.
THE CHAIRMAN: I can understand that, how it would be wrong to say that the clinical incident committee dealt with minor issues, that's putting it too low, but they didn't deal with anything as serious as the death of a patient.

A. Yes, chairman, and that's why we came up with the terminology of critical incident. I know a lot of people always struggle with that in the trust, wherever a clinical incident then became a critical incident because all clinical incidents are serious and important.
MR STEWART: Was there a committee that would deal with critical incidents?
A. No. No. Each critical incident was dealt with as a -- now, I mean, I'm -- can I say that I'm fairly content -- but there weren't a series -- there weren't a lot of critical incidents, so a critical incident was a very serious thing. Normally someone dying that you -- so -- I mean, this was the most serious of serious things. So I don't know that you needed as a committee to meet to discuss all of the -- because they would have been dealt with individually.
Q. Yes, because we've looked in vein --
A. Yes.
Q. -- for reference to Raychel's case being discussed at board level, being discussed in any other committee.
A. Chairman, I -- I have to tell you that I am so concerned about the fact that the trust board minutes are missing for the time when I believe it was discussed, which is for the July 2001 board meeting. I'm sure it must have

been discussed there. The files are still there, there have been -- I mean, there have been so many searches done to try to find --

Q. What is your theory for why those particular minutes, as opposed to others, have gone missing?

A. Well, can I tell you -- I mean, this is my theory, but I mean -- because, chairman, I have been searching for these for so long there's a trail of e-mails to the chief executive secretary, could they have been typed on their computer, but I think people used discs in those days as opposed to type -- saving them on their hard drive. My theory is that those minutes came out for the purposes of this inquiry to give to -- you know, that's my theory. And whoever took them out should never have taken them out without taking a photocopy. I know it wasn't me that took them out and didn't replace them, but I know they must exist somewhere and there have been --

Q. Who else could have got them out if it wasn't you?

A. I don't know.

Q. Because it was your job to --

A. I fully accept that, yes. Can I tell you, that I would want them -- I would want them to be there, so it doesn't help me not having them, so it does cause me great concern that they don't exist. I can only

apologise, I cannot find them.

THE CHAIRMAN: I can't assume that there's something damning of the trust in them, and that's why I haven't got them. If I don't have a document it's dangerous for me to make assumptions, but you will understand, Mrs Brown, how, given some other events in the case, how it is particularly unfortunate that these documents are missing.

A. Yes.

THE CHAIRMAN: I put it no higher than that for the moment.

A. Yes, chairman, I fully accept that.

MR STEWART: You said a moment ago when I asked you about whether her case was discussed, you said it was discussed at length.

A. Yes.

Q. Where?

A. I know it's hard to say, you know, where and when it was discussed. This -- this was -- as I said before, this was the most tragic of tragic events. It's been discussed since it happened. I mean, it's still being discussed today, it's being discussed in this inquiry, so it's been discussed -- it's been discussed at length. It hasn't been documented that it's been discussed, and I accept that.

Q. How many committees are there? Did you meet, for

example --

THE CHAIRMAN: Let me ask about one other particular committee that Ms Duddy referred to. She referred to the risk management standards committee, which does have formal minutes.

A. Yes.

THE CHAIRMAN: Now, did that committee discuss Raychel's case?

A. I believe -- Ms Duddy believed there was a risk management standards committee at that time. I never believed there was. I didn't think they sat until 2003. And in the agendas that I have found on Friday morning, there is a reference to trying to discuss the relationship between the risk management in October 2002, on the agendas, the relationship between the risk management committee and the clinical incident committee. So I still don't believe it sat until early January 2003. I'm not sure if those -- if the minutes of 2003 have not been found but I thought they had. I'm not sure.

Q. Was there a clinical governance committee at that time?

A. No, there definitely wasn't a clinical governance committee. And I know there is -- there's a clinical governance steering group, and I know there's reference in the annual report, but there wasn't a clinical

governance committee. I don't believe that there was a clinical governance committee.

Q. The 1999/2000 annual report of the trust tells us under "Clinical governance and quality":

"A clinical governance committee has been established and will provide assurance to the trust board the procedures relating to it are in place and the trust is functioning effectively."

You say that didn't exist.

A. There was a clinical governance steering committee, which was established, I believe, under the chair of the chief executive. Well, no, the chief executive asked for a clinical governance steering committee to be established. That -- you saw the draft clinical governance strategy, which -- which you've referred to, in 1998, and then there was a further clinical governance strategy, which was the final strategy, which was approved, I think, in 2002 at hospital management team. And that was the -- the clinical governance committee I am sure, but I could be wrong, didn't sit until February 2003.

THE CHAIRMAN: What makes you -- sorry, what leads you to come up with the date of February 2003?

A. Because I think it's in the annual report, the annual clinical governance report that it sat in February 2003.

MR STEWART: If we look at the page in front of you on the screen, you'll see that you have given the date as 2002 for your membership of that committee.
A. Of the?
Q. Risk management standards committee.
THE CHAIRMAN: No, sorry, we're talking about --
A. We're talking about the clinical governance committee. I think the earliest the risk management committee was -- based on my recollection, was about December -- November/December 2002. I believe that, I'm not sure if that's true. I can't find my diary to confirm that.
MR STEWART: Can I ask who writes these annual reports on behalf of the trust?
A. Um. I don't -- I wasn't involved in writing -- I don't know. Who wrote it in 1999/2000, I'm not sure who wrote it.
Q. It'd be a very serious matter, would it not, for a trust to claim things --
A. Yes.
Q. -- when they don't exist?
A. Yeah, I think that -- I do believe -- I do believe that's a misinterpretation of the -- I think that should have been a clinical governance steering committee. I do believe the word "steering" is out of that. That's my belief. I'm not sure if I'm right but that's my

belief.
THE CHAIRMAN: Mrs Brown, the difficulty for me and for everybody here is that if you're right that the clinical incident committee would not have discussed something as serious and gross as what happened to Raychel, and if you're right that the risk management and standards committee didn't actually meet until late 2002/2003, but you're right that Raychel's case was discussed at length, what we're struggling to find is documentation to show that it was discussed at length and what those discussions were.
A. Well, chair, I fully -- I fully take your criticism, but there was -- there was a critical incident review, there was the update for the chief exec, there was -- there was a lot of correspondence between clinicians. So there was a file that was kept, and those documents that were produced arose from discussions. They weren't in formal meeting settings, that's the point I'm trying to make. So they were meetings with clinicians, managers, and then there were memos, letters. So, I mean, everything isn't discussed in a formal meeting setting. I understand, you know, that -- the importance of that.
THE CHAIRMAN: I don't think anybody would say that every discussion about every point of Raychel's case has to be recorded or that every discussion between doctors has to

be recorded, but what we should find are some records of the essential meetings that did take place, and what we don't have, by way of example, is we've got an action plan for the critical incident meeting on 12 June, and we've been told about people like Sister Millar speaking out about lack of support from doctors and so on, but we don't have records.
A. Well, I think in the update, which I gave to the chief executive, I referred to the concern that Sister Millar -- that was -- and that is referenced where -- and Mrs Burnside, the chief executive, then asked for that to be actioned. So that arose out of a discussion that I had with Sister Millar. So --
MR STEWART: That arose out of a discussion you had with the entire nursing staff, Mrs Doherty, Mrs Witherow, Sister Millar, Sister Little, the auxiliary nursing staff, where certain points were agreed, but yet notwithstanding agreement of points, notwithstanding undertakings by Sister Millar to train people, there was nothing that was put in writing?
A. Well, there is the update for the chief executive. I mean, I fully understand the concern that you have that these are not minuted. Again, I'm stressing -- I mean, the admin support to do all of these things, it would have been much better if there had been

a minute taken of that meeting.
Q. Let's go to 022-097-307. Is this what we're talking about? This was your update to the chief executive --
A. Yes.
Q. -- on 9 July, and you see at point 4, a meeting has been held with everyone of importance in the nursing -- and to discuss in detail, the following has been agreed, point, point, point, point, point.
Point (g):
"Sister Millar to be involved in the training of staff."
A. Yes.
Q. That's a fairly detailed thing. That must have generated paperwork, documentation, and a note of precisely what was agreed before it was reduced by you into typewritten form?
A. Sorry, I'm not quite sure what -- what paperwork are you talking about?
Q. In order to produce this document, there must have been a trail of paperwork. This didn't suddenly come out of the ether.
A. Well, that was me, I wrote it. And it was, you know -- I don't know that there was a trail of paper -- there were different fluid -- if I -- there were different fluid balance charts shown, they weren't all attached,

I accept that. But there was -- I mean, I believe that was a recording, for what it was worth, of the meeting I had. I know it's not a perfect minute, it's not a minute, but --

Q. This isn't a recording of a meeting, it's an update to the chief executive.

A. Yes, but point 4 is summarising what had happened at the meeting.

Q. You must have a terrific memory.

A. No, sorry, I don't remember it. I don't remember the meeting at all. But that is the things -- sorry, I'm not quite sure what point -- what your point is regarding this.

Q. In order for you to draft this memo update to the chief executive, in order for you to draft paragraph 4 in the detail you did, you must have had to hand notes of that meeting and precisely what had been agreed at that meeting.

A. That -- I don't have -- I don't have those notes. If the notes had been there ... I ... I'm sorry, yes, I can see your point.

THE CHAIRMAN: It starts off, the first line is:

"This is an update relating to the agreed action highlighted by Dr Fulton."

A. Yes.

THE CHAIRMAN: So that's a reference to Dr Fulton's action plan.

A. The six points.

THE CHAIRMAN: Okay. So the outcome of -- the documentation we have about the meeting on 12 June is Dr Fulton's action plan.

A. Mm-hm.

THE CHAIRMAN: What we then have is your update about what has happened since over the intervening, say, two to three weeks, and it's brought together by you in a very specific, coherent form. But Mr Stewart's point is, in order for you to reduce all these points to A, B, C, D, E, 3, 4, 5, 6, you must be working from notes either that you've made or other people have made. Because you couldn't have written that on 9 July, Mrs Brown, without having some note or history before you.

A. I believe I received it from Mrs Witherow. I can't recall. There's no point in me speculating. I accept your point.

THE CHAIRMAN: When it says about the meeting at point 4, of the nurses' meeting in effect, was that a meeting you were at?

A. I don't know. I may have been. I don't know the way that's written. I don't recall the meeting. I do remember seeing a lot of fluid balance sheets, and

I don't know if it was at that meeting that that happened.

MR STEWART: I would assume that when you're engaged in work such as this, which is preparing an update for the chief executive no less, that you would have opened a file in the office --

A. Yes.

Q. -- on Raychel Ferguson case.

A. Yes.

Q. Critical incident review, updates, progress.

A. Yes.

Q. Where's the file?

A. Well, that is the file. I mean, if I can just maybe clarify for you. Every document that I had that was provided to me and all -- and in a lot of my paper notes -- I opened a file on the day that this started, on the day that the critical incident meeting happened, and every document was chronologically put into a file.

So I had what I called then an individual file. And why it was called an individual file is because it wasn't a medical negligence file, it wasn't -- you know, it was an individual file, so it was a file numbered. And I had a file and every document that I had went into that file. And that file has been -- the -- it actually became two files, and they were provided to the inquiry

as -- and they're on the website -- as individual file 1 and individual file 2.

Q. Perhaps as we go through your evidence, we'll bear in mind whether individual points in the narrative would have given rise to documents and whether or not they would have found a place in your file.

A. Yes, yes.

Q. Can I ask you, did you customarily meet with the nursing sisters or consultants as part of your work?

A. Well, I know we're talking -- we're talking 2001 and I was in post since 1997. I would have -- I had launched the clinical incidents policy. Something I was really passionate about was trying to get a clinical incident policy, and you might think three years is a long time to get one, but it was getting evidence from others across the water, trying to encourage incident reporting.

So I know at the time that I launched that policy I went round all the teams, all the team meetings, to share the new incident form. Because, before that, incident forms were mainly accident forms, it was really for the health and safety purposes. So this was something new, it was incident forms.

So I would have met a lot of people at meetings.

THE CHAIRMAN: Right. Just to get it clear, that's the

nursing team, the surgical team, paediatric team and so on?

A. Yes.

THE CHAIRMAN: Thank you.

MR STEWART: But that was relating to one particular initiative?

A. Yes.

Q. You didn't have regular periodic meetings with different members of the clinical staff?

A. Depending on the circumstance of the risk that was identified. It was very much dependent on after the policy was launched it was a chance then to go and work with individuals whenever an incident happened to see maybe -- you know, particularly if a trend came through in an area to see if something else could be done.

So, I mean, I have to say that it was all about trying to sell the idea of risk management. It wasn't particularly easy to sell this new idea of risk management, I thought, but in actual fact I had a lot of people who were interested. Dr Fulton was particularly interested in trying to learn from incidents.

So in actual fact, we had a risk management conference six months after I started post to try to sell it. So it was about being seen and letting people know the benefits of risk management.

THE CHAIRMAN: Sorry, just to go back to a point. That's fine, and let me make it clear that the work that was done on critical incident policy is at least keeping Altnagelvin up to date, if not maybe in some respects putting your head above what's going on. So there is absolutely no criticism of that.

But the point that you were making a few moments ago that you made a point of going to all the teams to show them the new incident forms, was that so that a critical incident would be reported in a coherent way and that would be the trigger for the critical incident review?

A. Well, no, that was really for clinical incidents, chair. I wasn't talking about critical incidents at that stage. The clinical incident policy that I -- was launched in February 2007, it was a fairly formal launch, if I can recall, it was telling them to use the form, and the purpose of the form was so whenever I saw it, I would know -- it sort of led them to different headings and the type of information you would want to know. So that was the purpose of it.

MR STEWART: Let's just look at it. It's at 321-004ff-001. This is the first page. Perhaps we can go to 002. February 2000, the policy for the reporting of clinical incidents.

There we are. We can see in the left:

"Clinical incident reporting is first and foremost an opportunity to learn and to improve our practice and secondly it acts as an early than warning of impending clinical negligence claims."

And then at the top right-hand side:

"Procedure for reporting clinical incidents. It is extremely important that any clinical incident should be reported on the appropriate documentation."

So may I take it from the use of the word "any" that that would in fact encompass a critical incident?

A. Chair, yes, it was always my -- you know, it was my expectation that incident forms should be used for all incidents, but it didn't mean that it must. I mean, the purpose of the incident form was to provide the format for reporting the incidents with -- the facts of the information were there. Now, it was about alerting to a report. It was making sure that the -- I knew that an incident had occurred so that -- and the purpose of saying that it should be reported on the appropriate documentation was so that the facts were clear at the time whenever the form came in. That was the purpose of that.

Q. Yes. But, of course, it did not happen in this case?

A. No, it did not happen in this case. It was reported directly to the chief executive.

Q. And it's a question of whether or not the policies and procedures ought to have been followed or were followed that we're interested in. Because if the protocols are not followed, then things perhaps sometimes fall by the wayside, aren't completed, and the end result is that there are deficiencies.

A. I'm not quite sure ... I think the reporting of clinical incidents was to make sure that incidents would be reported. So I'm not sure that the fact that it was reported, because it wasn't on the form on this occasion, was a concern. I had always said -- and in my going around perhaps -- in my going around to staff, to try to encourage doctors in particular to report incidents. I was very clear that I would accept an incident in any way. I accept that form wasn't filled in on this occasion.

Q. The paragraph continues:

"All incident forms will be sent to the risk management coordinator [yourself] who will inform the chief executive, medical director and director of nursing as appropriate."

Why did you deem it inappropriate to inform the director of nursing?

A. I don't know why. The director of nursing would have been informed of this death. I believe I informed her

of the death the first chance I saw her. The chief executive and the medical director had been informed, and the critical incident meeting -- they were informed on, I think, it was the Sunday. The critical incident meeting was on the Tuesday. I think it was later in the week, whenever the director of nursing -- she wasn't in the building, I believe -- came back. I don't know why the director of nursing wasn't informed but --

Q. She wasn't informed until after the critical incident review meeting had ended.

A. Well, that's right. I can only say that the chief executive was informed by -- immediately. The medical director was informed and the critical incident meeting was established. I wouldn't have -- I mean, I know the chief executive wanted a meeting held as soon as possible. So ... I wouldn't wait on all three people to be told before an incident would be reviewed --

THE CHAIRMAN: Her best guess is she that she must have been out of the trust doing something.

A. Yes.

THE CHAIRMAN: Do you think that but for that it's inevitable that Ms Duddy would have been at the critical incident review?

A. Chairman, the thing is that Ms Duddy and I, her secretary -- I more or less shared her secretary. So -- and her secretary's office was actually off my office, and we were -- I mean, every morning we came in -- you know, she came into her secretary's office and I was there. So I would not have kept something like this death that -- you know, so that minute I would have seen her I would have told her about -- I didn't telephone her. I accept I didn't telephone her.

MR STEWART: In fact, you wrote this document, did you?

A. I ... That is the final draft. I wrote -- there were a few drafts of that document before. There was a lot of discussion in the organisation regarding that document based on documents that were in England, and there wasn't a similar document in Northern Ireland. So it was -- I mean, it's a very crude policy. Now, I mean I look back now, it's not the way a policy should be written, but it was a policy in 2001 --

Q. I'm not criticising --

A. I am.

Q. There is no criticism of the policy, merely adherence to it. Did you also develop the protocol --

A. Yes.

Q. -- what's called the critical incident protocol?

A. Yes.

Q. That appears at 022-109-338.

A. I did, yes.

Q. You've described in your witness statement how in fact you developed this and you based it upon Miriam Lugon's suggestions and advice from her book Making it Happen, Clinical Governance.

A. Yes, sorry, yes.

Q. We had a look at the advice in Miriam Lugon and it appears -- we've got the pages. They appear at 317-034-002.

At the bottom of the page you will see the author says:

"The claims manager ..."

I take it that would really be you?

A. Yes.

Q. "... will need to be notified immediately so a copy of the documentation can be secured and a file created identifying that patient's administrative details, the list of staff involved, a chronological summary of the clinical events, worksheets and other relevant legal information. Staff must be interviewed and statements taken."

A. Yes.

Q. Then it goes on through the rest to the bottom of the page 95 there to describe the process of taking

statements, and then at the bottom:

"The actions of the organisation must be transparent and if negligence is identified during the investigation, this should not be hidden as it will serve no purpose and undoubtedly these facts will come to light during the legal process."

So this was the advice you got.

I wonder, can we go back to your critical incident protocol at 022-109-338. You have chosen not to say that statements must be taken.

In the middle of the page you suggest that staff may be asked to complete a statement containing factual information of their involvement to assist in the investigation, but note these statements may be discoverable in the event of future litigation.

Why did you choose to depart from the advice of Lugon and not make statement taking a mandatory part of the process?

A. This would have been in -- the reason why -- Dr Lugon in her book, she is talking about the critical incident meeting under the claims management process, so she's very focused on claims management at that stage. We were trying -- Dr Fulton, who was the medical director, and I were both working very clear on looking at the guidance that was coming out from America, from

some of the United Kingdom, and from the whole Organisation with a Memory document that had come out in 2000, which was about trying to learn from incidents.

So it was really -- this -- the purpose of this protocol was to try to follow a protocol that was identifying learning. So it was about keeping the processes separate, although interlinked, and I think that's where the reference to the future of litigation is mentioned in there. I mean, I can't recall -- that's my general recollection of my thinking. I don't know exactly why it was left, I can't remember exactly why it isn't in there.

Q. Her advice could not be clearer: staff must be interviewed and statements taken. It seems, might I suggest, very strange that you've decided to ignore her advice?

A. But she has put that under the claims management process of it.

Q. No --

A. I know she's talking about a critical incident protocol, but it's under the heading under the claims management section in her book, if you see up at the top.

Q. Yes.

A. So this was about trying to identify systems failings and learning. It wasn't about -- and absolutely,

I mean, statements should have -- you know, statements are good because statements can reaffirm what people say. I'm not saying that they shouldn't be done. But the purpose of this protocol was about trying to have a system for having what we'd heard was happening in England, was these root cause analysis investigations where people got together and tried to identify what systems failings there might be, and that was the purpose of this. It's probably not very clear now from this in retrospect.

Q. In that case, staff should have been interviewed individually. That doesn't find its place in your protocol.

A. No, that -- in actual fact, again, this -- basing -- working on the guidance, it wasn't that staff should be interviewed individually. What it was -- this was a new way of everyone in the team getting together to chronologically go through the history to have what we at that time started calling round-table meetings. This was the very first one of these that we did. So it was about everyone getting -- chronologically trying to identify what the systems failings might be.

THE CHAIRMAN: I think a concern might be that, yes, do have a critical incident protocol, but when you specifically add a note to the critical incident protocol that

statements which were made in the context of a critical incident review may be discoverable in the event of future litigation, you're militating against the openness with which people will engage with the critical incident protocol. Because in effect, you're saying on the one hand we're going to have a full investigation into this critical incident and we're going to learn lessons from it, and on the other hand, you're saying to them "But don't forget, whatever you say to us in the context of this review might be used in any litigation if the trust is sued". So isn't there an inherent contradiction?

A. Well, chair, I fully accept the point that you're making there, but in actual fact this was a step down to try to prevent that. In my thinking, where Miriam Lugon had suggested in her book, you know, about the trust solicitor being there, and I do say there may be -- you know, that -- she says a trust solicitor should be present.

I was -- you know, my thinking at the time was about trying to move away from that. I can understand in retrospect how you can see that but that was not what the thinking at the time was.

THE CHAIRMAN: Was that put in because -- I mean, you have said that -- I think you said a few minutes ago that you

were advocating this policy and the clinical incident policy and some people might have been a bit harder to bring along with it than other people were.

A. Yes.

THE CHAIRMAN: Was that one of the reservations that people had about it?

A. I think it was. I mean, chair -- I mean, this is a fact. I mean, it is a fact that statements could be discoverable in the event of future litigation. And yes, there were reservations. And as late as, believe it or not, 2005/2006, I think it was Dr Nesbitt and I spoke to a group of staff from Dublin and they were not even -- you know, they at that stage were not doing this, and this was in 2005. So, yes, it was -- and it was clinical staff.

THE CHAIRMAN: I understand that, this is one of the key problems in the inquiry because Dr Carson says in terms this still happens today, there's still the tension between investigating things on the one hand and doctors, primarily doctors but also nurses, being open and candid about what has gone wrong on the other hand, and it's this culture of defensiveness which he and others have said have bedevilled the whole system.

As you'll know generally, Mrs Brown, one of my concerns is that if you wanted an awful example of how

that culture has bedevilled the system, it's Raychel's case, with people's reluctance or failure or refusal to face up to and admit what happened. In a nutshell, that's my big concern. And I think the big concern for the families is that lessons aren't learnt because people don't want to spell out what those lessons are, because to spell out what those lessons are, you have to face up to what was done wrong, and there's a reluctance among doctors and nurses to do that.

Now, do you think that's unfair?

A. I do think that's unfair because, chairman, I have to say I have never -- I mean from I launched in policy in 2000 -- and if you go back over the incidents I was receiving 20 incidents -- clinical incidents in the first -- you know, you can see them incrementally going up. Staff did want to make -- I mean, clinicians -- I find -- I do find it harsh, but that's my view, I mean, because I have never felt people saying to me "I don't want to be involved in that investigation because", you know -- you know, they do, they want to learn from.

It. Perhaps I have the advantage of saying this is about learning and trying to encourage learning and -- so ... But that's your view, chair.

THE CHAIRMAN: It's not. I mean, the reason I'm listening

to evidence, Mrs Brown, and the reason why I want to hear from important people like you in Altnagelvin is to say whether this view which is shaping is fair or otherwise. I think that some people might think there's a difference between, on the one hand, somebody being willing to complete a clinical form, which of course they should do, to say there was a wrong name on medical notes, somebody almost got the wrong medication. Those are important things to refer to make sure there isn't some fault in the system, which can't be corrected. That's one thing.

But when a child has died or a patient, maybe less dramatically, has had inadequate or wrong treatment, which has set back their health, that's perhaps a more stark thing for people to face up to. And a lot of the evidence I've heard -- Sister Millar came to this inquiry and said that Raychel was recovering well on the Friday afternoon, and she wasn't. She said that Raychel received a very high standard of nursing care in Ward 6. She didn't. Sister Millar came to the inquiry and said that, and that statement is made in 2005, long after. It's quite clear that both of those statements are wrong. If that isn't a culture of defensiveness and a failure to face up to the reality of what happened, what is?

A. Chair, I accept your point. At the current induction of junior doctors, I am a second person on to speak to them in our trust now, after the medical director, and the point that I make is about the importance of incident reporting, the importance of learning. So that's still -- that is my feeling and my view on what we should be doing.

THE CHAIRMAN: Okay.

MR STITT: Mr Chairman, if I may respectfully say perhaps and ask you to revisit the last observation. I respectfully suggest perhaps you're being a little harsh by pointing out one witness, whose evidence you have correctly, if I may say so, surmised. That was her opinion. Now, you may not accept that, that's within your --

THE CHAIRMAN: But Sister Millar doesn't accept it. Sister Millar said she was wrong. But my concern, Mr Stitt, is she was still saying these things that she can't stand over long after the inquest, and long after it must have been blindingly obvious that things were wrong.

MR STITT: Yes. I'm not going to argue that point. The point is this, to go from the particular to the general, which is what you're doing, and saying that's evidence of a culture of defensiveness, in itself it could well

be, of course, but perhaps it's a little unfair to target the whole trust because of that one piece of --

THE CHAIRMAN: My concern is that Dr Carson has said that this was and remains a general concern. So when I make the point about you're suggesting that I'm tarring the trust, my point is even broader than that. My point is this appears to me to be a significant problem within the whole Health Service. It's not just Altnagelvin, but Altnagelvin is part of it.

MR STITT: Certainly Dr Carson, when I listened to his evidence, was talking provincially within the whole of the province of Northern Ireland.

THE CHAIRMAN: Yes, and in a sense, on a general level I'm not singling out Altnagelvin as being worse for being defensive than any other trust is, but that appears to be a general problem. We happen to have a rather stark example of it with Altnagelvin in this incident.

MR STITT: With this witness.

THE CHAIRMAN: With that witness. I will listen, obviously, to all the evidence, but the evidence I've heard to date suggests that in this incident there was a reluctance to face up to a number of things which had been done wrong.

MR STITT: I know you will consider all of the evidence.

THE CHAIRMAN: Thank you.

Mr Stewart.

MR STEWART: Just looking at the middle of the page in front of us in relation to who should attend the critical incident review, it finishes:

"On occasions the trust solicitors may be present."

Was there any consideration on this occasion to involving the solicitors at this stage?

A. No, no, there wasn't.

Q. What type of occasions would prompt you to engage, to include the solicitors?

A. We have never engaged the solicitors at a clinical incident meeting. I mean, again, it's very hard to really get across. The lack of evidence that there was out there on what should happen, so this was from -- Dr Lugon talked about solicitors and the legal point. We have never in the Western Trust -- or, sorry, in the Altnagelvin Trust there was never solicitors present at a critical incident meeting.

Q. What type of occasions would you have envisaged where they might be present?

A. I don't know. I was probably using the guidance that was in the document.

Q. This is a terribly rare case --

A. Yes.

Q. -- it's a desperate case. There's word coming back from Belfast, which is critical, of the healthcare she

received at Altnagelvin, wrong fluids being mentioned.

A. Yes.

Q. Surely those alone would be an indication a solicitor perhaps should be there.

A. I don't think so. I know the chief executive never intended it, the medical director who I was supporting in the meeting -- I don't think so.

Q. The medical director was Dr Fulton --

A. Dr Fulton, yes.

Q. -- who said that people were not willing to have the meeting minuted, they would rather have legal advice on that issue. Surely that alone, they'd rather have legal advice, that would suggest that a solicitor might or should have been present?

A. I believe that came from the people who were at the meeting. You're saying -- the trust solicitor was not invited. It was never my intention that they would be invited. I don't believe it was the intention of the chief executive or the medical director they be invited. I don't ...

Q. Very well.

THE CHAIRMAN: Just to give me an idea of numbers, can you give me an estimate offhand of how many critical incident reviews there were in Altnagelvin from, say, 2000 to date? Would there be -- just give me an idea,

Mrs Brown. Are there two a year, three or four a year?

A. I think you're probably right on perhaps the three or four a year. That might even be an exaggeration. They've got increased now because there's now a category of incident that we must report under the Health & Social Care Board's guidance. So at that time there wasn't really any guidance about what should be classed as a critical incident. So there would have been maybe two/three.

THE CHAIRMAN: Have there ever been solicitors present at those meetings?

A. No, no. I have not been at a meeting where there's been a solicitor present at a critical incident meeting. I could be corrected but I can't recall it. Not one that I've facilitated.

THE CHAIRMAN: Thank you.

MR STEWART: The whole purpose of these meetings is to identify the problems if they exist and to learn lessons.

A. Yes.

Q. And what Professor Lugon was very keen to point out was that you create a file with a list of the staff involved.

A. Yes.

Q. You didn't make a list of the staff involved, did you?

A. I didn't, no. I didn't at the meeting. I mean, I -- there was a list -- I believe there was a list of staff involved -- drawn up at a later stage. But at the meeting we chronologically -- I think Dr Fulton has put down a list of some of the staff.

Q. He did that after the meeting.

A. Yes.

Q. First of all, can I ask, why did you not put that advice, create a list of all involved in the protocol?

A. I don't know.

Q. And then why didn't you do it when you came to the review?

A. The critical incident -- at the critical incident meeting?

Q. Yes.

A. I believe Dr Fulton was doing that. And you're completely right, at the moment, if you have a meeting, there is a list goes round and everyone is asked to sign their --

Q. But that's a list of those who attend.

A. Yes.

Q. It's not a list of those involved.

A. Sorry, yes. The chronology would now be prepared. Should have been -- it was -- we went through a chronology of the time and event and I know Dr Fulton

did notes of who the relevant people were.
Q. But he did that later.
A. I thought he actually wrote the note at the meeting, but --
Q. If he'd wrote a note at the meeting, he has not provided it to the inquiry.
A. I think the note that is provided, I thought he had taken --
Q. The note that he has provided quotes, for example, Dr Gund's statement, which was prepared in December 2001. It was not contemporaneous.
A. I don't think he's quoting Dr Gund's statement, I think he's quoting Dr Gund as being involved. I mean, that's just -- Dr Fulton can clarify this, but I think what he was doing there was identifying who all the staff were. That is what I believe that document was.
Q. All right. In any event, you chose not to include this in the protocol and you didn't do it. What about the chronological summary, whose responsibility would that have been? Lugon says it would have been you.
A. Yes, it would have been me.
Q. You didn't do that?
A. No.
Q. What about gathering together worksheets, for example rotas in order to assist in the identification of the

staff involved?
A. That wasn't done. I didn't think there was an issue regarding the -- I mean, it should have been done, it wasn't done, and I don't -- I think we knew who the staff were that were involved at the time, whenever we went through the chronology.
Q. I don't think you did because when Dr Zafar's name emerged in December of 2001, six months later, that came as a surprise to you because you hadn't seen his name on the notes.
A. I hadn't seen his name but I knew that Dr Zafar -- Dr Zafar and Mr Makar, had been -- there was discussion at the meeting that they had come to the ward. I hadn't requested a statement from him, I should have requested a statement from him, and I had written -- I wrote to the coroner to tell him that.
Q. We'll find you a letter in a moment. I think Dr Zafar's involvement came as a surprise to you because you hadn't seen his name in the notes, and you said that in a letter, which I'll trace in due course.
A. I said I hadn't requested a statement from him as he had not written in the notes. It didn't mean that I didn't know that he had been there the next morning because he had already -- I mean, I think there was discussion at the meeting that he had come up to the ward, so

Sister Millar had mentioned him at the meeting.
Q. Can we go to 160-207-001. This is the very end of the year, 31 December, and you got in Dr Johnston's statement, which you're sending on to your solicitor, and you note Dr Johnston makes reference to Dr Curran.
A. Yes.
Q. Mr Zafar:
"I have not requested reports from these doctors as they have not written in the notes."
A. Mr Zafar had written in the notes.
Q. Yes, he was the only entry for 8 June.
A. That's right, yes.
Q. So you didn't know that he had written in the notes and you hadn't asked him for a statement at that stage, six months on.
A. No, I did know that he had been -- he had written in the notes. He had not written in the notes wherever -- the reference by Dr Johnston to Mr Zafar is at the time of Raychel's collapse, which is about three -- sorry, I've forgotten the times. So that is the reference to Mr Zafar and Dr Curran that's mentioned within that, is that it's regarding the collapse and he refers to them in his statements, not in relation to their treatment.
Q. You see, Dr Zafar was an important individual to any

assessment of this case because he was the most senior member of the surgical team to examine -- to actually examine Raychel on the entirety of the 8th. He was the only person to make a note on the 8th and indeed he attended Raychel after her collapse. Yet he wasn't at the meeting.
A. No.
Q. It looks, I suggest, as though you hadn't previously identified him.
A. No, I don't -- I believe I knew -- I believe I knew at the meeting that Mr Zafar had attended Raychel in the morning --
Q. Why did you not ask him for a statement before this date?
A. I -- because -- I'm trying to -- if you go back to the request from the coroner, he'd asked about the surgeon who -- and I believed that to be the surgeon who had operated.
Q. Well, first of all, let's go through the trail of how you got a statement from Dr Zafar. We'll take it now out of turn, but your first letter is the coroner writing to you, 022-081-212.
17 October 2001, we are four months on from the critical incident review, and the coroner says at the bottom of the page:

"I will be holding an inquest. It would greatly assist me if you would arrange to let me have as soon as possible statements from all those concerned with the care and management, including the consultant in charge, the surgeon and the nursing staff."

So quite clearly, he's asking you, in very clear terms, for statements from all concerned, including Dr Zafar, obviously.

A. Yes. Whenever I realised that I hadn't -- I mean, you will know that I then asked on 31 December for a statement from Mr Zafar. I should have requested a statement from Mr Zafar at that time, I didn't. I accepted that to the coroner.

Q. Yes, but it's why you didn't ask Dr Zafar for the statement that I'm interested in. And it looks from the papers as though it's because you simply didn't know he was involved in this case.

A. No, that is not -- that is not true. So I apologise, but that ...

Q. Let's go through the process of getting Dr Zafar's statement. So the coroner writes to you, 17 October.

You reply six weeks later, 27 November at 012-050u-261:

"Dear Mr Leckey. Just to update and advise, I am in the process of gathering the statements from the

relevant staff and these will be forwarded to you as soon as possible."

He responds to you soon afterwards to say he's still awaiting the statements.

You then write to him again in December, 012-050r-258, to say:

"I have received reports from a number of medical staff involved in the care of Raychel and these have been forwarded to the solicitor CSA and she has advised she will return the reports to me within the next few days, I will forward these to you."

So there we are, December, still no report.

You then forward to the coroner on 19 December a letter, 012-050p-255. And there you tell the coroner in the final paragraph:

"I enclose a list of the staff that I have requested statements from. There are five outstanding and I will chase these up."

That appears at 012-050p-256.

There's the list of staff that in December, mid-December, six months after the critical incident review, that you got statements from. There's no Dr Zafar there.

A. No, that's right. And that's why I then wrote subsequently whenever I identified to the coroner. Can

I --

Q. The question is: why had you not identified him before?

A. To request a statement from him?

Q. Absolutely.

A. That was telling him who I had requested a statement from and then -- can I refer --

Q. Sorry, please I must ask this again. Why had you not asked for a statement from Dr Zafar before that date?

A. I don't know.

Q. Okay.

A. Sorry, can I just refer to -- I think it's document 022-066 -- I'm not sure.

THE CHAIRMAN: 022?

A. 066.

THE CHAIRMAN: Just give us one moment. 022-066-165, please. This is a note from you to Dr Sumner?

A. Yes. I had sent the notes to Dr Sumner at the same time as I sent -- and I sent him the list of staff that I'd requested statements from. I knew he was -- I had -- I have identified the staff on the records so I went through the records, letting him see who I had asked for statements from.

MR STEWART: "I have identified the staff on the records."

You told Dr Sumner, but you hadn't identified Dr Zafar from the statements. That's the point. That's

precisely the point.

A. So -- I didn't send -- but I'd sent a list to the -- I'd sent a list off to Dr Sumner and to the coroner as to who I'd requested statements from. So I believe Dr Sumner was advising.

I hadn't requested a statement from Mr Zafar, I fully accept that I hadn't requested a statement and then realised that I did. I don't know if I did because Dr Sumner was back in contact or how -- you know, and I know doctor -- but the reference by Dr Johnston to Mr Zafar is about the collapse, it's not about the --

Q. Let's move on. The reason why you eventually go to Dr Zafar is that Mr Gilliland advises you to --

A. No, he doesn't.

Q. -- let's go to 022-060-159. You have now learnt of Dr Zafar's existence, as we saw in that earlier letter, and you now go not to the coroner for advice but rather you go to the surgeon involved in this case for advice and you say you have:

"... enclosed a copy of Dr Johnston's report and you'll not that Dr Johnston mentions that he bleeped the surgical SHO who was unable to come immediately. I have not yet requested a statement from Mr Zafar of Mr el-Shaffie. Do you think I should seek statements from them now or should I wait to see if the coroner

feels it is necessary?"

That would suggest that, first of all, you think that a Mr el-Shaffie is involved in this case --

A. No, sorry, I didn't. It was Dr Johnston had referred to him.

Q. Very well. But you, if you knew who was involved in this case, would have known that he wasn't. And secondly, you haven't requested a statement from Mr Zafar as at 31 December 2001, and you ask Mr Gilliland do you think you should get it. Why do you go to Mr Gilliland?

A. I was checking with -- because -- I was checking with Mr Gilliland regarding Mr el-Shaffie, if he had known that he was involved with the case, because my understanding was he wasn't.

Q. You write:

"Do you think I should seek statements from them now or should I wait to see if the coroner feels it necessary?"

In other words, if the coroner hadn't come back and Gilliland had said, "Don't bother", you'd have done nothing?

A. I'd also sent the list off to the coroner, and -- sorry, I'm not quite sure -- I've sort of lost my train of thought here. I'm not sure what the point is.

Q. Yes, you had sent a list to the coroner, we looked at it a moment ago and Dr Zafar's name was not on it. All right.

The next letter to the coroner is at the end of January. We're really going quite a long time from the review and quite a long time from when the coroner asked you to get the statements.

25 January 2002, which appears at 022-054-151 and 022-054-152.

You enclose statements. The top of the second page is the first time that the coroner learns about Dr Zafar:

"It now appears [it now appears] there is another clinician who I should have asked to prepare a statement for me. Mr Zafar, surgical SHO, who is no longer employed by the trust, saw Raychel on the ward in the morning following her operation. I will now ask him for a statement."

So it looks as if you're telling him you've only just come by this information.

A. It looks as if I hadn't -- what I'm saying is that I hadn't requested a statement from him.

Q. "It now appears that there's another, I should have."

A. That's my language there, which -- because I know I knew Mr Zafar was involved.

Q. Well, then you must have known you should have got a statement from him.

A. Exactly, yes.

Q. And you didn't.

A. I didn't no. I've accepted I didn't get a statement from him and I should have.

Q. And had you created that list of individuals involved in this case at the very outset, as Lugon suggested, this problem would not have arisen.

A. I agree.

Q. If you'd formed a chronology of what happened at that critical incident review meeting, you'd have known exactly who saw her from the notes and you'd have got a report from Dr Zafar immediately, wouldn't you?

A. Yes.

THE CHAIRMAN: And it's not just Dr Zafar, sure it isn't, because Dr Devlin and Dr Curran aren't on the list.

A. Dr Devlin, Dr Curran are not on the list, no, and I didn't request statements from them, they didn't write in the notes at all, and, chair, the normal process --

THE CHAIRMAN: I'm sorry --

A. I didn't know they were involved, yes.

THE CHAIRMAN: The problem is that whatever the depth of the discussion was, they were the last two doctors to see Raychel before her collapse. They were the two very

junior doctors who were called in by the nurses to help.

A. Mm-hm.

THE CHAIRMAN: And if you're putting together a review of what happened, your starting point must be to find out exactly who was involved and who prescribed and gave Raychel any treatment. But I understand from what you're saying that you simply didn't know that Dr Devlin and Dr Curran were involved.

A. I did, I knew there were junior doctors involved. I wouldn't have identified them. The discussion was around the role of the junior doctors at the meeting. But the notes had gone to Dr Sumner, and this is where I was hoping that someone like Dr Sumner would help identify other clinicians who he felt we needed reports from based on the statements that he'd received.

MR STEWART: You had to wait until the following March, the end of March 2002, before you got Dr Zafar's statement, didn't you?

A. Yes, he had left the trust and there was difficulty finding an address for him.

Q. I'm not sure it was worth waiting for, but let's have a look at it. It's at 160-239-001:

"Dear Mrs Therese. I saw Raychel Ferguson on 8 June 2001, who had appendicectomy operation on 7 June 2001. On my ward round she was free of pain and

apyrexial, plane [sic] was to continuous observation."

You then wrote back to Mr Zafar at 021-001a-002.

And you say:

"Inquest is now adjourned.

"2. I enclose draft statement. Please amend.

"3. I enclose a statement from Dr Johnston."

When you were asking this witness to amend, what did you have in mind?

A. Well, there was discussion with -- I believe, with -- Mr Zafar's statement had gone off to solicitors for advice and then Dr Johnston's statement had gone off to solicitors for advice. So the solicitors had come back and said, if I can recall, that Dr Johnston had mentioned that Mr Zafar had come to the ward after the collapse.

And then I -- so I was absolutely surprised myself whenever I went back into the evidence and saw that I'd actually sent someone else a statement off to another person, but the reason being, I remember clearly trying to speak to Mr Zafar. I had great communication difficulties with Mr Zafar and he -- I wanted to be clear -- let him see that where he was referenced, and the solicitor had said, you know, for his consideration.

The "please amend", it was not ever -- I have never, ever amended anyone's statement or told them that they

must amend a statement. I know this says "please amend", but it was please amend following a discussion on the advice of the solicitor, which I'd had with them, I believe the solicitor had had with them as well.

Q. So do I take it that the solicitor is advising you to advise --

A. Yes.

Q. -- the witness to amend the statement?

A. No, to consider further information and amend if he requires. I mean, I know Mr Zafar said that, you know, he -- clinicians are always reminded that the statement is their statement. There's suggestions that they might want to consider, but it is their suggestion. But he clearly -- I'd had a conversation with him and he now accepted that he hadn't recalled that he'd come to the ward after the collapse.

THE CHAIRMAN: So the purpose of the request to amend was for him to make a more complete statement --

A. Yes.

THE CHAIRMAN: -- by adding a reference to his second and later involvement with Raychel?

A. Yes. It wasn't regarding the first one.

MR STEWART: Yes, and I take the point that in this case that might have been innocent enough. But would you agree that asking one witness to amend their statement

in the light of another witness's statement is a very poor practice?

A. Well, that was -- I don't know what discussions go on between witnesses whenever they are meeting with their solicitor and who is advising them regarding their statement. But I would believe that if something -- if you've missed something out that you were involved in, then you would want to draw that to somebody's attention. I personally have drawn typing errors to people's attention and, you know, it's up to them if they want to change it or not change it.

Q. We're not talking about typing errors.

THE CHAIRMAN: No, no, I think it's the failings rather on Mr Zafar's part by not making a rather fuller statement in the first place.

MR STEWART: Indeed. And the statement he finally comes up with is only augmented by one additional paragraph, and he doesn't even sign it.

THE CHAIRMAN: And [inaudible] exaggerates the depth of it.

MR STEWART: Sir, would this be a convenient juncture?

THE CHAIRMAN: Yes, we'll take a break.

(11.40 am)

(A short break)

(12.00 pm)

THE CHAIRMAN: Mr Stitt?

MR STITT: Just to go back to the documents to which you made reference earlier. Those are the documents which Mrs Brown found on Friday. The position is that they have been redacted in terms of personal details --

THE CHAIRMAN: Okay.

MR STITT: -- and they will be e-mailed to the inquiry. I haven't seen the documents. My concern is that there's a possibility that if one takes a date and a certain something on the notes there's a possibility that perhaps in the locale of the Derry, Londonderry area, that somebody on the website one might be able to identify a patient. I don't know that, I'm just speaking from the Bar, as it were.

Would it be a worthwhile suggestion for the inquiry obviously to have the documents but perhaps run them past one of the inquiry experts, just to have him or her satisfy themselves that they're sufficiently redacted, because I don't think it's fair on my instructing solicitor to have that responsibility?

THE CHAIRMAN: Do you know when they're going to be e-mailed?

MR STITT: Any time now.

THE CHAIRMAN: If they're through with us by lunchtime, then what I would suggest might be done over lunchtime is if they are broadly along the description Mrs Brown has

indicated, then I think that will confirm that what happened at these clinical incident meetings was not relevant to Raychel's case.

Mr Quinn, sorry, if Mrs Brown's evidence from this morning is correct, it would rather suggest that what was discussed at the clinical incident meetings which were on a quarterly, then monthly basis, is not really relevant to Raychel.

MR QUINN: That's correct.

THE CHAIRMAN: What I was wondering is if there was a look at the papers involving Mr Stitt, yourself and Mr Stewart, and if that did appear to be what was emerging from the papers, then we could agree that that is the position and move on without necessarily referring to that evidence later, other than to record that the documents have been provided and that the description given earlier by Mrs Brown is correct.

Now, that doesn't bring an end to the issue because then we're looking to see where are more relevant documents --

MR QUINN: Exactly.

THE CHAIRMAN: -- but it might dispense with that point.

MR QUINN: I totally agree that that would save time. I agree with that point.

THE CHAIRMAN: If it doesn't dispense with that point, then

we will need to decide how to take it forward, but could we maybe look at that as an idea at lunchtime first?

MR STITT: I think that's certainly, sir.

MR QUINN: Mr Chairman, I just want to record that I'm very concerned, and I'm waiting for my learned friend Mr Stewart to ask the questions in relation to how the documents were discovered on Friday morning. Because it strikes me that the point I made last week on two occasions when I got on my feet, in relation to where the documents are and why they can't be found now seems even more relevant.

THE CHAIRMAN: Well, we'll see, but I'm not sure if the answer to it isn't actually, yes, we have got these documents but they're not relevant. So if what has been described is correct, it means that the trust is now providing us with redacted documents to show that there was a system of clinical incident review but that Raychel did not come within that system of governance.

MR QUINN: Yes, I fully accept that, but if one can find the clinical incident review meetings, one could certainly find the most important documents that we now know exist somewhere, and that's the -- particularly the action points because I would have thought, Mr Chairman, that following up whether or not the action points were dealt with is one of the main considerations of your inquiry

in relation to this part of Raychel's case.

THE CHAIRMAN: Yes, it is, and we'll come on to that. I understand.

MR QUINN: Thank you.

A. Excuse me, chair, could I just perhaps re-clarify again how those particular documents came up? It was following Miss Duddy's evidence on Thursday when she referred to the clinical incident meetings. The clinical incident -- I knew they weren't documented so I knew there weren't minutes taken of them. Whenever I went into the clinical incident files, which were retained, and in those files were the -- at the end of each quarter were the agendas and the -- I went -- after she gave her evidence I went on Friday morning at 7 o'clock and got them, exactly where I knew the clinical incident meetings would be. So it's not that they were something that were relevant that weren't provided before.

MR STEWART: Had you ever previously checked through the clinical incident committee documentation for reference to Raychel, through the agendas, the spreadsheets and so forth?

A. I didn't actually recall that there were agendas done, I have to say.

Q. So you hadn't checked?

A. I hadn't checked those particular files, but I knew Raychel wasn't discussed at those meetings whenever -- so I was fully aware that she wasn't discussed at those quarterly meetings.

Q. Well, still keeping to the theme of documentation, you have said that you opened a file on Raychel's case.

A. Yes.

Q. When did you open the file?

A. I probably opened it on 12 June.

Q. We've seen a number of documents that have come to us recently. Margaret Doherty prepared a report which looks as though it was made for the critical incident review. I think she says that she made it afterwards. It appears at 316-085-009 and 316-085-010.

Now, one would assume that that would have come to you and would have been included in your file.

A. I never saw this document until after the clinical evidence had been given at the inquiry, and I didn't even know that this document had been found until it came in to the evidence at the inquiry, because at that point I'd received a witness statement and I wasn't aware that this had been found.

Q. You were the principal person behind the coordination of the critical incident review and you opened a file, and this is the clinical services manager's report, and it

looks as though it's been done, I would suggest, before the critical incident review, and it looks as though, from the top of this, where it says, "MD copy", that's presumably a medical director's copy, although I suppose it could be Margaret Doherty, it looks as though there might have been several copies of this.

A. Yes, it does. I've never seen it before. I'd never seen it. I didn't know it existed, so ...

Q. Would you suppose in the normal course of events for a clinical services manager to prepare a report and, indeed, furnish copies maybe to the medical director and it not to come to you?

A. No. I would have expected it would have.

Q. Yes. Now, do you see at the top of the right-hand page she notes that Staff Nurse A Noble verbally reported to Sister Little that she had checked pupil reaction and so forth. That comes from notes taken by Sister Little at Mrs Doherty's behest in order that Mrs Doherty might prepare a resume for the meeting.

Were you shown copies of those interview notes, telephone interview notes with --

A. No, all of these documents came to light, my understanding is, whenever Mrs McKenna found them in a cupboard.

Q. It was Mrs McKenna that found them, was it?

A. I think so. Maybe I'm wrong but that's what I heard in the evidence her that she had discovered them.

Q. I haven't heard that.

A. Maybe I could be wrong, but I know they were found, and I wasn't aware that they were found because I had received a witness statement and wasn't allowed to discuss it with --

Q. We'll come on to why you didn't find them in a moment, but first of all, I'm interested in a moment in working out why it was you had never seen them before, because these are documents that you would have thought would have gone straight into your file at the review stage.

A. You're exactly right. I didn't see them. I was never given a copy of them.

Q. And why might that have been?

A. I don't know. I can't explain.

Q. You were coordinating this review.

A. Yes.

Q. You're not chairing it but you're coordinating it.

A. Yes.

Q. So you didn't make a list of those who were involved, and now we find that the documents which you should have had in your file weren't in your file.

A. Yes.

Q. Can you offer any explanation for that?

A. Just that they were never given to me.

Q. Tell me this. Staff Nurse Gilchrist made a statement, which purports to be dated 10 June 2001, and that appears at 098-293-771. Do you see?

A. Yes.

Q. You've in fact stamped it, the top right-hand corner with your receipt --

A. Yes.

Q. -- of 25 November of 2002, when it says it's written on 10 June 2001. Had you ever seen that prior --

A. No.

Q. -- to the end of November 2002?

A. No. That was whenever I received it.

Q. And that was after you wrote to Staff Nurse Gilchrist asking for a statement, wasn't it?

A. Yes.

Q. Do you think it was available on 10 June?

A. Well, it says on it that it was written on 10 June. I don't know, I didn't receive it until 25 November, so I'm not sure. It's quite possible it was written just immediately after the event so that it would help Sister Gilchrist remember the event.

Q. Indeed she told the coroner that she made a statement immediately after the event. If she made the statement immediately after the event, one might suppose it might

come to you as part of the review team.

A. That's right, yes.

Q. Did it?

A. I don't recall seeing it. I mean, I recall seeing it, I have it stamped 25 November, so I would presume that's when I received it and first saw it.

Q. Is it possible that you had a file that's now gone missing?

A. No.

Q. So did you have any of Sister Little's interview notes, her interview notes with Staff Nurse Noble?

A. No, Sister Little's interview notes, I didn't see before.

Q. Okay.

A. I didn't know Sister Little had any involvement in doing anything regarding Raychel's death because Sister Millar was the ward sister. I didn't know Sister Little had done anything.

Q. But Mrs Doherty, the clinical services manager, was at the review.

A. Yes.

Q. She would surely have drawn the review's attention to the fact that she had interview notes, that she had prepared a report.

A. I can't recall her ever saying that.

Q. If she did, you'd have heard it and said "Well, thank you, please give me a copy of that report for my file".
A. I would have done, yes.
Q. Please continue.
A. I'm not sure if I've anything left to say.
THE CHAIRMAN: I think you were agreeing with Mr Stewart's propositions that if these documents had been mentioned at the critical incident review meeting, then the expected reaction from you would have been to ask for them.
A. Absolutely, yes.
MR STEWART: Tell me this. Can I refer you to page 160-214-002. This is a document prepared by the solicitor just before you go into the inquest and it details all the reports held, the statements held and so forth, and the dates which obtained. Apart from Gilchrist at the very bottom there being 10 June, at the very top, do you see it says "[Something] report --
A. I think that's autopsy report.
Q. "Autopsy report of 11 June 2001". What report's that?
A. I would believe -- I mean, I'm not sure, but I would believe that is the -- that must have been from the pathologist, the initial autopsy report.
Q. No, there's no autopsy report at June 2001 that I'm

aware of, unless I'm mistaken.
A. It's definitely something to do with whatever's come from the -- I don't ...
Q. It's a "something report", isn't it? But the "something" has been copied out of this particular document. And I wonder -- I'm asking you what report would there have been on Raychel's case dated 11 June 2001?
MR STITT: I do apologise to my friend. Just for the record, the expression "copied out" has been used. It does look to my untutored eye as though the page is folded over.
MR STEWART: I didn't mean that pejoratively. It's been so copied --
MR STITT: Yes, it doesn't appear, yes.
MR STEWART: It does look as though it's been copied and unfortunately whatever it is, whatever report it is, is now no longer legible.
A. I'm sure that can be sorted. It's not one of my documents. It's not one of the documents ...
Q. But this is a list of documents that most of them have come from you to the solicitor.
A. No, because there was something from Dr Loughery to Dr Heron definitely didn't come from me on 24/10/01. It definitely didn't come from me.

Q. Well, those are the sorts of dates, October 01, when you might have expected post-mortem autopsy reports to date from.
A. Is there not normally a preliminary report? I don't know, I'm sorry, I can't help.
THE CHAIRMAN: Mr Stitt, if this is a DLS document, can that be tracked through DLS?
MR STITT: Yes, we're doing that at the moment.
MR STEWART: That request, I think, was made some time ago. I wonder if we might go to one of the notes of the agreed action plan. That appears at 022-108-334. This is a copy of the action plan that I think came to you.
A. Yes.
Q. It's stamped by your line manager, director of nursing, and has your handwriting on it.
A. Yes.
Q. It also has written, do you see, in the bottom left-hand quadrant:
"Bring back complete report."
A. Yes.
Q. What report does that refer to?
A. Um, I don't know. I would believe it is -- it's dated 15 June. It actually is the director of nursing's secretary's stamp that did that, so that's probably the director of nursing's copy, and it must have been the

director of nursing expecting that the completed report would come to her, and, as we know, I didn't do a completed report.
Q. I'm not sure she told the inquiry the other day that she expected a report.
A. Well, that's -- well, that's ... It's not -- I don't know if it's the director of nursing's writing or if it could be the director of nursing's secretary's writing, which in fact -- it probably is her writing.
THE CHAIRMAN: Did you not share the secretary?
A. Yes, we did. We did, that's why I recognise the stamp as well. I had a different stamp, I had a risk management stamp, and that was the director of nursing's stamp, so that's her copy.
MR STEWART: This copy came to you because that's your handwriting all over it, isn't it?
A. Yes, but that's a copy of my copy. I know it sounds silly, but whenever I was gathering all the information for the inquiry, as I was asked to do, this copy then went into my file for the inquiry. So that's how that came.
Q. When you saw --
A. I think there's more copies of this document. I think there are more.
Q. There are indeed. When you saw that note on it "Bring

back complete report", what did that indicate to you?
A. I didn't see that. I would have seen that whenever I was gathering evidence for the inquiry.
Q. Was --
A. Sorry. That's not my copy.
Q. Was there expectation of a report?
A. A report wasn't completed.
Q. I asked was there an expectation of a report.
A. Um ... I'm sure there was an expectation of a report. If I look back at Dr Lugon's book, she says that a report should have been done.
Q. Your own protocol says --
A. Yes.
Q. -- the risk -- I'll read it. It's at 022-109-338. Your own protocol, which I believe you wrote yourself --
A. Yes.
Q. -- says in the penultimate paragraph:
"The risk management coordinator will provide the chief executive with a written report with conclusions and recommendations within an agreed timescale."
Was there an expectation that a report would be written?
A. Yes. I'm sure there was an expectation.
Q. At what stage was it agreed that should be dispensed with?

A. I don't ever remember anyone saying that we will dispense with a report. I was never told "You don't need to write a report".
A report was my responsibility. I didn't write a report. I should have written a report. I accept that.
The chief executive was -- this was a protocol that was developed in November 2000, I think, but the intention of developing a system of investigation, learning -- systems learning and a report would have put that in it. There was the action plan, there was the update for the chief executive.
I -- everyone -- the chief executive was heavily involved in updates, so there wasn't a report done, it should have been done, and I can make no further explanation other than that I didn't do it.
Q. Well, you're the only person who can give an explanation.
A. Absolutely.
Q. But tell me, did your chief executive not say to you, "Mrs Brown, when am I having my report?"
A. I don't recall the chief executive ever saying that to me. The chief executive was regularly -- well, you can see the update on -- there's an update on 9 July, I think it was, for the chief executive. The

chief executive was asking about progress and actions. She didn't specifically say the words to me "Where's my report?" Having said that, it shouldn't have taken her to ask me for the report -- to do a report, and a report wasn't done.
Q. She didn't in any event. Did you at any time go to her and say, "Mrs Burnside, in terms of agreeing with you the timescale for the presentation of the report, you're going to have to give me four weeks, six weeks"?
A. No, no. I had done reports for the chief executive before. There normally were timescales on them. This case, it is hard to explain how -- this was such a tragic event, and the fact that a report was not done is not good enough. I would accept it should have been done.
Q. It's hard to understand given --
A. It is.
Q. -- that this was such a big and serious --
A. Absolutely.
Q. -- and important case.
A. I accept your criticisms regarding the report. I accept the criticism of Professor Swainson regarding the report.
I do think the one point that he makes is that -- and I think a report would have been very good,

probably -- it should have been done. The point that he makes is that it would have -- it would have provided a root cause analysis methodology, and we could have identified a lot more learning out of the report.
I don't think I would have had the skills, or anyone in Northern Ireland would have had the skills, at that time to do a proper root cause analysis in a report. I think a report would have been a summary of everything we'd done to date with conclusions, actions and recommendations. I don't think it would have been a proper root cause analysis.
Q. That's fair enough. But at the very most basic level, if the object of the review is quality improvement, then you have to clearly define your conclusions in order to make clearly defined recommendations.
A. I agree.
Q. And it's pointless up to a point otherwise.
A. I accept your criticism.
Q. Going to the six-point plans which did emerge from the meeting, were you at the meeting for the entirety of the meeting?
A. Yes, I was.
Q. And at the end of the meeting, did the people in attendance agree the action points?
A. I'm ... I'm trying to think back. I know that what

happened was the action points were written down by Dr Fulton. He probably went -- I can't recall if he went over the action points there, but I know the very next morning he and I met together and we typed up from his handwritten note the action -- the one that you have.

Q. Yes.

A. And that was shared with everyone who had attended the meeting.

Q. So you typed it up?

A. Yes, I did.

Q. All right. Can we have on the left-hand side of the screen, please, 026-011-014, and, on the right-hand side of the screen, 022-108-335.

Here we have on the left-hand side the action sheet in Dr Fulton's hand, dated 12 June, and, on the right-hand side, the working copy presumably prior to you typing it out on 13 June?

A. Well, I think we were -- I think I typed that version as well.

Q. There are a number of versions.

A. Yes.

Q. Perhaps we could move on then, and on the right-hand side of the screen put up 022-108-336, which is the next page.

A. Yes.

Q. That's the way it ends up after you typed it up?

A. I think that's the final version, yes.

Q. You'll see point 1 on the 12 June version is:

"Evidence [tick] change to Hartmann's."

Point 1 on the following day's agreed action is:

"Review evidence for use of routine post-operative low electrolyte IV infusion and suggest changes if evidence indicates. No change in the use of Solution No. 18 until review."

So on the left-hand side we have a change to Hartmann's, on the right-hand no change in current use of Solution No. 18. So there would appear, on the face of it, to be a change.

A. Yes.

Q. Now, if you typed up the right-hand side on the 13th --

A. Yes.

Q. -- and the left-hand side was agreed on the 12th, who agreed the right-hand side version on the 13th?

A. Dr Fulton -- I'm not completely sure about this because it obviously happened without -- I wasn't there, but I think there was a discussion between Dr Fulton and Dr Nesbitt that -- well, I think -- was it we were going to change to Hartmann's and then there must have been a discussion that -- that was on the day, on that night,

the night after the meeting that it was going to change, and then I think it was a discussion that review and see if it should be changed ... I think it -- that was a -- I think that's how that came about.

Q. It does look as though there's been a change after it was agreed and that the change wasn't agreed.

A. I don't really think -- I mean, this meeting happened at 4 o'clock. It went on about half past six at night, and there was discussion about the fluids and the use of Hartmann's and -- which was all totally foreign to me at that stage. I had never heard anything about Hartmann's and Solution No. 18. So Dr Fulton and I then were typing this up, so there must have been discussion between Dr Fulton and Dr Nesbitt regarding that.

Q. I see. So that would be an agreement between --

A. Yes.

Q. -- those two members of the review team?

A. Yes.

Q. What about point 4, where it seems that on the 12th it was agreed that there should be a monitoring of urinary and, query vomit, output? But by the following day, the vomit has been omitted from the agreed action plan. How might that have come about, do you know?

A. I read that differently. I thought that was to do with pluses. You know, the pluses on the ...

Q. Well, it might be to do with how vomit is recorded. That might be a plausible explanation, but in any event it's left out as well --

A. Yes.

Q. -- because there's no mention of vomit measuring and recording.

A. Well, I thought that actually encompassed -- I thought point 4 encompassed what was being said there in the final version.

Q. Sorry, there's no mention of vomit, vomiting at all.

A. Well, all urinary output should be measured and recorded -- no, there is no mention of vomit, you're right. I thought it should -- it should have been. Yes, it should have been.

Q. And it seems from the accounts we've received that there was agreement that surgeons were hard to get hold of in terms of attending upon their paediatric patients. That seemed to be agreed at the meeting.

A. I have to say, I don't recall that being discussed at the meeting on 12 June. I thought that became a new issue when -- after our previous discussions, whenever I then updated the chief executive. I don't remember -- I remember the point at the meeting about the surgeons were in theatre, whenever they tried to bleep the surgeons whenever Raychel had collapsed. I believe

that's what the discussion was about. That's my recollection of it.

Q. Of course, there will be several different --

A. Yes, yes.

Q. -- recollections, and Sister Millar gave her own account of what happened.

THE CHAIRMAN: Sister Millar was referring, I think, Mrs Brown, to a general problem about being able to contact surgeons.

A. Yes.

THE CHAIRMAN: There's nothing on the agreed action plan from 12 June about that.

A. I don't think -- my recollection of the meeting was that that wasn't discussed at that meeting, but it was -- it then came to my attention subsequent to that and that's why it was on the update for the chief executive. So on 9 July.

MR STEWART: I think Dr Fulton has a different recollection from you again when he says it was and indeed it failed to find expression in the agreed action plan, and indeed the whole question of who was responsible for the supervision of the intravenous therapy was also discussed.

A. I will bow to people's change [sic], but to me it was a new point, and that's why I put it in as a new point

at 7 in the update. That's just my recollection.

Q. The reason why I'm drawing these discrepancies to your attention is to highlight the importance of recording the deliberations of a review, the outcome and recommendations and conclusions of a review.

After the meeting itself on the 12th, was there any further reconvening of that group of people to look at it two weeks later, four weeks later?

A. Well, there were the nursing meetings, there were the -- I mean, the update that went to the chief executive, I was meeting -- that came from -- I believe I met with Dr Fulton. I think Dr Nesbitt had input into conversations with Dr Fulton. There was no formal meeting of the group two/three weeks later.

Q. Do you think there should have been?

Professor Swainson --

A. I know he does say that. I agree it would have been very beneficial. It even still isn't really normal practice at this stage that a group would get together in a root cause analysis a few weeks later. What would happen is that the meeting -- the draft report would be sent out to staff and they would agree it or disagree it. Obviously, meeting is always a good thing, it's always a chance to review where you're at with something, but it didn't happen.

Q. Were you aware at that time of the recommendations of the NCEPOD 1999 --

A. No.

Q. -- report, which is at 220-002-023, which might have been something that might have been useful to you in these circumstances?

Do you see on the left-hand column at bullet points 3 and 4, this is in 1999 they are recommending:

"The death of any child occurring within 30 days of an anaesthetic or surgical procedure should be the subject of peer review, irrespective of the place of death."

Next put point:

"The events surrounding the perioperative death of any child should be reviewed in the context of multidisciplinary clinical audit."

That would suggest to me a different type of analysis from the one conducted by you at the critical incident review.

A. Yes, I would agree.

Q. And do you think that that might be something you should have incorporated in your practice?

A. That -- I believe that is something -- that's something that we still discuss and talk about. I think that's something that happens within the clinical team and

should be outside the risk management practice unless that review would show that there would be a risk management concern. That's almost like morbidity and mortality meetings. That would still be, I believe, what happens throughout the United Kingdom, that peer reviews would happen under that process, and then the -- the processes should sit separately, I think.

Q. This refers not just to peer review -- I take your point in relation to that -- but also multidisciplinary clinical audit, and you, of course, sat on the clinical audit committee.

A. Yes.

Q. So was the clinical audit committee aware of these recommendations at the time?

A. Of the?

Q. Of the NCEPOD recommendations.

A. I don't -- I don't recall. I wasn't aware of them, so I was a member of the committee and I wasn't aware.

Q. Was any audit conducted in response to serious clinical incident reports?

A. Um ... Yes, but not through the clinical -- not through the clinical ... At that time, not through the clinical audit committee. This was really the first critical incident investigation that we'd had.

Q. Sorry, this was?

A. This was the first since we launched the policy. It was the first serious critical incident investigation that we'd had.
Q. But you told the inquiry a moment ago that you had prepared written reports before this.
A. Yes, I'd prepared written reports before for the chief executive particularly under -- but it wasn't reported as a clinical incident because it was pre the clinical incident policy.
Q. But it's a report into the clinical incident for the chief executive.
A. Yes, it was.
Q. It doesn't matter what protocol it comes under. You'd had previous --
A. Yes. Yes, the sterilisation cases in Altnagelvin Hospital. I was involved in writing that report for the chief executive. That did create an audit. There was an audit of a number of cases over a period of years, comparing different consultants. So, yes, that had happened and that had happened pre this.
Q. Can we go, please, to -- I hesitate to refer yet again to the 1999/2000 annual report of the Altnagelvin Hospitals Health and Social Services Trust, but it appears at 321-004gj-042.
This is the clinical governance and quality report

for that year, and you can see coming down the page:
"Key achievements. The establishment of a multidisciplinary clinical audit committee..."
And you sat on that:
"... which takes the lead in evaluating outcomes of care. It aims to encompass two major activities; audit of current practice against evidence-based standards; audit in response to serious clinical incident reports."
So it looks as though the committee that you were on did this, according to the report.
A. What year's that report?
Q. 1999/2000. It's the year preceding Raychel's admission to hospital.
A. Yes, and that part was talking about the -- that was talking -- I'm sure that was talking about the sterilisation cases.
Q. I'm sure it's not because if we read the entire page, we can find no reference to that.
A. I don't think you would put that into ...
Q. Well, not only are you putting it in but it seems to be trumpeted as a key achievement.
A. I'm not quite sure of the point.
THE CHAIRMAN: I think the point is it's not saying this is what we did in one instance, this is saying this is a new committee which has been established, it takes the

lead in evaluating outcomes. It aims to encompass two major activities. So you can't read that sensibly to mean that we did that once and that's it. It's stating what will now happen.
A. Yes. And that was the plan that should happen and that is good practice, absolutely.
THE CHAIRMAN: Absolutely, yes.
MR STEWART: Why didn't it happen in Raychel's case?
A. It didn't happen in -- I'm not sure. What are you asking me in relation to? I've lost the train of thought.
Q. Why was there not an audit, multidisciplinary clinical audit, into the case of Raychel Ferguson?
A. I don't know. There was a critical incident review. There wasn't an audit that I can recall in relation to it.
THE CHAIRMAN: But it's the last few words of this first bullet point:
"Audit in response to serious clinical incident reports."
A. Yes.
THE CHAIRMAN: Serious clinical, in effect, is critical, isn't it?
A. Yes.
THE CHAIRMAN: So this says there will be an audit or the

aim is to have an audit in response to critical incident reports.
A. Yes.
THE CHAIRMAN: Now, is that not different from the critical incident review?
A. Yes, it is. Yes, it is.
THE CHAIRMAN: Right. What should that audit involve? That should involve the multidisciplinary clinical audit committee?
A. Yes. I would think -- well, I don't know that it ever meant that they -- I think they should oversee the audit, I don't think it ever meant that they should do them.
THE CHAIRMAN: Was an audit conducted for them to oversee in Raychel's case?
A. No.
THE CHAIRMAN: And can you help explain why not, if this is being put forward at least a year earlier as a key achievement in Altnagelvin?
A. No. There was a subsequent audit in relation to fluid management, which was undertaken a few years later whenever the new guidance came out from the Department regarding fluids.
THE CHAIRMAN: To make sure that the guidelines were --
A. Yes.

THE CHAIRMAN: -- being properly implemented?
A. Well, this is in relation to the individual -- some individual patients about the type of fluid that they were receiving and how they responded to that. That was a prospective audit on three years' data on children who were getting particular fluids and how they responded to that.
MR STEWART: Can we perhaps turn to your witness statement, WS322/1, page 17?
MR STITT: This might be an appropriate time just to go back to a point that was left in the air earlier, fairly non-controversial. It's the page-turning point.
THE CHAIRMAN: 160-214-002.
MR STITT: Yes.
THE CHAIRMAN: Have you tracked it?
MR STITT: Yes. The original one will be e-mailed to the inquiry, but just so that we can clear it up and get it out of the way, it does say "autopsy". Mr Stewart had indicated that he wasn't aware of an autopsy report at that time, but if we could pull up this document, 160-235-001. That's the autopsy report and it's dated -- the autopsy is 11 June.
MR STEWART: Yes, but this report is not dated 11 June. Apart from anything else, the anatomical summary is only signed by -- it must be one of the pathologists -- on

20 November.
MR STITT: One would have thought the person who was conducting the index would start with the base document and that was going to be the --
MR STEWART: Maybe that's the explanation, I take that point.
MR STITT: I don't think it's controversial. There is an autopsy report. They either did have it or didn't, but it's clearly a relevant document. It was the starting point.
THE CHAIRMAN: Okay, thank you.
MR STEWART: I'm grateful for that.
Your witness statement, please, at WS322/1, page 17, where at question (v) at the bottom of the page there you are asked indeed whether consideration was given to performing a detailed audit of all aspects of the case, and your response was that there was a realisation early on that because the death had been reported to the coroner, that an inquest would be held by the coroner.
Did you mean by that that because it had gone to the coroner, there was no necessity to carry out an audit?
A. No. I think I've -- I have answered that question wrong. I was not thinking on the purposes of clinical audit in that answer. I know it's under the heading of clinical audit, but that is -- there was never

a discussion that we would or wouldn't audit.
Q. I see.
A. Sorry, that's a misleading answer.
Q. Going back to immediately after the review, you were copied into a letter on 14 June, passing from Dr Nesbitt to Dr Fulton, and that appears at 022-102-317.
Here is your copy:
"Dear Therese."
And so forth.
Do you see the part of this we've been paying particular attention to is the second paragraph about the change -- move away from No. 18 solution to Hartmann's:
"This change occurred six months ago and followed several deaths involving No. 18 Solution."
When you received that letter, did that particular passage catch your attention?
A. No.
Q. Following several deaths involving No. 18 Solution?
A. No, really, it didn't. I'm not ... I'm not a doctor, so I wouldn't have believed that they were deaths, that they were problems.
Q. Sorry, this change occurred six months ago and followed several deaths. As a layperson, I suggest to you you'd have read that saying there have been deaths from No. 18

solution and that's why the change occurred.
A. I don't -- it didn't ...
Q. Did you not read that letter?
A. I did read the letter.
Q. And did you not take it in? Because if ever there was a wake-up call to do a report, it's getting information like that. Did you talk to anybody in the hospital about that?
A. I think that's why we -- the letter from Dr Nesbitt clarified that we were going to change the solution. That's what I was concerned about at the time in Altnagelvin, and it changed that day.
Q. Did you talk to Dr Fulton about it over the weeks that followed?
A. Talk about the deaths?
Q. Yes, about Raychel's case, about what was happening and what was being done.
A. Yes.
Q. And did he tell you that he'd been to a meeting of medical directors in Belfast?
A. Yes.
Q. And did he come back and tell you what he'd learnt at that meeting?
A. I'm sure he did. I can't remember what he did tell me.
Q. Did he tell you about another death?

A. The first that -- the first, if I can remember, that I was aware about another death was whenever the coroner phoned me in December 2001. I mean, obviously, that was in that letter from Dr Nesbitt, but the first I remember being aware of another death was, I think, early December.
Q. So you're saying that Dr Fulton didn't tell you about that?
A. I can't -- I'm sure he did.
THE CHAIRMAN: The thing that strikes me as being curious, Mrs Brown -- I mean, I understand that there's a bit of soreness in Altnagelvin that the Royal had changed its practice and hadn't told the area hospitals. Okay?
A. Yes.
THE CHAIRMAN: But what's far worse than that is Dr Nesbitt telling Dr Fulton and you that the reason why the Royal changed was because there had been several deaths involving No. 18 Solution. Now, if you read that, would you in Altnagelvin not have been shaking your heads in disbelief that when children were dying and the Royal knew about children dying and had changed its practice, it didn't tell you in Altnagelvin what was going on?
A. I know there was great concern, there was great concern that we had not been told about the No. 18 Solution. That was -- that's what drove Dr Nesbitt, I believe, and

Dr Fulton to try to -- I know the working group was established and Dr Nesbitt was very unhappy about this No. 18 Solution not being cut off the list.
THE CHAIRMAN: That's one thing. But it makes it even worse if you find out that the reason it's been cut off in the Royal is because there have been several deaths. It's one thing for the Royal not to keep you informed about a change in practice. Isn't it a much worse thing for the Royal not to keep you informed about a change in practice which has been adopted because several children have died?
A. Yes.
THE CHAIRMAN: Now, surely that must have registered, and you must have thought, "Good God, what are they doing in the Royal at all? Why aren't they telling us, why aren't they telling Daisy Hill, why aren't they telling the Erne what's going on?"
A. Well, we were very concerned that we were using a solution that we believed was safe and other hospitals weren't -- the Royal wasn't using it.
MR STEWART: Concerned? You must have been furious by the idea that they might have told you about it and that the death that happened in your hospital might have been prevented, avoided?
A. Yes.

Q. Well, that would have been something you'd have talked about?
A. Yes, well, we were talking about the No. 18 Solution. Sorry, the point that I am thinking -- whenever I first knew about Adam Strain's death was December. I'm trying to get all my dates right. It was Adam Strain's death. Yes, I did(?) know about previous deaths before that.
Q. Yes, but I'm asking, did Dr Fulton not come back from his meeting in Belfast and tell you what he had learned there --
A. Yes.
Q. -- which was about another death. In addition to the several deaths that Dr Nesbitt writes to you about, he comes back, it is thought, with information relating to another death. Did that not come to you?
A. Yes, I'm sure -- yes, it did.
Q. It did. And what was done when you learnt that?
A. I'm not sure. There was ongoing discussion and concern regarding -- there was ongoing discussion regarding the use of Solution No. 18. On 14 June, following this Solution No. 18, this poster was put up on the ward that surgical patients should no longer have Solution No. 18 and they should have Hartmann's. And I knew that Dr Fulton had raised it to the attention of the chief executive, the chief executive had written to the,

I think it was the board. So there was a lot of escalation going on at the most senior management level within the organisation. The CMO had been contacted, so that is exactly what was happening.
Q. And were deaths of other than children being mentioned in the process of all this activity?
A. Yes, in -- I think in the e-mail from the chief executive, she refers to previous deaths. I think so. I can't recall it exactly, but I think she does.
Q. Which e-mail from the chief executive?
A. To the CMO -- is it the CMO or the -- someone in the board.
Q. Which board?
A. The Health & Social Care Board. It might have been to Dr McConnell or it might have been --
THE CHAIRMAN: The Western Board?
A. Yes. I know the chief executive wrote fairly soon after it. This is the one where there's a reference to the rumour e-mail.
MR STEWART: Yes, that's an e-mail that I think appears in 2004, some very considerable time later.
A. No, no, it was definitely 2001. It was before, it was June.
Q. I'd be grateful if you could direct me towards that page if it's possible to locate it.

Of course, your job was to keep the chief executive informed throughout the investigation and afterwards with updates, wasn't it?
A. Yes.
Q. That was you. Nobody else was reporting back to the chief executive?
A. I wouldn't agree with that. I mean, I would believe that the medical director should have been reporting back to the chief executive, which I know he was. I suppose I had a responsibility to coordinate everything, but the medical director would have been feeding back to the chief executive, Dr Nesbitt would have been feeding back to the chief executive. It was Dr Nesbitt that had actually raised the issue with the chief executive. So it's not as if everything had to sit in paper for it to be raised. It was all ...
Q. All right. 022-109-338. This is your protocol and it's the third from the end:
"The chief executive will be kept informed by the risk management coordinator throughout the investigation."
A. Yes.
Q. So it's your specific task.
A. Yes.
Q. Your first update to the chief executive is four weeks

or so later, on 9 July 2001. That's at 022-097-307. Was this the first update you had prepared?
A. It was the first written update.
Q. The chief executive would presumably have to go into a board meeting and be prepared to answer questions about the case, so he would require a briefing document?
A. Yes.
Q. And when would the July 2001 board meeting have been held?
A. It normally was held on a Thursday. That may have been prepared just -- I think it was due to be on 5 July, 4 or 5 July, going back to the board minutes that we had tried to locate. I believe that would have been the Tuesday, the Monday or Tuesday after that, I think. So whether ...
Q. So this wasn't prepared for the board meeting?
A. No, I don't believe it was.
Q. Would you therefore have prepared a briefing minute for the board meeting?
A. Um ... No. Well, I would have -- I wasn't required to prepare for the board, I was preparing for the chief executive.
Q. Exactly. The chief executive was going in to the board --
A. Yes.

Q. -- there has been the death of a child. The chief executive's got to know something about it. You are specifically tasked with that duty under the protocol. Did you do it? Did you give the chief executive a briefing note before the board meeting?
A. I -- sorry, I've lost that question. Sorry.
Q. Did you prepare a briefing note for the chief executive before the July 2001 board meeting?
A. No, I didn't.
Q. Why not?
THE CHAIRMAN: How can the chief executive report to the board in any coherent form what's happening unless she has the benefit of a update along the lines of the one which you now think post-dated the board meeting?
A. Yes. I believe it post-dated the board meeting, and my thinking is, but I can't be certain, that it was done after the first board meeting for the chief executive, for the next -- you know, so that she would have it then to brief the board the next time. I can't be sure.
THE CHAIRMAN: Yes, that might well be right, but how could she brief the board for the July meeting unless she had some form of coherent record or update along the lines of the document which is on screen?
A. Well, she had had the action plan and she had regular

conversations with myself, with Dr Nesbitt, with Dr Fulton.
THE CHAIRMAN: But the action plan was agreed on 12 June, 13 June, about what was to be done.
A. Yes.
THE CHAIRMAN: And she would want a note along these lines to go into the board meeting.
A. Yes.
THE CHAIRMAN: Raychel's death was not unknown in Derry; isn't that right? The fact that Raychel had died was known in Derry?
A. It was well-known, yes.
THE CHAIRMAN: It was in the local papers. And your board members would have been concerned to raise this, even if it hadn't been raised as an item on the agenda.
A. Yes.
THE CHAIRMAN: So if I take your evidence as it is, Mrs Brown, when Mrs Burnside went into this meeting as chief executive, she had the action plan from the day or day after, the critical incident review, and she had verbal updates but nothing in writing.
A. She had nothing in writing, no.
MR STEWART: How could the trust board then be properly informed themselves about what was being done to prevent any possibility of a recurrence?

A. Well, Dr Fulton was on the trust board as well --
Q. Yes.
A. -- and Dr Fulton could have been -- would have been updating trust board on the actions that were being taken. He was the chair of the review, so he was a member of trust board. So they would have had the opportunity to question and ask him regarding what action was being taken.
Q. Can you remember any incidents where the board would have requested a report on an incident in hospital?
A. Um ... A specific report?
Q. A specific --
A. I can't think of a specific case off the top of my head.
Q. It didn't happen in this case. One wonders what sort of case would have to happen before the board actually required a report from somebody.
A. Yes. There's now a process for doing critical incident reports.
Q. There was then.
A. There's a form -- Western -- there's a regional requirement now to complete root cause analysis investigations in certain categories of incidents. There wasn't then a regional requirement. That was our internal trust policy.
Q. When was the next meeting to review the progress made on

putting in place the action plan?
THE CHAIRMAN: The next meeting with who?
MR STEWART: The next meeting of the review group or indeed any group within the hospital.
A. There was ... it's very -- there was a formal -- as I said earlier, we were meeting regularly. I work closely with Dr Fulton and we were reviewing the actions. The chief executive's office was practically beside mine as well, she was just down a corridor, and then there was the meeting that had happened with the nursing staff. A formal meeting of the review group did not happen until April 2002.
Q. And that is now ten months after the death, and that was in the face of the inquest, wasn't it?
A. That's right, yes.
Q. And indeed, when asked in a witness statement what Dr Fulton's pre-inquest consultation was, you believed that to be the same thing as the review of the review meeting of 9 April 2002.
A. Yes, that's right, yes.
Q. So really, if it hadn't been for the necessity to appear before the coroner in his court, perhaps there wouldn't have been a review?
A. Well, I think the case was always going to be going before the coroner, so I think there always would have

been a review. It was a death, so it would have been reviewed. I'm not sure really what the point is there.
Q. Well, it was only going to receive that review just before the inquest hearing. So in other words, the implication is that you're rather more concerned about knowing what your case for the coroner's going to be than actually reviewing what had been done to prevent a recurrence.
A. Well, I don't accept that criticism. I know that Dr Fulton was keen to ensure that all the actions had taken place so that -- he called a review meeting of everyone in April 2002. It coincided with the coming of the inquest, I accept that.
THE CHAIRMAN: If there's been a disaster in Altnagelvin, which has led to a girl's death, you agree in fairly quick order to make important changes.
A. Yes.
THE CHAIRMAN: Those are discussed between you and Dr Fulton, Dr Nesbitt's involved, there's a separate meeting with the nurses, but the next time people sit down to confirm what has happened, what has actually been done is 10 months later, and it comes about just on the eve of the inquest.
A. Just on the, sorry?
THE CHAIRMAN: The eve of the inquest, or what's expected to

be the time for the inquest. So that's why it looks as if it came about not as a coincidence with the inquest but because the trust wanted to be in a position to say to the coroner, "We have taken all these commendable steps since then".
Why would you not review in October, November or December 2001 what had been done and how effective those steps were?
A. Well, I think if you go back to the update for the chief executive, as far as I can see the action -- I believe the actions were in place then, following the six points in Dr Fulton's action plan. Then I threw in a new point. So I don't know how long you would keep going over your actions if you thought you had taken action on them.
MR STEWART: All right. Here's an example at 021-047-103. It's a memo from you, May 2002, to Sister Millar, and this is almost a year after the event.
A. Yes.
Q. "At the clinical incident meeting it was agreed that daily U&E post-operative children would be undertaken. Can you advise how you currently ensure that the above is carried out on all these patients? In particular can you advise that this is carried out when you are not on the ward.

"Many thanks.

"Therese."

So it looks as though you're waiting for almost a year before you find out how it's being implemented?

A. Yeah, but, if -- I think, can -- sorry, can you put back up the further document, the one that you had previously there? Because my understanding was that they were being done. I'm not sure if you -- sister Millar has already actioned this. So I'm not sure if the document in May then came about as a result of an incident where someone else hadn't received a U&E.

Do you understand what I'm saying? So that then I was saying, "Look, we'd agreed this way back in July 2001 and yet there's still an incident", you know, because I believed it had been actioned, so that was just checking -- asking her in my job how can you assure me that it is still being implemented.

Q. The point is, it's important to receive these assurances --

A. Yes.

Q. -- in writing.

A. Yes.

Q. You clearly believed it so. That's why you write in letter on 29 May 2002. That happens to be just after a consultation in preparation for the inquest at the end

of April 2002. I want to know why you did not think to write this self-same letter in the weeks and months following the critical incident review, not a year later?

A. Because I did believe that it had been actioned so that it was happening.

Q. You may have believed that, but it's good to get it in writing, isn't it?

A. But Sister Millar had told me she'd already actioned it.

THE CHAIRMAN: So are you saying then that what you were really asking in the May letter was for confirmation that something which you thought had been done was in fact being done?

A. Yes.

THE CHAIRMAN: Okay.

MR STEWART: Sir, this might be a convenient juncture in the evidence.

THE CHAIRMAN: We'll break for lunch, Mrs Brown.

Have the documents come through by e-mail? They have? If we allow until 2.15 so you can get some lunch and then Mr Quinn, Mr Stewart and Mr Stitt can have a look at the documents.

We'll resume at 2.15.

MR STEWART: Thank you, sir.

(1.05 pm)

(The Short Adjournment)

(2.15 pm)

MR STITT: Mrs Brown, over lunch we've had chance to look at the clinical incident meeting agenda and the spreadsheets. Some of them do seem to refer to critical incidents as opposed to minor matters.

Would it be possible for the 2001 material to be gathered together so we might look at them?

THE CHAIRMAN: Sorry, there are two points from what we've seen over lunch. The first is that the notes we've received are from 2002 and 2003. There's nothing from 2001.

A. No, they are. They're from 01 to 02, I'm sure, 01 to 02, and then 02 to 03.

Q. I stand corrected --

A. They're from April 2001 to March -- that's -- absolutely certain of that. Unless -- because that's what I provided.

THE CHAIRMAN: I don't want you to read out anything. Do you understand? But would you look at this? (Handed).

A. I have the original. I brought the originals, so that's -- I'm sure they are ...

THE CHAIRMAN: I'll tell you what I'll do. I'll stop for five or ten minutes and for this purpose, Mr Stitt, you can speak to Mrs Brown. I don't think that in any of

the notes that I've seen over lunch we have anything from 2001. So if Mrs Brown has the originals from 2001 here, perhaps you could confirm that and see what can be done.

Thank you.

(2.17 pm)

(A short break)

(2.23 pm)

THE CHAIRMAN: Okay. What we'll do is rather than wait, at the moment the 2001 papers are being copied, and after the questioning is finished we'll break for a few minutes and look at what's in the 2001 papers and pick up anything that needs to be picked up at that point. Otherwise we're going to be sitting waiting for copying to be done, which is sort of pointless.

A. Thank you, chairman.

MR STEWART: Can we start looking at the whole process of gathering material together to go to inquest. That started off quite soon after the coroner wrote to you asking you to get the statements, and here's an example of what you did respond to. It's at 022-079-210.

This goes out a week or two later, 7 November, to, in this case, Dr Nesbitt, asking him for his statement, and your statement, you say:

"... will be provided to our solicitor prior 20 to

release to the coroner."

And he comes back very quickly, 14 November, with his response and statement. That's at 021-066-157. That is Dr Nesbitt's statement.

You'll see there he makes no reference at all to the critical incident review or to the findings of the review or to the action plan. Did you think that perhaps he might or could or should have mentioned those things?

A. No. I didn't think that was the purpose of a statement for the -- I thought the purpose of the statement -- because Dr Nesbitt had been involved in Raychel's clinical care, that that -- the statement was about his clinical management. And any statements before or since, even, that are for a coroner are, I believe -- I understood, was in relation to their involvement in the treatment.

Q. Of course, you obtained a statement from Dr Fulton --

A. Yes.

Q. -- who --

A. Yes, so that was what his statement was, to inform the coroner of the process.

Q. Yes. Why didn't you ask Dr Nesbitt if he had any comment on the process as well?

A. I wasn't -- I was -- my role in getting statements for

the coroner is not about me asking people what I think I should do. I mean, he's a consultant, he would have been asked for statements for the coroner before. I was only, I see it, as a post-box in getting statements, sending them off to the solicitor if there's going to be legal representation, and then coordinating in between that and sending them off to the coroner.

THE CHAIRMAN: Can I just clarify this? Was Dr Fulton involved in treating Raychel?

A. No.

THE CHAIRMAN: Okay.

A. That came very later on, almost before the inquest, before he was asked for it.

THE CHAIRMAN: Right. And who asked him for it?

A. I think that -- if my recollection serves me right, that was discussion between counsel and the coroner --

THE CHAIRMAN: Right.

A. -- and an additional statement would go in regarding Dr Fulton's involvement.

THE CHAIRMAN: Right. This is to explain what happened afterwards.

A. Yes, but I wasn't involved in that discussion.

THE CHAIRMAN: So it's not about how Raychel was treated or how that led to her death, it's about what the trust has done after the event to try to put things right to avoid

a repetition?

A. Yes.

THE CHAIRMAN: Right. So that gives the trust an opportunity to explain to the coroner what positive steps have been taken in light of the circumstances of Raychel's death?

A. Yes.

THE CHAIRMAN: Right.

A. Can I just say that currently now, that role would often fall -- because there is the formal -- the regional process for incident review investigations, critical incident reviews, which is a process, those are normally shared with the coroner, the whole -- you know, there's a formal(?) process and sometimes I would be called to the coroner's court to give evidence on that. So that's where that's captured normally, now, currently.

MR STEWART: For the purposes of clarification, you are not suggesting, are you, that the coroner suggested that Dr Fulton give evidence?

A. I don't -- I was not involved in discussions with -- I know there were discussions in chambers with the coroner, I wasn't party to those discussions.

Q. No, but you were party to practically every single pre-inquest consultation with Dr Fulton, were you not?

A. No, I wasn't. I don't think I was at them, I think

I was at some of them. I think the notes -- why I put myself in -- think the notes weren't clear that I was at them all and I have possibly me in, but I wasn't -- I wasn't at every consultation, but I wasn't at consultation in chambers with the coroner and counsel.

Q. But the term --

THE CHAIRMAN: Sorry. Is that during the inquest or is that before the inquest?

A. Before the inquest.

THE CHAIRMAN: Okay.

MR STEWART: And what was the consultation in chambers about?

A. Sorry?

Q. What was the consultation in chambers about?

A. I don't know. I wasn't there. I'm not sure what -- sorry, I've lost the train of the question.

Q. The question is quite simple. You seemed to suggest that it might have been the coroner who suggested that Dr Fulton give evidence.

A. It probably was the trust.

Q. It was the trust.

A. Right, okay, I didn't ...

Q. Can we just come back to Dr Nesbitt. So you didn't suggest to him that he ought to make any comment about the process, as you call it. Do you remember that you

discovered at the critical incident review that Dr Nesbitt and Dr Jamison together went and made a retrospective annotation of the anaesthetic record?
A. Yes.
Q. Do you remember that?
A. Yes.
Q. Did you think it might be appropriate for Dr Nesbitt to make reference to that in his statement?
A. No.
Q. Why not?
A. Because Dr Nesbitt's statement, I believe, at that stage, was about his involvement in treatment of her. Now, Dr Jamison had made a note in the chart about the change, the retrospective note, had made the note regarding the fluids. Or Dr Nesbitt had made that note regarding the fluids.
Q. Yes.
A. And -- but that was, I think, the advice of the trust solicitor that that should change or that she shouldn't quote that in her statement.
Q. All right. So you made no request to Dr Nesbitt to mention it. Can we now go to --
A. Excuse me, sorry. Chair, I wasn't -- I wouldn't have been suggesting to anyone, you know, what should go into the statements. I think there's a feeling that I should

have suggested -- I would have been telling people that I thought they should say.
THE CHAIRMAN: When Mr Zafar made the supplement to his statement, was that at the suggestion of DLS rather than yourself?
A. I believe it was. I think because it was that there was an additional -- he was referred to somewhere else.
THE CHAIRMAN: So just to get to your point, you say that it would not be your role --
A. No, I was coordinator --
THE CHAIRMAN: -- to suggest changes, even blindingly obvious changes? Sometimes a change can have a sinister or suspicious interpretation, but let's suppose there's a blindingly obvious point like, as it turns out, Mr Zafar has mentioned his first role with Raychel on the ward round but he hasn't mentioned being called back in after the collapse. Would that be your role to suggest to him, entirely properly and entirely innocently: look, you had a second involvement with Raychel, do you not think you should refer to it? Or is that the role of somebody else?
A. I believe my role was in coordinating statements, gathering them up from staff in consultation with our solicitors, who would have been giving advice regarding statement.

THE CHAIRMAN: I want to get this clear, Mrs Brown, it's very important. Are you saying it would be DLS who would be suggesting Mr Zafar needs to consider adding something to his statement rather than -- and you would relay that to Mr Zafar?
A. Yes.
THE CHAIRMAN: But it would not be at your instigation?
A. I don't believe it was at my instigation.
MR STEWART: At that time, did you see yourself as assisting the coroner or assisting the trust in this process?
A. I saw myself as coordinating statements for the coroner and in that -- I was -- and I've coordinated statements for the coroner before. So I would see myself as being someone who has got a request from the coroner, I am the trust representative coordinating those statements for him. So how you see it -- I'm an employee of the trust. So it's about a trust representative assisting the coroner in his investigations.
Q. Well, when he wrote to you, and we looked at the letter this morning, and said, "Get statements from all the staff involved", and you didn't do that, I wonder to what extent you saw yourself as fulfilling your objective of assisting the coroner?
A. Sorry, can you ask that question again?
Q. The coroner wrote to you and said, "Please get

statements from all staff involved", and you didn't do that. You didn't go to Dr Zafar, who was the main surgeon seeing Raychel on 8 June. So he asked you for assistance and you didn't do it. To what extent did you see that as assisting the coroner?
A. Well, I believe that I had -- well, I -- you're quite right, I didn't ask for a statement time from Mr Zafar until sometime in January. But I was informing the coroner all the way along of the staff that I had requested statements from.
Q. Yes, but he could not look at all the papers and determine himself who was involved, he relied on you to do that.
A. Well, he had copied me into a letter -- he had copied -- I'd copied him into a letter I'd sent to Dr Sumner. He had advised me Dr Sumner was his expert. So Dr Sumner was writing a report for the coroner. So that's why I was very clear in my document. I think there was quite a long list of staff that I told him I'd requested statements from, so that he -- and Dr Sumner got a copy of that so that he could see who else he would potentially require statements from, and I had annotated them on the notes.
Q. Yes, but the question remains, he is reliant upon you to identify the relevant staff and --

MR STITT: These questions do seem familiar, Mr Chairman. I thought we had gone from A to Z ending up with Zafar this morning.

MR STEWART: We'll just visit another one, and that's in relation to a matter that Mr Stitt drew attention to, something he objected to earlier on. You've just drawn attention to the fact that you did draw the statements to the attention of Dr Sumner, and this is something that Mr Stitt was concerned about, there is reference in the correspondence to the earlier statements going astray.

A. Yes.

Q. And Mr Stitt was concerned that that word "astray" should have been put in inverted commas, as though it carried with it a pejorative connotation. This is where you may have told Dr Sumner who might have been involved but you didn't tell the coroner.

A. No.

Q. Can we have 012-050 --

A. I copied the letter to Dr Sumner to the coroner.

Q. I am sorry?

A. I copied the letter to Dr Sumner to the coroner. I thought I gave a list to the coroner of the staff involved.

Q. This is the question, and maybe you can clear this up

terribly straightforwardly. 012-050g-246. This is the letter where you -- we're now into March 2002.

A. Yes.

Q. And he's been writing to you, saying, "Where are the statements?"

A. Yes.

Q. And you say:

"I enclose to you a copy of my earlier letter to you of January 02 which refers to the nine statements which I sent to you."

Of course, he hasn't got them, and you then go on to say:

"This letter with the original statements appears to have gone astray."

A. Yes.

Q. And the question is on your files that letter of 25 January appears. It's at 022-054-151 and 022-054-152, and the question is: if you sent the letter to the coroner, how is it that the letter headed and signed letter remains on your file?

A. That's a photocopy of the letter. The ...

Q. Sorry, can I just ask? Do you customarily photocopy letters as they go out or do you keep a file copy? Because there's no other single incidence of the original remaining on your file, but maybe I'm wrong.

A. I don't know. I know for a fact that the letter had gone to the coroner with the statements. I was extremely concerned that it -- the coroner hadn't got it because I was in telephone conversation with the coroner. It had gone to a different address and the statements then were copied to the coroner.

Q. Yes, but are you saying that you photocopied it before sending it on 25 January 2002?

A. I photocopied the?

Q. You're saying that in order for this to appear on your file, you're saying you photocopied it before you sent it.

A. What's in my file is a copy. I would have got the letter printed off and re-signed it again.

Q. Let's move on. So Dr Jamison --

A. Excuse me, chair, I know the statements went to the coroner at the address that was previously -- it had previously gone to. That's where it was sent to.

THE CHAIRMAN: Right, okay.

MR STEWART: All right. So your evidence previously was in relation to Dr Nesbitt's statement that although he was engaged with Dr Jamison in amending retrospectively the anaesthetic note, you didn't ask him to amend his statement but you did indeed ask Dr Jamison for an amendment, and that appears at 022-056-154.

It says:

"Thank you for your statement regarding the care of Raychel Ferguson. I have forwarded a copy of your statement to the trust's solicitor for perusal prior to forwarding it to Mr Leckey. I note that you do not make reference to the post-entry note, which you made on 13 June 2001. I think it is important that you do refer to it. Do you wish to amend your statement? I am returning a copy for your attention."

Now, it looks as though you're making this suggestion to her off your own bat, or does it?

A. Well, "I forward your statement to the trust solicitor for perusal". I believe that then I had a conversation with the trust solicitor.

Q. In which case you'd have said, "I've forwarded to her for perusal and she indicates that she might think about making an amendment", but you don't. You say "I note that you do not make reference, I think it is important. I am returning a copy for your attention."

A. Yes.

Q. That looks to me as though you're asking her to amend a statement.

A. Yes, I mean, I was drawing attention to an entry which may be of assistance to her if she was going to be questioned at the inquest regarding the note. It might

help her to have it in and have it clarified in her statement.

Q. But you've been at pains to point out that you never ask people to amend their statements.

A. No, but that's -- I don't know if that was off my own bat or -- I mean, I have written to Mr Zafar and asked in writing that he amend a statement, but it was in consultation with solicitors, legal advice.

Q. In fact, on the same day, you write a letter to your solicitor, to Ms Carey. 022-057-155. The same day as you write to Dr Jamison suggesting she amend, you write to the solicitor saying:

"Please now find enclosed for your attention, statements from Dr Date and Dr Jamison. I have written to Dr Jamison and asked her to make a reference to her post-entry note and Mr Gilliland has sent his statement off to the defence organisation."

So there's absolutely no mention there of conversation and no reference to it being the solicitor's idea to ask for an amendment.

Does that jog your memory?

A. Yes. It's there, I did write the letter. I'm not sure if I wrote it after having spoken to the solicitor or if it was -- and it's dated the same day, so I accept your point. I think it was a good thing that Dr Jamison put

it in.

THE CHAIRMAN: And that might well be the case. There's no doubt, whatever criticisms there are, that Dr Jamison has made it absolutely clear in the clinical notes that she is making a retrospective note so there's no pretence that this note was made at a much earlier time.

A. Mm-hm.

THE CHAIRMAN: Okay? But the point, I think, which is being made from this is that since you were just sending Dr Jamison's initial statement to the CSA for their information, your letter which was written on the same day to Dr Jamison suggesting that she should include a reference to the post-entry note seems much more likely to have been your own idea rather than the solicitor's idea because the solicitor would not have seen the statement.

A. Yes, that does seem ...

THE CHAIRMAN: Right. That's why I was asking you a few minutes ago, and you were really quite clear, Mrs Brown, that you would relay requests or suggestions for change to witnesses at the behest of DLS but you didn't instigate changes yourself. And these two letters on 25 January do rather suggest that this is at least one instance of you instigating a change yourself.

A. Yes.

THE CHAIRMAN: Right, thank you.

MR STEWART: In fact, this trail of correspondence continues at 022-047-134. We're into February now, you're writing again to the solicitors saying:

"I await your views on the statements by Dr Jamison and Dr Date. I have already asked Dr Jamison to include her reference to the post-entry records. I enclose her amended statement."

So she complied with your suggestion. Do you remember asking her to make any further amendments to her statement?

A. Yes, I think there was a subsequent request, which definitely didn't -- I don't believe generated for me -- and she was clear she didn't want to make any further changes, which is always what would be advised to staff if they -- it's their statement.

Q. What further amendment did you ask her to make?

THE CHAIRMAN: That they don't have to?

A. Yes.

MR STEWART: What further amendment did you ask her to make?

A. I don't remember. You might have it there, I don't --

Q. I was asking you, because I thought you might remember --

A. No, I don't. I don't remember. I think -- I do remember seeing a letter from Dr Jamison at some point

where she says, "This is my final statement", or I say doesn't she wish to amend her statement, or something like that.

Q. Yes, indeed, that appears at 022-045-125. This is on 18 February, again you to the solicitor, saying:

"Please note that Dr Jamison was unwilling to amend her statement further."

I suggest to you that this body of correspondence suggests that you were actively engaged in seeking amendments to witnesses' statements.

A. That was in consultation with the trust solicitor. I know I wasn't. I don't know what you -- I don't know what this question is suggesting. I'm not quite sure.

Q. I'm not suggesting any wrongdoing specifically on your part, rather a system that may have been inadequate. Because, to be fair to you, you do write to the coroner, telling him this. It's at 022-055-153. This is a list you put together of the clinical staff involved in Raychel's care, and whilst the list may be itself inadequate, you do asterisk a number of individuals, and indicate that by the asterisks that you have received statements that they've been returned for minor amendments.

A. Yes.

Q. So you're quite open with the coroner and you tell him

that you have been seeking minor amendments. At any stage, did you let the coroner know what those amendments were?

A. Well, the amended -- the amended statements would have gone off.

Q. Yes, but he wouldn't have known what they were amended from. Did the coroner ever express any disquiet that you were returning statements for amendment?

A. No. I think there was an early stage where I advised the coroner of who are the trust's -- who the trust's solicitor was. I mean, the coroner often suggested that staff -- accepted, I believe, that staff would have the right to send their statement for advice to their solicitor and get advice on it.

Q. Okay. When you --

THE CHAIRMAN: Sorry. I just want to follow the sequence properly, Mr Stewart. I'm just looking at Dr Jamison's statement to the coroner, and it doesn't appear that she made the amendment which was suggested by covering the retrospective note.

A. She does. There's two statements.

THE CHAIRMAN: Sorry, it's in the second statement then. I'm looking at 012-034-164 and 165, if they could be brought up together, please.

So that's just a first statement, is it?

A. No, that's your final statement to the coroner.

THE CHAIRMAN: But where has she added in it?

A. You see, in the second paragraph there where she -- the bit where she goes:

"A litre of Hartmann's' solution was run through and connected to her cannula prior to induction of anaesthetic of which Raychel received approximately 200 ml in total during the course of the anaesthetic."

So that's -- that's the added bit.

MR STEWART: It did read "300 ml", did it?

A. It did at one time, yes, but that -- even that was an amendment, but I think the litre of Hartmann's piece wasn't in for her statement, if I understand it correctly.

THE CHAIRMAN: Okay. But what she didn't add was that the note was made retrospectively, but she ends up on the right page being questioned about that.

A. Yes, that's right.

THE CHAIRMAN: Okay, thank you.

MR STEWART: The post-mortem report arrived with you at the end of 2001 on 5 December, I think you received it.

A. Yes.

Q. And you shared it immediately with the principal doctors concerned, Gilliland, Dr Nesbitt and Dr McCord.

A. I think I also shared it with Dr Fulton.

Q. Maybe you did. At 026-017-032. This is your note --

A. Yes.

Q. -- it looks as though Dr Fulton received it, he's marked there, 7 December. And you have written:

"I have copied to Mr Gilliland, Dr Nesbitt and Dr McCord."

A. Yes.

Q. And the actual report itself -- I wonder can we go to the last page of the report at 022-070-176.

You'll see this is the commentary, and if we can look at the last sentence of that main paragraph in the middle where the pathologists concludes and comments:

"The abnormality of sodium balance and thus the cerebral oedema which led to her death was thought to be caused by three main factors.

"1. Infusion of hypotonic fluids.

"2. Profuse vomiting, and.

"3. Antidiuretic hormone secretion."

Did you receive any objections from Dr Fulton, Dr Nesbitt, Dr McCord or Mr Gilliland in respect of the conclusion that profuse vomiting was involved?

A. No, no.

Q. You then received the report of Dr Sumner on 18 February at 160-197-001. (Pause).

THE CHAIRMAN: It'll be in the coroner's file 12. Give me

a second.

MR STEWART: In any event, the report from Sumner is received around about February of 2002. You circulated it as well.

A. Yes.

Q. And did you circulate it again to the same group of doctors, Fulton, Nesbitt, McCord, Gilliland?

A. I believe I did.

Q. Did they come back and point out any factual inaccuracies in relation to the assertion that Raychel suffered severe and prolonged vomiting?

A. I think there's a letter where I quote the factual inaccuracies.

Q. Yes, indeed there is. It's at 160-183-001. This is where you relay back to the solicitor on 11 March some of the comments relating to the factual inaccuracies drawn to your attention by Dr Nesbitt and Dr McCord. They are detailed things in relation to the amount, the timings and the nasogastric tube, but there's no objection there to the reference to severe or prolonged vomiting; is that correct?

A. Yes.

Q. And that is on 11 March 2002. Is it correct that a consultation was held on 20 March 2002? It's referred to by you in your witness statement that there was

a pre-inquest consultation on 20 March. That's at WS322/1, page 23.

There we are, at the top of the page:

"Consultation, 20 March 2002. Present: Mr Makar, your solicitor [Scott] Mr McAlinden, Dr Nesbitt, Mr Gilliland, Dr McCord and possibly [yourself]."

Why have you, can I ask you, only included yourself possibly?

A. Because I got that information from DLS whenever I was preparing the statement. I didn't have a record of those consultations so I wasn't sure who was in attendance at them and I couldn't access my diary.

Q. Is it normal for there to be consultations with the solicitor, with counsel, and the lead clinicians in a case without you being there?

A. It is possible. It happens -- it happens on occasions. I don't attend every consultation with counsel and the solicitor.

Q. But at this consultation on 20 March, we have Nesbitt, McCord and Gilliland.

A. Yes.

Q. And these are the individuals who had had the reports of post-mortem and Dr Sumner circulated without any objection to the reference to vomiting.

Now, I wonder, can we turn to the letter of very

shortly after the consultation of 20 March, it's a letter sent on 29 March by the solicitor to the coroner and it's at 160-163-001.

This is a letter to set out for the coroner various submissions and a statement of what the trust's case was going to be at the inquest. Did you know that Ms Scott, assistant director of legal services, was going to write this letter?

A. I knew that she was going to make contact with the coroner. So I'm not -- I haven't read over here what the key points are.

Q. I draw your attention to the final page, first of all, which is 004. The final page concludes with the advice, the express advice, that the trust:

"... wished me to bring these matters to your attention well in advance of the hearing of this inquest."

So she's writing this letter expressly on behalf of and in consequence of the trust's wishes.

I wonder, can we go to page 003 of this document, 160-163-003, and to the second paragraph, where Scott writes:

"Another issue which is of concern to the trust is Dr Sumner's conclusion in page 4 of his report in the comments numbered 2 and 5, that the deceased suffered

very severe and prolonged vomiting. This conclusion is strongly disputed by the trust. The nurses who were caring for the deceased during the relevant period have been interviewed in detail about this matter and they are all of the opinion that the vomiting suffered by the deceased was neither severe nor prolonged."

Can I ask you who was the first person to articulate this dispute and to disagree with the opinion of Dr Sumner?

A. I honestly can't recall who was the first person. I believe the letter came after the consultation, as you quite rightly say, and my --

Q. Was this the solicitor's idea?

A. Pardon?

Q. Was this the solicitor's idea to write this?

A. To write the letter?

Q. To express this opinion.

A. I would very much doubt it.

MR STITT: Mr Chairman, we are getting very close to me having to make an objection on legal advice privilege, which I'd prefer not to have to do.

THE CHAIRMAN: Okay. We'll be very careful how this questioning continues, but let's put it this way, there had just been a consultation at which doctors Fulton and Nesbitt were present.

MR STEWART: Sorry, no, Nesbitt, McCord and Gilliland.

THE CHAIRMAN: I'm sorry, right. And as Mr Stewart was taking you through, there had been no previous objection raised to a point taken about the pathologist's report, saying that Raychel's vomiting was profuse.

A. That's right.

THE CHAIRMAN: So what we're interested to know is where the notion came from after the consultation that Raychel's vomiting was neither severe nor prolonged.

A. I -- I don't know. My recollection is that I had never heard before that -- from the nursing staff. I think part of this arose because at that stage the coroner may well have sent out initial lists of people who he wanted to call along to the inquest, and I don't think any nursing staff were on it.

THE CHAIRMAN: That's right.

A. And I was concerned, so I think that's how the conversation had started. I know I personally was concerned that nurses -- that the statements had -- you know the statements that we talked about, about going astray, that the coroner still hadn't got those statements, and -- so that's where I believe the point of the nurses. I think there was a discussion regarding that the medical staff felt they would not necessarily be able to clarify the issues around the vomiting in the

notes, the pluses and the -- I can't exactly recall the reasoning for that, but I think that's what was the background to it.

MR STEWART: You see, the evidence is and has been, first of all Dr Fulton has said that the critical incident review acknowledged, recognised, that the vomiting had been prolonged.

Staff Nurse Noble told this inquiry that it was recognised that the vomiting was both severe and prolonged at the critical incident review.

And Sister Millar the other day recognised that it was prolonged and could indeed be categorised as severe.

So how is it that this letter is written when it was known that the critical incident review did not make these findings?

A. I have to -- I was at the critical incident review. I remember it well. There was never any agreement at the review that the vomiting was profuse or severe.

Q. Was there a difference of opinion at the review as to whether the vomiting --

A. No.

Q. -- was prolonged?

A. No.

Q. Everyone was agreed it was not prolonged; is that what your evidence is?

A. No, I'm not saying -- I'm not saying that any one person said, "Oh, that was very prolonged". There was discussion regarding the vomits, and there was discussion regarding the documentation of the vomits. I don't remember the discussion getting into that point. That's my recollection of the meeting.

Q. You see, Dr Fulton did remember. Was this letter sent to Dr Fulton for his approval before it went?

A. I -- I don't believe the letter was sent -- I didn't see it before it went so I don't believe --

Q. Can I ask you further about this?

THE CHAIRMAN: Sorry, when you say there was no agreement at the critical incident review about whether the vomiting was profuse, prolonged or severe, is that because the critical incident review didn't go as far as to look for an agreement or a consensus on that point? There were issues raised about vomiting, but there was no consensus sought or reached about how severe the vomiting was?

A. I -- I mean, being a non-clinical person, I recall the discussion regarding the vomiting. There was a discussion about the documentation, the recordings of the vomiting, there was discussion, absolutely, that Raychel's vomiting was not any more unusual from vomiting of other children. So my belief of profuse

would be something that is very, you know, extreme. But then I'm not clinical, so I don't know what the clinicians would mean by that. It absolutely lasted over a period of time. So from that point of view it was prolonged. I'm sure most children will have recovered. But there was no disagreement about the period of time that it lasted over.

THE CHAIRMAN: So it was prolonged?

A. About the prolonged, but that it was severe, definitely. That is the -- that was not -- a discussion point at the meeting no one gave any indication that it was unusual.

THE CHAIRMAN: No, but if it's not a discussion point at the meeting that means it's not dealt with at the meeting.

A. No, the vomiting was discussed. The vomiting was definitely discussed because I remember it being discussed and the point about the pluses and the points about the recording of vomiting. But in relation to it being severe, I don't recall it being mentioned that it was severe. I recall discussion that it was not unusual.

THE CHAIRMAN: Well, when this letter says that the -- let me just get the wording.

MR STEWART: The second paragraph, third line down:

"The nurses who were caring for the deceased during the relevant period have been interviewed in detail

about this matter and they are all of the opinion that the vomiting suffered by the deceased was neither severe nor prolonged."

THE CHAIRMAN: When were they interviewed in detail?

A. They were never interviewed in detail. The critical incident review was the critical incident review. There was never separate interviews of the individual staff. I don't recall it.

MR STEWART: Well, how did this letter come to be written in these terms if there was no interviews?

A. I can't explain that. I didn't write the letter so I can't explain that.

Q. Could it be that your solicitor is off doing something on her own without your authority or the authority of the trust?

A. I don't know.

MR STITT: If we want to extend the list of witnesses and compel a solicitor to come and give evidence --

MR STEWART: It's a fair question for this witness to answer.

Was this written without the authority of the trust and without your knowledge?

A. I know that the solicitor was writing -- I mean, after the consultation I knew the solicitor was writing to the coroner. I didn't formulate the letter, the letter

wasn't approved by me before it went. I don't know if it was approved by anybody else. So that was based on consultation, I believe.

Q. So you were at the consultation?

A. Pardon?

THE CHAIRMAN: I think the witness might have been at the consultation. But let's summarise it then. Emerging from a consultation is a letter to the coroner on behalf of the trust, which is wrong when it says that the nursing witnesses have been interviewed in detail, and which is wrong when it says that the nurses are all of the opinion that the vomiting was not prolonged. So the only issue is whether there was agreement that the vomiting was not severe. So in the three points that are raised, on three issues that are raised about the nurses, two are wrong. Is that correct?

A. Well, there weren't interviews.

THE CHAIRMAN: That's right, there weren't interviews, and they didn't agree, from what you've said, insofar as the critical incident review is somehow regarded as interviews, which is something of a misnomer --

A. Yes.

THE CHAIRMAN: -- then there was no agreement at the critical incident review that Raychel's vomiting was not prolonged.

A. No.

THE CHAIRMAN: No. So the only issue is how extensive her vomiting was.

A. Yes, and --

THE CHAIRMAN: The autopsy report, which already has been referred to the trust, says it's profuse.

A. Chairman, I am satisfied in my own mind that the view at the meeting was at that vomiting was not severe or profuse.

THE CHAIRMAN: Let me put it this way. I've heard the nurses over a number of days giving their evidence and the nursing -- first of all, I do not understand how you could reach that -- the nurses could reach that view unless there were proper records, because there aren't.

A. I accept that, yes.

THE CHAIRMAN: And also, if there's coffee-ground vomiting, that is at least a sign, if not more than a sign, that vomiting is severe.

A. Yes.

THE CHAIRMAN: Right? Do you remember that being discussed? Do you remember at the critical incident review meeting the fact that the vomiting had become coffee-ground vomiting being discussed?

A. Well, that document -- that reference was made to the coffee-ground vomiting.

THE CHAIRMAN: At the critical incident review?

A. At the critical incident -- all the vomits, because it was documented.

THE CHAIRMAN: Right. So was that not taken at the critical incident review as at least an indication of severity?

A. I don't -- I know I came out of that meeting believing that there was no concern about the severity of the vomiting. That's my recollection of the meeting.

THE CHAIRMAN: Thank you.

MR STITT: Mr Chairman, one of the earlier questions which brought this subtopic up was a reference to the critical incident meeting, and Mr Stewart indicated that notwithstanding whether the witness could remember or not, whether there was discussion about the amount and type of vomit that Dr Fulton could -- and was the letter sent to Dr Fulton for his approval before it was being sent. An entirely appropriate question to ask.

I think it's probably fair of me to suggest that if one was to look -- and perhaps this could be pulled up, 043/3.

MR STEWART: Page 14.

MR STITT: Page 14.

THE CHAIRMAN: This is a witness statement, is it?

MR STITT: Yes, it's the Fulton witness statement. It ties into the last questions. I hope that's the right

reference.

THE CHAIRMAN: Yes.

MR STITT: No, that's not, sorry.

MR STEWART: That's the wrong witness statement.

MR STITT: Sorry, I said 43. But it may have sounded like --

MR STEWART: It's 043/3, page 14.

THE CHAIRMAN: WS043/3, page 14, please.

MR STITT: If I can go to the bottom half of that page and the last paragraph, because this issue goes to this letter and the provenance of the letter and the accuracy or otherwise, and this is Dr Fulton, no doubt you will ask him about this.

He says:

"Question. The extent type and duration of the vomiting suffered by Raychel."

And the question is at the top of the page in relation to the critical incident review meeting:

"Please also confirm whether consideration was given to..."

And then we fast forward down to (e), down to -- it's not lettered, but it would be (f), the extent, type and duration of the vomiting.

And the point to which I was going to refer was this is answered:

"This was described by the nurses who clearly believed it was due to prolonged post-operative vomiting. They agreed that the vomiting was prolonged but not unusual after this type of surgery. They did not believe that the vomiting was excessive, though they said they may not have witnessed all the vomit. The nursing method of recording vomit."

Et cetera.

And then the last sentence. Could we go to page 15, same reference, the next page.

The third sentence down:

"I was unable to reconcile the different views of the nurses and the family over the severity of the vomiting."

So I'm suggesting to Mr Stewart that really it's unfair to suggest that this letter has no reasonable provenance.

MR STEWART: Hang on a second. Just read the sentence that's there above that one:

"The nurses said that the Ferguson family told them during 8 June that they, the family, believed that Raychel's vomiting was repeated and severe. Accordingly, I was unable to reconcile the different views of the nurses and the family."

So there's no determination on the issue, he wasn't

able to make a determination, but what he is able to say is what he says at the bottom of page 14:

"They agreed that the vomiting was prolonged."

And that's the point I put to this witness, that Dr Fulton recalled it as being identified as prolonged at a meeting.

MR STITT: I don't take issue with the question of the fact that the word "prolonged" clearly appears there, but it's in the sense of the fact it was prolonged but it was believed by them to be post-operative vomiting.

THE CHAIRMAN: But that's not the point. The DLS letter says specifically the nursing witnesses have been interviewed at length, which they weren't. It says they agreed that the vomiting was not prolonged, which they don't, and then it says that they agreed the vomiting is not severe, and that's the only point on which this issue is accurately raised in the DLS letter to the coroner.

MR STITT: Prolonged and severe is a two part. And it's clear that the word "prolonged", Dr Fulton's evidence was adopted by the nurses, but with the proviso that they felt, wrongly perhaps, it's a matter for you and others, that that was normal but prolonged post-operative vomiting.

But the context of the letter and the context of the

report from Dr Sumner is to take -- without reference to the nurses, to take the conclusion that the vomiting was prolonged in a bad way or in an unusual way, and that's clearly the difference between the nurses and Dr Sumner, whether prolonged was a bad prolonged or a normal prolonged, for want of a better term.

THE CHAIRMAN: Okay.

MR STEWART: Do you think that this letter -- let's go back to 160-163-003. This is a serious letter to write to Her Majesty's coroner. It's a lengthy four-page letter. I'm not sure whether you think -- is it normal to write to the coroner, setting out an argument or a case before the case is begun? Is that normal?

A. Well, I -- the letter is in relation to -- I think the whole purpose of the letter is in relation to the article 2 point of the --

Q. Well, it isn't the whole purpose because we've just been dealing with one of the purposes of the letter.

A. Yeah, but I think it was following the consultation there were a number of points going off to the coroner.

Q. Yes. This is the one we're dealing with. Do you think that the coroner might have been misled by this paragraph that we've been looking at?

A. I'm not sure.

Q. Might he have been misled into believing, for example,

that the nurses had all been interviewed?

A. I mean, I'm thinking back to this particular point here, and that followed the consultation, so I don't believe that -- there must have been communication at the consultation that the nurses have been asked or the nurses -- you know, so to say they've been interviewed at length is not factually correct, but the nurses had already -- had said -- I mean, this wasn't -- this was information that was coming to the solicitor through other people, which was that the nurses had --

Q. Let's go back to the nurses in a moment, but do you think that the coroner might have been misled by this letter?

A. I ... Well, if it's factually incorrect --

Q. Yes.

A. -- there's a potential to mislead.

Q. Yes.

A. But I don't -- I mean ...

Q. Because when we come to that -- the four lines up from the bottom of that second paragraph, Ms Scott expresses one of the reasons why she's writing:

"... because I would simply question whether the requirements of procedural fairness are satisfied by permitting such expressions of opinion as are expressed in Dr Sumner's report."

It's taking a moral high ground here about procedural fairness.

Do you think, in the light of the fact that it's factually incorrect, that that is appropriate?

A. Sorry, I'm at a bit of a loss here, I'm not sure exactly --

Q. When did this letter first come to your attention?

A. Oh, it's in the papers. I've seen -- I've seen it in the papers.

Q. How many days after it was written did it first come to your attention?

THE CHAIRMAN: Do you remember being copied into it or it being copied on to you after it had been sent by DLS?

A. No. I wouldn't have expected it to.

MR STEWART: You wouldn't have expected a long letter, setting out the trust's case to the coroner, to be brought to your attention? Is that what you're telling the inquiry?

A. I didn't expect to see -- I mean, I know I didn't see the letter, so if I didn't see it and didn't request it, I mustn't have expected to. I knew there was a letter going regarding the issues, particularly around the article 2 point and particularly around the Dr Sumner report. So I knew a letter was going. I didn't ask to see the letter and I wasn't copied into it.

Q. Who would have told Ms Scott that the trust wished her to bring these matters to the coroner's attention?

A. I don't know. It probably ...

THE CHAIRMAN: I'll infer that that's done as a combination of the trust witnesses and representatives on the one hand, the trust counsel and trust solicitor. Okay?

A. Yes.

MR STEWART: And can I also ask, will you agree with me, with this basic interpretation of that section dealing with the vomiting, that essentially what you're saying here is "this is the trust case, the vomiting wasn't severe, the vomiting wasn't prolonged", and that's the trust case because the evidence is that the nursing staff don't have that view?

A. Yes.

MR STITT: Sorry to interrupt more than perhaps I should, but very briefly, with respect, it's perhaps slightly unfair to say that's the trust's case. The fact is that if they're in possession of opinions, right or wrong, that the nurses think this was prolonged but normal after an operation and it wasn't severe, and there's a difference with the family, the nurses may be completely wrong in that, but the letter is saying, "Look, just hear the nurses and form your own view", and that's what the coroner was going to do and what he did

do.

MR STEWART: It isn't just requests to "Oh, just hear the evidence please, make up your own mind". It is put in the starkest of terms:

"This conclusion is strongly disputed by the trust. The nurses had been interviewed in detail about this letter and they're all of the opinion that the vomiting suffered by the deceased was neither severe nor prolonged ."

MR STITT: The coroner is his own master, he can form his own view as to whether he believe there's any weight to be given to any nurse or any doctor or any individual.

THE CHAIRMAN: He can. Okay. Let's move on.

MR STEWART: That all occurred as a result of a consultation on 20 March.

The next consultation occurs, it looks like in April 2002, the next month. That appears from your witness statement.

And immediately after that, Dr Nesbitt then writes a letter to the CMO on 1 May 2002, and that letter appears at 022-091-298.

He writes to Dr Campbell, the CMO, to express his interest to know if guidance was issued following the death of the previous child in the RBHSC five years before and whose death the coroner investigated.

Were you at that meeting, consultation, in April 2002?

A. Possibly.

Q. Possibly. Because it seems that on that occasion it was doctors Fulton and Nesbitt with the solicitor and Mr McAlinden.

A. Yes, I think it was to go over their witness statements in preparation for the inquest.

Q. So it was the two medical directors?

A. Yes.

Q. And this letter was the outcome of that consultation?

A. No, that letter's written to Dr Campbell, so I didn't think it was.

Q. Was it discussed and planned at that consultation?

A. Well, Dr Fulton's statement was discussed --

Q. Yes.

A. -- at the consultation. So yes.

Q. And then also immediately after that consultation, you write to the DLS on 3 May at 160-143-001. You ask -- in fact, you ask your solicitor:

"Is it possible for you to ask the coroner to receive a copy of any recommendations made by Dr Sumner after he investigated the death five years ago? Perhaps we cannot request this."

So it looks as though you and Dr Nesbitt are

following the same path of investigation about information relating to what is probably Adam Strain's case.

A. Yes.

Q. And what did you hope to do with that information, why were you interested in it at that stage?

A. To have the information so that trust witnesses -- so that Dr Fulton would know if there was information that had come out. The guidance was all being discussed at the time in April and May, so it was to see what the -- the coroner had told me that Dr Sumner had represented him at a previous inquest. So it was to see what guidance he had. It was to gather all the information together really.

Q. Yes. You see, Dr Nesbitt had served on the CMOs working group himself. He knew precisely what guidance there was in the mid-1990s in Northern Ireland, didn't he? He didn't need to write to the CMO at that stage to ask him this question.

Was this in fact an essay in damage limitation, you were putting together mitigating circumstances to bring to the coroner's attention?

A. I don't believe -- that's not how I see it. It was about gathering information because Dr Fulton was being asked to do a statement and it was so -- it was to

follow up on Dr Fulton's statement, I believe. I don't know the exact reason.

Q. Is that because you possibly weren't there at the --

A. I wrote the letter, though, on 3 May.

Q. Yes. The next consultation then is Halloween, 31 October 2002. That appears from your witness statement again, and you're there on 31 October?

A. Yes.

Q. As indeed is Mr Gilliland, Dr Nesbitt and Sister Millar.

A. Yes.

Q. Again with the solicitor D Scott and counsel, Mr McAlinden. That was on 31 October. And it appears that the next day, Dr Jenkins is briefed.

What I'm attempting to demonstrate here is that not much happens in this case except when there's a pre-inquest consultation and then there's a flurry of activity. So Dr Jenkins was briefed on 1 November. And also on 1 November you ask for nursing statements about the vomiting.

Can we go to 022-017-056?

This is your letter to Nurse Gilchrist, who may indeed have supplied you or somebody with a statement in June 2001, and you say that you have the two-day inquest listed, 26 November:

"Dr Nesbitt and I met with the 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 to do this he feels it is important we bring along the nursing staff."

And so forth.

And then the positive aspects of the case.

So the nursing staff are unaware until 1 November that they have to go along and give evidence about the vomiting?

A. Yes. The nursing staff weren't on the list of witnesses the coroner had provided, and I believe that at that consultation on 31 October that the medical staff felt that if they were asked questions, which they would have expected the coroner to ask about the pluses and vomiting, you know, the process, so it is exactly as it says, it was exactly what was discussed, which I put in writing.

Q. Yes.

THE CHAIRMAN: The point of having Sister Millar at the consultation on 31 October would be to explore this issue.

A. Yes, try to explain it.

THE CHAIRMAN: And without going into too much detail about what happened at the consultation, the outcome of

that is that the nurses who were involved in Raychel's care are then asked for witness statements for the coroner?

A. Yes -- no -- well, most of them had read -- this is only one additional nurse. The other nurses had already all been asked, but the coroner had been didn't and she had also appeared in the notes. I'm not sure if she'd written in the notes, but she's also been referenced in somebody else's statement.

THE CHAIRMAN: Okay. So this is to complete the circle?

A. Yes.

MR STEWART: Then if you don't mind us just following the trail in chronological sequence. The next important thing is that Dr Jenkins furnishes you with his report on 12 November 2002, and it appears at 022-010a-040 and 041.

Essentially, Dr Jenkins is unable to form a firm conclusion, but he seeks more information, and he says that on a number of occasions.

Going to the conclusion, he says:

"Having carefully studied the statements provided by the doctors and nurses involved in Raychel's care ..."

So he obviously doesn't have the statements back, for example from Gilchrist, who you just asked for a statement from. He says:

" ... my impression is that they acted in accordance with established custom and practice in the unit at that time. It is, however, important that further details are obtained of relevant nurses and medical procedures and management in relation to fluid administration and post-operative monitoring of fluid intake, urine output and other losses ... In particular, information needs to be obtained regarding the local policy for post-operative fluid administration in children. Was the prescribed regime in this case in keeping with this guidance?"

What steps did you take to furnish Dr Jenkins with all the information that he seeking? (Pause).

A. I can't recall providing Dr Jenkins with any information. I never actually, as far as I can recall, ever spoke to Dr Jenkins.

Q. Did you take any steps to provide him with any information?

A. Well, it would have been done through -- I believe it would have been done through DLS, but ... So obviously statements will have been provided, but I don't think there were any relevant nursing and medical procedures in management in relation to fluid administration. I don't think there were any written procedures.

Q. Is there any correspondence between you and the DLS in relation to this matter?

A. No.

Q. No. Then after that, on 3 December 2002, Dr Warde in Dublin is briefed. That appears at 160-083-001.

Dr Declan Warde is given a brief synopsis of the case, he's told of the dates for the proposed inquest, and he's told that Sumner has been retained and a report obtained and he's asked:

"I would be obliged if you could provide comment regarding the treatment provided and the issues raised by Dr Sumner in his report. I thank you for agreeing to prepare a report and attend the inquest hearing on behalf of the trust in respect of this matter. I look forward to receiving your report as soon as possible."

So at that stage it was intended that Dr Warde should give evidence at the inquest, was it?

A. Yes that was my understanding. I didn't know of -- I didn't know Dr Warde but I knew there was -- because Dr Sumner was a paediatric anaesthetist, I think that's why there was a suggestion that we should get the advice of a paediatric anaesthetist. And my recollection is that it was to do with a lot of the issues that Dr Sumner was really -- he had made comments about, I think it was about the nasogastric tube, some of the

discussions that he had made regarding managing vomiting, which staff did not believe would be common practice in hospitals in Northern Ireland.

Q. He's asked specifically to deal with the issues raised by Dr Sumner, not a particular issue.

A. Yes. No, I know, but I think that's why there was a suggestion that -- Dr Sumner made some discussions regarding those things and I think that's why there was a suggestion it should be a consultant paediatric anaesthetist.

Q. In any event, his report is then received and it's received by you from the DLS under cover of a letter of 20 January 2003, and he actually expresses an opinion. It's at 022-006-023.

You see there:

"In my opinion [blank, that's Raychel] died as a result of developing acute cerebral oedema secondary to acute hyponatraemia, which was itself caused by a combination of severe and protracted post-operative vomiting."

Do you remember when this report was received by you? Did you read it?

A. I remember -- I did receive it. You probably --

Q. Sorry?

A. The date I'm not -- I know it was some date in January,

yes. I got a fax, I think.

Q. Well, here we are, 022-006-026.

To you from D Scott:

"I refer to our earlier telephone conversation regarding the above matter and now enclose herewith a copy of the report which was received from Dr Declan Warde for your attention."

So did you give it your attention?

A. Yes, I think I copied it to -- I believe I copied it to Dr Nesbitt and Dr Fulton. So I know I did do that.

Q. Because almost immediately afterwards it's decided that Dr Jenkins should be approached and his response to Dr Warde's opinion sought.

A. Yes. I didn't do that, that was done through a solicitor, yes.

Q. Of course, but she wouldn't do that without your say-so, would she?

A. No.

Q. She would have to act to your authority to go to an expert.

A. Well, Dr Jenkins was already instructed so the trust had already instructed that he be --

THE CHAIRMAN: Counsel might suggest that. Counsel's instructed, he's got a report in from Dr Jenkins, he gets a report in from Dr Warde. He might suggest that

Dr Jenkins is asked. It doesn't have to come through the trust.

MR STEWART: Were you normally asked for your authority at the outset before retaining a consultant?

A. Yes, well, we had already -- I agree that I was involved in the authority to instruct Dr Warde --

Q. Yes.

A. -- and Dr Jenkins.

Q. Yes.

A. That would have been part of my role in providing authority on behalf of the trust.

Q. Well, let's look at the letter that the solicitor did write to Dr Jenkins. It's at 160-045-001. And that's very soon after, three days later, 23 January 2003.

This is a letter written to Dr Jenkins by the solicitor, 23 January, and she writes -- I'll read out the entirety of the letter:

"Dear sir, re Raychel Ferguson deceased.

"I refer to the above matter enclosed herewith a copy of the report which has been received from Dr Declan Warde, the consultant paediatric anaesthetist retained to advise the trust. I would be gratefully obliged if you could consider Dr Warde's report and provide me with any further comments which you have, which might assist the trust. As a matter of urgency,

please revert ..."

So in consequence of that, Dr Jenkins comes back a few days later with his second report. That appears at 022-004-013.

There in the middle of that page, he refers to Dr Warde, makes reference to the significance of vomiting:

"I pointed out in my report of 12 November the importance of seeking further information regarding the frequency and severity of Raychel's vomiting in the opinion of senior staff given the comments in the report by Sister E Millar. I have also not been provided with any further details of relevant nursing and medical procedure and management in relation to fluid administration of post-operative monitoring of fluid intake, urine output and other losses such as vomiting."

At that stage was any attempt made to tell him that you hadn't attempted to locate this information and you probably couldn't supply him with it because it didn't exist?

A. I can't recall that. I don't see any documentation on my file of me doing that. I didn't have any direct communication with Dr Jenkins, it was through DLS, so I'm sure I would have been asked for it by DLS but I don't have any record of it.

Q. Well, the next thing to be noted, next development, is at 160-044-001. This is from the DLS file.

This is somebody saying:

"[Asterisk] I left a message with Dr Warde's wife and advised that he was not required to attend the inquest hearing."

Dated 28 January 2003.

Who decided that Dr Warde shouldn't come to the inquest?

A. I believe it was a decision taken in consultation with counsel and the clinical staff that --

Q. Sorry, who decided?

A. I don't know who exactly made the decision, but I -- I think that came -- that came from DLS, so it was probably in consultation with our legal advisers that the report from Dr Warde wasn't saying anything different to Dr Sumner's report. So that's my recollection, so that Dr Sumner was already being called as a witness. I think that was the rationale behind that.

Q. Are you saying there was a consultation after Dr Jenkins' second report came in on 27 January prior to this message --

A. No, there was definitely wasn't a consultation.

Q. So there wasn't a meeting --

A. No, there wasn't a meeting --

Q. Who discussed it?

MR STITT: Might I repeat an objection and a claim which I made previously in this inquiry dealing with any form of legal advice and I --

THE CHAIRMAN: Okay. I understand, unfortunately, this is an area we can't get into, but let me make this absolutely clear. I find it very hard to accept that a decision was taken that Dr Warde should not be called to give evidence simply because he agreed with Dr Sumner and wasn't adding anything further.

MR STITT: That's part of the problem. That's part of the problem in trying to distil a complicated issue into a short conclusion.

It's quite clear that there has been legal input and legal advice input into the decision as to which evidence would be relied upon and which would not. I have already made my points in relation to the appropriateness in law of so doing, and I note your views in relation to that, Mr Chairman. But the point simply is this, one cannot without having a full discussion on the matter, and without doing that it's just simply impossible to sum up in one sentence.

THE CHAIRMAN: Okay. We'll move on, Mr Stewart.

MR STEWART: Very well.

THE CHAIRMAN: I'm sorry, let me just ask one point. You're the risk management coordinator in the trust.
A. Yes.
THE CHAIRMAN: Do you have any input into a decision about which experts are called, since you've given authority for these experts to be engaged?
A. Yes.
THE CHAIRMAN: And it is your authority, you made that clear a few minutes ago --
A. Yes.
THE CHAIRMAN: -- do you not, then, have some input into the decision about which experts are called or not called at the inquest?
A. From the trust's point of view?
THE CHAIRMAN: Yes.
A. Well, only -- it's very unusual that the trust does actually look for experts. Normally, now, we would suggest to the coroner that he should perhaps get an expert in another particular field. That would be the normal --
THE CHAIRMAN: Let's look at this scenario.
A. Yes. So it's not a usual thing to do. I have to say it is very unusual.
THE CHAIRMAN: All the more reason why you might remember it.

A. Yes.
THE CHAIRMAN: You gave authority on behalf of the trust to the trust's lawyers to get both Dr Jenkins and Dr Warde to report.
A. Yes.
THE CHAIRMAN: Right. And the trust has to give that authority for the expenditure involved.
A. Yes.
THE CHAIRMAN: So a decision is then taken not to use Dr Warde in any way at the inquest.
A. Yes.
THE CHAIRMAN: Did you have any input into that decision?
A. I wouldn't have had the clinical knowledge to have an input into that decision. I wouldn't have had --
THE CHAIRMAN: With all due respect, Mrs Brown, I entirely accept that you might not have had the clinical knowledge, but if the trust had declared through DLS that it was going to challenge Dr Sumner's conclusion about vomiting --
A. Yes.
THE CHAIRMAN: -- and to that end, and to cover a number of issues, the trust then engaged Dr Warde, and Dr Warde comes back and significantly endorses what Dr Sumner has said, you don't have to have the clinical knowledge to understand that Dr Warde is largely in agreement with

Dr Sumner so that if you're going to challenge Dr Sumner, your case isn't helped if there's a second report before the coroner from Dr Warde, which is along the same lines. That's pretty obvious, isn't it?
A. I accept that, yes.
THE CHAIRMAN: So let me ask you again. Did you then have any input into the decision that Dr Warde would not be used as a witness at the inquest?
A. I don't recall. I knew that Dr Warde wasn't coming, so yes, I knew he wasn't coming. Whether it was my instructions to the solicitor not to call him or not, I knew he wasn't coming to the inquest.
THE CHAIRMAN: When you answer it like that, does that indicate that there's at the very least a possibility that you had some input into the decision or that in fact it might have been on your say-so that Dr Warde wasn't called?
A. But I am not a doctor so I don't believe I could have said that Dr Warde's report was any -- you know, the coroner had Dr Sumner's report.
THE CHAIRMAN: Yes.
A. So this was information to go -- Dr Warde is a witness -- calling him as a witness.
THE CHAIRMAN: The coroner had Dr Sumner's report.
A. Yes, and he was calling Dr Sumner.

THE CHAIRMAN: All right. Dr Sumner's going to give evidence. The trust has written through DLS to the coroner to say: there are some points that Dr Sumner makes which we don't agree with. Right?
A. Yes.
THE CHAIRMAN: So the trust to strengthen its response to Dr Sumner, Dr Warde is engaged --
A. No, Dr Jenkins was actually got initially.
THE CHAIRMAN: Right, but Dr Warde is also engaged --
A. Yes.
THE CHAIRMAN: -- and he sent Dr Sumner's report and he's asked to respond to the issues raised by Dr Sumner.
A. Yes.
THE CHAIRMAN: So he comes back with a report, which I will broadly, crudely summarise by saying it broadly endorses what Dr Sumner is saying.
A. Yes.
THE CHAIRMAN: So if the trust is going to contest at least some of what Dr Sumner has concluded, then that's why it's going to call for instance the nurses. Right? Because Dr Sumner says the vomiting was severe and prolonged, the nurses say it wasn't, so the nurses are going to be called to give evidence.
But you now have a report from Dr Warde, which says the vomiting was severe and prolonged. So somebody

decides "Let's not call Dr Warde", I'm asking you, did you make that decision or have some input into that decision?
A. I do not recall having Dr Warde -- to call him as a witness but I accept that --
THE CHAIRMAN: Well, DLS called him --
A. Yes.
THE CHAIRMAN: -- and spoke to his wife --
A. Yes.
THE CHAIRMAN: -- and told his wife that Dr Warde was not required. I'm looking to find out who made that decision that Dr Warde was not required.
A. I don't know whose advice it was to DLS that we would not require Dr Warde.
MR STEWART: Who made the decision?
A. Pardon?
Q. Who made the decision?
A. Not to?
Q. Call Dr Warde.
A. I don't remember. I'm sure I would have instructed DLS that he wasn't being called. I don't know. I don't remember who made the decision.
Q. Who else apart from you would have made the decision?
MR STITT: Well, we all know, and Mr Stewart knows, that one of the persons who could make -- one of the bodies of

people that could have made the decision were legal advisers --
THE CHAIRMAN: Yes.
MR STITT: -- or it could have been the trust or it could have been a combination of the two.
THE CHAIRMAN: That's why I'm asking the witness. I accept your point about going behind the decision. What I'm simply asking is who made the decision.
MR STITT: That's why I didn't interrupt, sir, when you were asking those questions, and the witness, I thought, had answered as best she could.
THE CHAIRMAN: I'm sorry, the witness said -- Mrs Brown, sorry, I don't mean to crude referring to you as the witness, Mrs Brown, it's rather disrespectful, but you said a few moments ago -- I'm just looking to see exactly what you said. Sorry, what you said was:
"Whether it was my instructions to the solicitor not to call him or not, I knew he wasn't coming to the inquest."
A. Yes.
THE CHAIRMAN: That suggests that it is at least a possibility that you instructed DLS that Dr Warde should not be called as a witness at the inquest.
A. Yes, I accept that, after advice and discussion with -- I'm sure Dr Warde, Dr Jenkins -- I mean, after

discussion with our legal advisers and clinical input into that discussion.
THE CHAIRMAN: Okay. Thank you.
MR STEWART: Perhaps now we'll move into a slightly related question in a more minor key.
Dr Jenkins then produces two days later another report, a third and this time a final report which appears at 022-004-010.
This is the report that ultimately goes to the coroner and forms the basis of his deposition.
A. Mm-hm.
Q. This is obviously not the same as the second report, which dealt with Dr Warde's opinion, but it's an amended version of his first report, and he leaves out several sections and he adds one additional section. And he leaves out the bit where he concedes the possibility that it might be possible to agree with Dr Sumner. Did you know anything about Dr Jenkins going off to write a third report?
A. I had no input -- I knew there were consultations with Dr Jenkins. I had no input into Dr Jenkins, you know, discussions with his counsel, with our counsel regarding Dr Jenkins' second report.
Q. I'm asking you a different question. Did you know that he was writing a third report?

A. I'm sure I received a copy of it on the -- I think that's the fax enclosing it to me, I think.
Q. The third report is an amended version of the first report. Were you aware of the fact that he had amended his initial opinion?
A. Yes, because I saw the statement, the two statements, and it was -- he was going along to the inquest to give evidence so he was giving his -- going to be giving his evidence to the coroner, so that was a statement for the coroner.
Q. Do you think it appropriate to give a coroner one version of a witness's statement, not all the versions?
A. I don't -- I'm -- I believe that was the process.
Q. Well, that is not what the coroner told this inquiry. In fact, he --
A. Excuse me, sorry. I didn't provide the copy of this statement to the coroner. So I didn't --
Q. You didn't, the DLS did. The DLS wrote to the coroner -- 012-070b-386 -- to forward the report but they term it:
"I refer to the above matter and enclose for your attention a copy of the independent report prepared by Dr John Jenkins. The original report will be forwarded to you upon receipt."
The coroner was given no inkling of the fact that in

fact this was one of a number of reports, as opposed to the single sole report.

Do you think that was right?

A. Chair, I am -- I feel that these are questions that are for, you know -- it came through legal team, so it was an advice of the legal team. I didn't know the practice was that you shouldn't give the final statement. He was being called as a witness. So my understanding was that witnesses could amend their statements before they go in to the coroner and the coroner was aware of that.

Q. This is an expert, and Mr Leckey, the coroner, gave evidence to the inquiry on 25 June 2013.

At page 110 at line 8, he says:

"Can I just add this, that I usually get expert reports from hospital trusts and I do so on the basis -- that I hope isn't mistaken -- that there has been complete disclosure because I, in turn, provide complete disclosure of anything that I've obtained."

The chairman:

"So you'd like to think that the reports and the statements which you receive are in fact the original reports and statements?

"Answer: That is correct."

Ms Anyadike-Danes:

"So therefore you don't want to have version 3,

which removes some of the caveats that may have been present in version 1?

"Answer: Not at all."

So you can see what the coroner thinks about this.

THE CHAIRMAN: Did you know at that time, Mrs Brown, that in the High Court, in a medical negligence claim, you wouldn't have been able to do this?

A. Yes.

THE CHAIRMAN: So you were conscious of the fact that -- and there was no rule, there's no coroner's rule against this, but you knew that in the High Court if you were going to ask Dr Jenkins to give evidence, you would have to produce Jenkins 1, Jenkins 2 and Jenkins 3?

A. Yes, but I wasn't -- I would have believed that legal advice.

THE CHAIRMAN: Yes.

MR STEWART: So you're saying really that everything that was done was done on the advice of the lawyers; is that what you're saying?

MS GOLLOP: I hesitate to interrupt, sir. A moment ago you just told us that in the High Court in a medical negligence claim you wouldn't have been able to do this.

THE CHAIRMAN: Yes.

MS GOLLOP: Could you just explain so we understand your thinking what it is you're saying would have been

prohibited in the High Court?

THE CHAIRMAN: I'm subject to correction from members of the Northern Ireland Bar here present. If a doctor is used to give evidence in cases, the doctor's reports, the full exchanges in the reports have to be provided. You cannot exchange report 1 -- you cannot provide report 3 and not disclose that there are previous reports.

MS GOLLOP: For an expert witness?

THE CHAIRMAN: Yes.

MS GOLLOP: Thank you.

THE CHAIRMAN: Just for the assistance of our friends --

MR STITT: I'm not taking any point in relation to it.

THE CHAIRMAN: But what the witness has said is that she knew that that was a rule in the High Court and was taking advice about what happened in the coroner's court.

MR STITT: Might I respectfully suggest that the witness has been going for an hour and a half and could you consider giving her a short break.

THE CHAIRMAN: At the next convenient point, we'll certainly do that, Mr Stitt. Is this now?

MR STEWART: Yes, I'm quite happy.

THE CHAIRMAN: I don't think there's much left, Mrs Brown, but we'll take a break for a few minutes.

(3.50 pm)

(A short break)

(4.07 pm)

THE CHAIRMAN: Just to give you some indication, as best we can, Mrs Brown, we'll certainly finish this afternoon, and hopefully we'll finish comfortably before 5 o'clock.

A. Thank you, chair. Thank you.

MR STEWART: Sir, we left -- we were considering Jenkins' third and final report, and I was indicating one or two of the things it omits to mention. And, of course, it omits to mention any reference at all to Dr Warde or his report. Neither Dr Warde's existence in relation to this case nor his report were brought to the attention of the coroner.

You were at the inquest?

A. I was, yes.

Q. Who else from senior management was at the inquest? Was Mrs Burnside there?

A. No.

Q. Dr Fulton and Dr Nesbitt?

A. I believe they were, yes.

Q. So --

A. Excuse me, they were witnesses to the inquest, so --

Q. Yes. Who decided that nobody would mention Dr Warde's report?

A. Um, I wasn't -- I didn't give evidence at the inquest, so --
Q. No, I asked who asked that nobody would mention Dr Warde's report.
A. There was no decision made to my recollection that Dr Warde's report should not be mentioned.
THE CHAIRMAN: Okay.
MR STEWART: It seems to be a coherent approach, nobody mentioned the report. Nurses gave evidence that they were unconcerned about the vomiting, they didn't think it unusual, and nobody mentioned Dr Warde as having a view in line with Dr Sumner.
A. Yes. I didn't give evidence, I couldn't have mentioned it. I don't -- but there was no decision not to -- I don't -- it was a coroner's inquest, so ...
Q. Yes, because you know what the coroner thought about this approach and he expressed it to this inquiry on 25 June 2013 at pages 108 and 109.
At line 23, it has just been revealed to him that there was another expert report in the possession of the trust at the inquest in relation to Raychel, and it hadn't been brought to his attention.
So at line 23 he asks by way of an answer:
"Can I just clarify that there was an expert report from a Dr Warde in Dublin --

"Question: Yes.
"Answer: -- which I didn't -- I wasn't provided with a copy?
"Question: Exactly, exactly, you weren't provided with it, and the explanation of why you weren't provided with it because that is subject to privilege, they've got the report and they didn't have to show it to you.
"Answer: Anyone who appears in any inquest I conduct will be aware of my practice, and that is that any expert report that I get will be disseminated to all involved and my expectation is -- and I've said this on a number of occasions -- that I would expect an exchange to be provided with a copy of my expert report they obtain. There may be an issue raised of privilege. What I would say is, are we not investigating in this case the death of a child and let's not dwell on legal niceties first. We want to get to the truth."
So that's his view.
A. Yes.
Q. What do you think now about the trust approach of not telling him about Dr Warde's report?
A. Chairman, I have to tell you that I always believed that Dr Warde's report would automatically go to the coroner. I thought it had to go to the coroner.
Q. When you sat there that day at the inquest and it didn't

go, did you send a note to the solicitor saying, "Please, please, before this ends, make sure the coroner is informed about Dr Warde's report"?
A. I didn't know that the coroner didn't know that --
Q. You sat at the inquest, didn't you? How many days did the inquest go on for?
A. I think it was three, and he didn't mention Dr Warde's report.
Q. And didn't you think he ought to be informed about it?
A. I believed he should -- I believed that a copy would have gone to him.
Q. Well, you had no reference to it. Why didn't you draw his attention --
A. I don't know. It was not in my mind to think about Dr Warde's report at the inquest.
Q. Was it perhaps because nobody from Altnagelvin had the remotest intention of bringing this rather embarrassing, contradictory report to the coroner's attention?
A. I don't believe that's the case. I believe that's an unfair assumption.
Q. And there was nothing more than a concerted conspiracy to withdraw it from his attention, to bury it?
A. I believe that's an unfair assumption.
Q. What other assumption would be fairer?
MR STITT: The assumption, Mr Chairman, that every party,

whether they be a public body or an individual has legal rights. You, sir, if your report does change the law, we'll go with that. We are dealing with 2001 and my clients, the trust, had a legal right.
THE CHAIRMAN: They did, and I said this last week, Mr Stitt, and I come back to it again, the trust had the right to claim privilege for the report. My query is why the trust chose to exercise that privilege. The trust could simply have presented the report to Mr Leckey and it chose not to, and it's one thing to have legal privilege, it's another thing not to. And particularly another thing not to do it when the coroner operates on the misunderstanding that the parties are disclosing to him, those who are interested in these events are disclosing to him what they know.
MR STITT: Reference has been made by the coroner to not wishing to dwell on legal niceties. Phipson on Evidence makes it absolutely clear that no one is to be criticised for exercising a right of privilege, and that's the law whether we like it or not, and that includes a public body.
THE CHAIRMAN: It does. You're quite right. It does.
A. Chairman, I just want to say that my understanding was that it would go to the coroner. I accept I didn't mention it at the inquest. It didn't enter my head to

enter it to the inquest. But my understanding of the law was different, regarding -- I thought he automatically got it.

THE CHAIRMAN: Let me explain it this way. We don't need to go on about this issue much longer. Mr and Mrs Ferguson go to the inquest to find out what happened to their daughter.

A. Yes.

THE CHAIRMAN: Dr Sumner's given a report in which he says, among other things, that she had prolonged and severe vomiting.

A. Yes.

THE CHAIRMAN: A number of nurses give evidence to say, "We have seen children with the same vomiting, we might even have seen children with worse vomiting, and nothing happened to them which is in any way comparable to what happened to Raychel". Right?

A. Mm-hm.

THE CHAIRMAN: Do you see from the Fergusons' perspective that it might more difficult for the trust and for the nurses to run that argument that this wasn't prolonged and severe vomiting if there wasn't one expert's report in front of the coroner but there were two expert reports in front of the coroner? Because it's not just Dr Sumner out on a limb saying about the vomiting, it's

a second expert who's saying exactly the same thing.

A. I accept your point, chairman.

THE CHAIRMAN: And that's why the Fergusons must be suspicious about why the trust exercised its legal right.

A. Chairman, I have to tell you, the thinking that it was a legal right being taken at the time was -- I believed it was going to be shared. I hadn't sent --

THE CHAIRMAN: You believed the contrary?

A. I believed the contrary, and I was never instructed by anybody within the trust not to share it. I believe they believed it would go. They may have thought that I was going to send it. It wasn't sent. I accept it wasn't sent. But I was never instructed not it send it and I believed it had to go.

MR STEWART: You believed it had to go?

A. Yes, I believed all reports would go to the coroner.

Q. Leaving aside the legal technicalities of the matter, do you believe that when Dr Warde's report was not mentioned that the trust was being entirely candid with the Ferguson family?

A. Sorry, can you just ask me that question again?

Q. Leaving the legal niceties on one side --

THE CHAIRMAN: I'm not sure you can do that because I'm not sure that Mr Stitt would agree that it's a legal nicety

to claim privilege. It's arguably more than a nicety.

MR STEWART: All right then. Can I put it in this way. Did you think it was morally appropriate that that report should not have been referred to the coroner?

A. Chair, the difficulty for me is now that I'm being asked about something that -- so I wasn't thinking morally at the time that there was something being withheld.

THE CHAIRMAN: Because you thought it wasn't being withheld.

A. Yes.

THE CHAIRMAN: Okay.

MR STEWART: After the conclusion of the inquest, litigation started, and a letter of claim was written at the beginning of May of 2003.

A. That's right, yes.

Q. At that time you were sitting on the scrutiny committee.

A. Yes.

Q. And you were charged with reviewing the clinical negligence actions and deciding what to do about them; is that right?

A. Yes, yes.

Q. One of the things you might have to do is to request additional information or statements.

A. Yes.

Q. I know there's some correspondence with the solicitor. Did you in fact obtain any additional statements?

A. No, no.

Q. Did you obtain any additional reports?

A. No.

Q. No additional reports?

A. I think there's a letter there saying that we wouldn't request statements or -- statements because the matter had already been the subject of an inquest.

Q. Okay. So, therefore, in that committee, you had to make a decision about whether to defend the case or settle the case?

A. Yes.

Q. And was a decision taken at that time in 2003 about whether to defend or settle?

A. I think there was --

MR STITT: That's clearly -- it goes to the absolute heart of legal advice privilege.

MR STEWART: In my respectful submission, it doesn't, because I'm asking was a decision taken, because under the policy they have to do that. I'm wasn't asking on what basis the decision was made, I was asking was the decision made and who makes it.

MR STITT: You're asking for confidential information about a meeting where people were going to address a legal action which had started. It couldn't be clearer.

THE CHAIRMAN: Let's do it this way. Have you got the DLS

letter from last Thursday, Mr Stewart?
MR STEWART: Yes, this is the letter of 30 August that Mr Stitt read last week and he said -- it says, it's signed by Mr McGuinness, chief legal adviser:
"I can confirm to you that my client, having taken into account the evidence heard during the inquiry, including national independent expert evidence and the interim comments of the chairman, formally admits liability. The trust apologises unreservedly for Raychel's death and regrets any further hurts and distress that the delay in admitting liability has caused the family."
Can I ask you, who made the decision to admit liability?
MR STITT: I object to that. That is clearly a question which begs an answer which I'm indicating would involve legal advice privilege.
THE CHAIRMAN: The trust has admitted liability.
MR STITT: Yes.
THE CHAIRMAN: We're not asking for the legal advice which it received on the basis of which it decided to admit liability, we're simply asking for the name of the person or persons in the trust who decided to admit liability. Why is the identity of the individuals a matter of professional legal privilege?

MR STITT: The admission of liability, which I hope was frank.
THE CHAIRMAN: Yes, it was, absolutely it was. And you will have heard, and to be fair to you, Mr Stitt, and to be fair to Mr and Mrs Ferguson, it was very much welcomed last week.
MR STITT: I hope it was.
THE CHAIRMAN: It was.
MR STITT: The phrasing of the first two paragraphs of the letter was done with considerable thought to deal with not just the liability but also the delay in admitting liability, which has obviously been a problem, and we've acknowledged that. My point is this, and again it's not a legal nicety, but the sort of discussions that have gone on have been detailed, but they have involved at their absolute heart legal advice from a number of sources, including more than one counsel and solicitors and certain representatives of the trust.
By admitting liability in a frank manner, we weren't waiving privilege to the discussions which had gone on, which include --
THE CHAIRMAN: I'm not asking that to be --
MR STITT: No, but by asking who was the person that decided to admit liability, it's a trust decision on legal advice, it's as simple as that.

THE CHAIRMAN: Yes, but it's not the cleaner in the trust who decides it; right? It's not a cardiologist who works for the trust who decides it. There's an identifiable person or persons in the trust who decided to go with the legal advice or to go against the legal advice, whatever. Let's assume to go with the legal advice to admit liability.
Now, I'll still not entirely clear --
MR STITT: I won't pursue my objection. Now that you have articulated it in that way, I won't pursue the objection to the question.
THE CHAIRMAN: Just to make it clear, Mrs Brown, we're not asking you to break any legal confidence or to say this barrister said this, that barrister said that, that solicitor said something else, I'm not asking any of that. I'm just asking you whose decision was it in the trust to decide to accept legal liability?
A. The chief executive.
THE CHAIRMAN: Thank you. Going beyond Raychel's case into other cases, is it inevitably the chief executive who has to approve an admission of liability?
A. No, it's not.
THE CHAIRMAN: But it was in the particular circumstances of this case?
A. Yes. There are certain delegated levels of authority

within the organisation.
THE CHAIRMAN: Right.
MR STEWART: Normally, small-ish cases would be dealt with by you?
A. The scrutiny committee, yes. Yes. Chair, from my personal view, which is totally my personal view because I didn't give in September, whenever that letter was written -- my view was that we should try to resolve this case because a child had died in our care, she shouldn't have died, and that is why I wrote the letter I wrote to the letter to the solicitor and didn't request and additional statements, which would be the normal process of requesting statements with all the doctor and I didn't see the point -- that was my personal view at that time that I wrote that letter.
THE CHAIRMAN: In September what year?
A. After --
MR STEWART: Is that 024-005-005?
A. "This case... I feel it is better that we discuss this at the review meeting and then see what outstanding information is needed."
I didn't want to be -- I believe the letter of claim came in in May.
Q. 1 May.
A. And that was my personal view and I wrote that personal

view.
Q. But you've told us that no --
THE CHAIRMAN: Sorry.
A. Yes.
THE CHAIRMAN: Forgetting --
A. Yes, yes.
THE CHAIRMAN: You're volunteering something which --
A. Yes.
THE CHAIRMAN: -- I don't want to get into about the views you expressed internally and what advice was received.
A. This is before there was a scrutiny committee. I accept that. I'm just telling you, I didn't want to delay the process.
THE CHAIRMAN: Thank you.
MR STEWART: It's 10 years ago. I wonder, can I raise with you the question of documentation, which has so vexed us all.
This morning you told us that the clinical incident committee didn't really deal with anything like a critical incident and that the records, agenda, spreadsheets, reviews from 2001 to 2003 had no reference to Raychel.
A. That's my understanding.
Q. And then you provided the records but not the 2001 records, and when this was pointed out to you, you have

now provided the 2001 records, and we find on looking at them --
A. Excuse me, chair, I had provided the 2001 records. I believed I had handed them --
MR STITT: I think somewhere along the line in the e-mail trail they weren't picked up in Belfast. I think to be fair to this witness, she had given everything in one go.
THE CHAIRMAN: Okay.
MR STEWART: And we find, on looking at them, interestingly, in Ward 6, on 4 June 2001, some child received the wrong amount of fluid.
A. Yes.
Q. And we find on 12 June 2001, a critical incident review following the death of a child on Ward 6, an investigation was undertaken. That's clearly Raychel's case, isn't it?
A. Yes. I didn't believe there was any reference to Raychel's case at that --
Q. Well, did you look very hard? Because there are so many documents that should exist but have not been provided and have not been provided on your assurance that no such documents exist?
A. I didn't believe -- until Ms Duddy mentioned it on Thursday, I didn't believe there were any notes of --

there weren't any minutes. I knew --
Q. You're on the committee, why didn't you check?
A. I knew there weren't any minutes, I don't think there are minutes --
THE CHAIRMAN: Sorry, it's not quite the point. What you told us this morning, and let's forget the ambivalence for a moment or the mix-up about 2001 documents on the one hand and 2002, 2003, you told me this morning absolutely clearly that Raychel would not have been raised as a clinical incident because she was a critical incident.
A. Yes.
THE CHAIRMAN: The documents which we got just after the toing and froing around lunchtime has in effect a specific reference dated 12 June 2001, almost exactly on the right date, for a critical incident following the death of a child on Ward 6. Now, I'm assuming that's Raychel?
A. It must be, yes, it is, yes.
THE CHAIRMAN: Just for reassurance, that is the extent of the note. There's no other entry, Mr Quinn. So it's not something which advances the investigation, save to say that it is raised and noted on the list of clinical incidents reported.
What I'm bound to ask you, Mrs Brown, is how could

you have missed that?
A. Are you asking me how could I have missed it when?
THE CHAIRMAN: This morning when -- in fact, if you look through these records for 2001 to 2003 and you forwarded them to DLS, how could you have missed the fact that in June 2001, the very month Raychel died, there's a reference in the clinical incident records to the death of a child on Ward 6?
A. Is that -- that's not in the action notes. Is it on the spreadsheet?
THE CHAIRMAN: Is that the spreadsheet? (Indicating).
A. Yes.
THE CHAIRMAN: It's there.
MR STITT: Could I just help the witness? Could she have a brief look at it to refresh her memory?
THE CHAIRMAN: Of course. (Handed).
MR STEWART: I've lost the thread. What entry is that?
THE CHAIRMAN: It's the one which says "12/6/01 Ward 6 critical incident following death of child".
MR STEWART: It's the one that has the handwriting on the right-hand side.
A. No.
Q. I think it's Mrs Brown's handwriting. I'd like her to interpret it.
A. That's not my handwriting.

THE CHAIRMAN: Is the first piece of handwriting in relation to a different entry?
A. Yes.
THE CHAIRMAN: "No further action"?
A. Yes.
THE CHAIRMAN: And then there's an arrow down, it says Ward 6, and then below that "PU, vomit, IV fluids management, U&E taken post-op".
A. Yes.
THE CHAIRMAN: Then it says "Solution No. 18 Ulster" on the left-hand.
A. Yes.
THE CHAIRMAN: That's not your writing?
A. No.
MR STEWART: Can I ask you to move four pages further on in that document. You'll find another document on the same page with handwriting annotating it. Do you see the entry, the same entry, 12 June 2001, Ward 6, investigation undertaken, and it looks like your handwriting, Mrs Brown?
A. Yes.
Q. And have you written there "Reinforced in writing by Raymond?"
A. Yes.
Q. "Research of evidence". Now, That must be

Raymond Fulton?
A. Yes.
Q. So something must be done in writing by Raymond Fulton.
A. Yes.
Q. What's that?
A. I'm not sure. I believe it's -- I believe it's regarding the -- sorry, what was the heading? It's gone again.
THE CHAIRMAN: There it is. (Handed).
A. "Research of evidence". I think that was regarding the use of the solution.
MR STEWART: Yes. And when would this note have been taken?
A. I don't know.
Q. Sorry?
A. I'm not sure.
Q. Well --
A. It probably was -- probably July 01. It must have been July --
Q. July 01. Okay. When it says reinforce in writing it's obviously not the six-point plan?
A. No.
Q. And who was it who did the research into the evidence?
A. Dr Nesbitt.
Q. Why do you say Dr Nesbitt?
A. Because that was the -- that was the research of the

evidence regarding fluid management.
Q. Well, let's have a look at the 9 July 2001 update to the chief executive. It appears at 022-097-307. Do you see the first paragraph, which is emboldened in bold type. It says:
"Further action required. Mrs Brown to undertake a more extensive review of the research."
That's you, isn't it?
A. Yes.
Q. There's note here "Research of evidence" in your handwriting, a note there from you that Mrs Brown is to do it. So did you do further research?
A. Yes, I do recall somewhere there's somewhere in the documentation where I was in contact with the library, Ciaran Cregan in the library and got a lot of research on articles that there were regarding --
Q. The director of nursing did that, not you.
A. No. Well, she did it with me, I was sent off to the library to get the evidence. I know I went down to the library and he gave me a whole printout of it.
Q. And did you research the evidence?
A. Well, he did for me because --
Q. He got you the material but did you research it?
A. I believe the research of the evidence for me would be to find it, not understand it.

THE CHAIRMAN: And then what happens? Okay, that's a start.
A. Yes.
THE CHAIRMAN: So you have identified materials, the librarian has helped you get them. Has he printed out a series of articles?
A. Yes.
THE CHAIRMAN: And what's the next step?
A. That would be for the clinical people to meet.
THE CHAIRMAN: So you would provide that to, what, doctors Fulton and Nesbitt?
A. I'm sure I would have done, yes.
MR STEWART: So when you wrote of yourself "Mrs Brown to undertake a more extensive review", you didn't mean that, you say. What you meant was Mrs Brown to go off and find the books and somebody else to undertake a review?
A. Yes. I wouldn't have had the clinical knowledge to do anything.
Q. So where in writing does that review of all the literature exist?
A. I don't think there is anything in writing regarding that.
Q. You don't think there is? Tell me, when you, the trust, receive the letter from the Permanent Secretary, Mr Gowdy, asking for all documentation to be located and

secured -- let's have a look at that again. It's at 021-017-035. He says:

"There is a need to ensure that all relevant records and documents are secured so that if necessary they can be made available for independent examination. The Department now requires you to take whatever steps were necessary to secure and keep safe all documentation."

You were then charged with the job of going off and securing the documentation, weren't you?

A. Well, if you look at the letter that then came from Mr O'Hara himself on 1 December --

Q. What's the reference for that?

A. 021-004. That's Mr O'Hara's letter.

Q. Mr O'Hara's letter.

THE CHAIRMAN: Me.

MR STEWART: 1 December.

A. It's the letter from Mr O'Hara, asking for the information. I think it was to be sent off on 10 December to the inquiry. So that was a request for the information to come in.

Q. This is the Permanent Secretary's request and in response to that this is what you do, and it appears at 021-012-029?

THE CHAIRMAN: If you've got 021-004-015 and 6 together, please. It's the penultimate paragraph on the first

page, I think, Mrs Brown. Sorry, it's the last paragraph on the first page:

"Therefore I would ask you to arrange for all notes, documents, records and reports relating to Raychel to be delivered to [the address]."

A. Yes. I sent those off -- well, there was, I think, six different files went off on the -- I received that on 6 December and I think they went off on the -- we were late. It went off on 13 December to your office. I think there were six box files went off of the case notes and the individual files that I'd retained the communication files other documentation, the information on Lucy Crawford that the Altnagelvin Trust held and the medical negligence file all went off.

MR STEWART: There's no doubt whatever that you did submit considerable quantities --

A. Yes.

Q. -- documentation.

A. Yes.

Q. The inquiry's very much interested to know whether or not there yet exists quantities of information that you have not provided the inquiry and that is why I'm asking this series of questions. Can I ask please to have a look at 021-012-029, because this is your direct response to --

A. Yes.

Q. -- what you were asked to do in consequence of Mr Gowdy's letter to secure all documentation in relation to those three individuals, Raychel Ferguson, and you say:

"I have secured all the paper records relating to the matter."

A. Yes.

Q. Did you go and get the director of nursing, Miss Duddy's, paper records relating to the matter?

A. Yes, I think I did because there is a copy of Ms Duddy's -- she had very limited information, but there's a copy definitely of one of her papers in the papers that went off because you showed it earlier. So yes, I believe I did.

Q. Okay. What about the clinical services manager who was also at the meeting, did you get her paper records?

A. I didn't. I accept that I didn't. But this information was going to Tom -- this was going to Tom Melaugh to try to get information off people's computers.

Q. Sorry, can I just stop you?

A. Yes, I didn't --

Q. You did not go to the clinical services manager --

A. No.

Q. -- who was part of your critical incident review team,

who was part of the nurses' meeting that you updated the chief executive with, who had collected together information from interviews and who prepared a report for the critical incident review, and you didn't go and ask her about her paper records?

A. No, I didn't believe she had any.

Q. What about Mrs Witherow, the clinical effectiveness coordinator? Did you go to her?

A. No.

Q. Well, she was at the critical incident review, she was at the nurses' meeting, she was involved in these issues and sat on these committees. Why didn't you go to her either?

A. I didn't believe she would have any information on computer. I mean, I can't explain why I didn't go to her.

Q. What about the following list towards the bottom of the page:

"I understand that information may be held on the following computers."

You don't have Ms Duddy there, do you?

A. No.

Q. Why not?

A. Ms Duddy's secretary and my -- was my secretary as well at the same time. I don't believe --

Q. So?
THE CHAIRMAN: But that doesn't mean that the information which is held on your computer is the same as the information which is held on Ms Duddy's computer.
A. No, I accept that.
THE CHAIRMAN: Because there has to be a separation between you, doesn't there?
A. That was the -- yes.
THE CHAIRMAN: Okay.
MR STEWART: Do you think you should go back to the trust and perhaps look for any more documentation?
A. Yes. In actual fact, since we've had -- we have done that. There has been requests through our IT department to track back Ms Duddy's computer, and they have been trying to pull off information and documentation off those computers, they were trying to track back the hard drives. So yes, that has happened. That's happened. There have been searches on all of those computers. Mrs Burnside's secretary's computer has been searched. The IT have been asked to contact and go through all of that. This has been going on for the last six months since the inquiry have been asking for information.
Q. This is something you should have done almost 10 years ago.
A. I agree. It should have --

Q. What about the board minutes? Board meeting minutes? The chairman made a point on --
A. Yes.
Q. I think Thursday --
A. Yes.
Q. -- that there would be more than one set of minutes circulating because clearly the individual members of the board, the directors, have to be able to read them and signify their agreement with them. So what efforts have been made to track down the missing board minutes?
A. The very point that you're make something that I have gone back to the then chief executive's secretary, who still happens to be in the trust in a different role, asked them to try and identify who all would have been at the board meeting. I understand that for non-executive directors who would have been at the board meeting -- because there would have been hard copies, they wouldn't have been emailed -- the non-executive directors were always asked to hand back their papers, I believe for shredding if they wished, or -- you know, so that was -- so we wouldn't go to the non-executive directors, they no longer are non-executive directors.
We have checked -- the other trust members are no longer employed and Dr Nesbitt is the -- no, Dr Nesbitt wasn't on the board. No one who was on the board

in July 01 is still working in the trust.
Q. Do you think, given your concession that you didn't go to the clinical services manager for records and you didn't go to the clinical effectiveness manager for records and you didn't go to the director of nursing for computer records, do you think in the light of that that you have co-operated with this inquiry?
A. I do believe that the evidence will show from the documentation from the e-mails that I have sent round the organisation and before I was no longer allowed to -- well, I was asked that I would no longer take part in that, the e-mails, there are hundreds of them, trying to assist and provide and -- the inquiry in all their documentation requests.
Q. In your position within the trust, do you belong to any professional association or organisation of Health Service managers?
A. No.
Q. So you're not subject to any codes of ethics or behaviour?
A. I'm subject to my contract of employment. If I was -- and if I was failing to provide information, I would believe that would be a disciplinary matter. If I -- so that is -- it's the code of employment and my own personal views on being honest and truthful. So that's

what I stand by.
Q. And do you also subscribe to the public service values of those who work for the Health Service --
A. Yes.
Q. -- that there should be sufficient transparency about NHS activities to promote confidence between the NHS authority or trust and its staff, patients and the public?
A. Yes.
Q. You do?
THE CHAIRMAN: Okay.
MR STEWART: Thank you. I have no further questions, sir.
THE CHAIRMAN: Mr Quinn, have we covered all the ground?

Questions from MR QUINN

MR QUINN: We've got a couple of questions to ask.
Mr Chairman, in relation to the Jenkins report and the Warde report, the witness has said that she would have relied on the DLS to furnish the reports to the coroner. We know -- and I don't want to go into this in any great depth, it is late -- we know that this witness was tasked with collecting and coordinating the provision of statements to the coroner. We've seen a lot of information, e-mails and letters on that, and I want to ask then, setting that as a background -- I want you to ask, sir, who did send the Jenkins report

to the coroner.
THE CHAIRMAN: Can you recall if that went from DLS or from the trust?
A. It absolutely -- it didn't go from the trust.
MR STEWART: We've looked at this, sir, and it was DLS. It was at 012-070b-386.
THE CHAIRMAN: Yes, that's dated 20 --
MR STEWART: 30 January 2003 is the letter from --
THE CHAIRMAN: Yes, 30 January 2003, thank you.
MR QUINN: And would you have been copied in to that letter?
A. No, I don't see that I was copied into it.
Q. Would you have made any enquiries from Donna Scott as to what reports had been sent?
A. I don't recall doing so. I should have done so. I understood that the Warde report was going and that Dr Jenkins report -- that was my knowledge at the time. I didn't -- I should have done and I didn't.
THE CHAIRMAN: Thank you.
Before I come to Mr Stitt, any other questions from the floor? No?
Mr Stitt?
Questions from MR STITT
MR STITT: One thing through you, sir. If I could ask you to go back, you may or may not want to go back, I can read it, but it's page 21 of today's draft transcript.

THE CHAIRMAN: I'm afraid, Mrs Brown, this is the only document we can't bring up for you, today's transcript. Bear with us for a moment.
MR STITT: The background, while you're scrolling that -- it was to do with the statement made by the witness that:
"I mean, it's still being discussed today, it's been discussed in this inquiry so it's been discussed at length."
And Mr Stewart asked how many committees has it been, and the witness wasn't able to or didn't provide any further -- I think you came in at that point:
"And let he ask you about one particular committee that Ms Duddy refers to."
And you refer to the risk management standards committee --
THE CHAIRMAN: Yes.
MR STITT: -- which does have formal minutes, you see? And I wanted to come in on the back of that through you, sir, to ask if you would consider asking the witness -- if a document could be pulled up, which -- bear with me one second. If the witness could be asked if she is -- yes, this document, inquiry reference 316-006j-004.
THE CHAIRMAN: Okay.
MR STITT: I'm advised that this is a minute of the hospital management committee, and I wonder if you would consider

asking the witness to tell the inquiry what level of committee that is and whether the reference to the report on fluid balance is at all germane to this issue.
THE CHAIRMAN: Right. So the first point, if you could outline who's on the hospital management committee.
A. I wasn't on it. I believe it was -- I think Ms Duddy outlined for you earlier last Thursday. It would have been the clinical directors and the clinical services managers, and the chief executive didn't always sit on it, I think, a deputy chief executive may have sat. So it'd have been the management team, the clinical services managers and the clinical directors.
THE CHAIRMAN: Thank you. So --
A. Mrs Burnside obviously did sit on it, but I don't think she was on every meeting. Sometimes it was herself or the deputy chief exec.
THE CHAIRMAN: But in other words, it's a very significant committee with that line-up of members.
A. Yes.
THE CHAIRMAN: And then --
A. I wasn't senior enough to sit on it, chair.
THE CHAIRMAN: And then the report on fluid balance, is this -- this is Raychel-related, isn't it, because it says below the three bullet points that that Dr Nesbitt referred to the recent death of a nine-year-old child.

A. Yes.
THE CHAIRMAN: And in brackets at the end of that there's a copy of the presentation made could be obtained through the offices of the chief executive.
MR STITT: Dr Nesbitt no doubt will be asked about this tomorrow. I can't take the witness any further. She wasn't present. But could I ask you, sir, to consider asking her one further question?
Could she in the same vein help the inquiry in relation to the drugs and therapeutics committee, could the witness perhaps explain to the inquiry the level of seniority and what that does? It's the same point and Dr Nesbitt will deal with it.
A. It's more or less -- again, I do sit on it now in the current Western Trust but in the Altnagelvin Trust I didn't sit on the drugs and therapeutic committee. It was the -- I believe the medical director chaired it, I could be wrong, the head of pharmacy and a number of senior clinicians in the organisation, and it was very doctor orientated, I think. Some nurses were on it as well, some senior nurses, but I think it was mainly very doctor orientated and pharmacy orientated.
MR STEWART: And the clinical services manager played a major part in it?
A. In the drugs and therapeutic? I'm not sure -- I could

be wrong. Dr Nesbitt may well say I'm wrong but I believe they were in the hospital management team. I'm not sure they were all in the drugs and therapeutic committee.

THE CHAIRMAN: Okay. Thank you very much.

MR QUINN: Mr Chairman, just before the witness leaves the witness box, could I ask just for some clarification on the documents that were recently discovered just after lunch? That is a document, Mr Chairman, that you held up, which is the spreadsheet with the written instructions on the side, PU vomit, IV fluids management, U&E taken post-op. It's about halfway through your bundle, Mr Chairman.

THE CHAIRMAN: I've got it.

MR QUINN: We're not quite sure what this means and what the instruction is. The 04/06/1, Ward 6, did you take that, Mr Chairman, to refer to Raychel even though it is the wrong date?

THE CHAIRMAN: No.

MR QUINN: It's another child we're talking about?

A. It's a different case.

THE CHAIRMAN: But I'm taking it as that, because it's not a child who may be identifiable there's a limit to --

MR QUINN: Of course.

THE CHAIRMAN: Am I right in taking it to be a different

child?

A. I believe it is and I do believe it is.

MR QUINN: Can we ask the witness, then, were these instructions then, these bullet point on the side of the page, were they written in relation to the child of 04/06?

A. No, I think they were written in relation to Raychel.

MR QUINN: That's where the confusion's arising on our team.

THE CHAIRMAN: Thank you very much.

MR QUINN: And Solution No. 18 Ulster, that was Raychel?

A. Yes.

THE CHAIRMAN: Okay. Thank you very much indeed. We've finished everything we want. Mrs Brown, thank you very much for coming, unless there's anything you want to say --

A. No, chair, just that I didn't get reading Dr Carson's evidence and I was surprised -- was slightly surprised for somebody working on the ground your comments that he said things hadn't changed. My experience working on the ground is that doctors particularly are very keen to learn from mistakes.

THE CHAIRMAN: Yes. Sorry, maybe I've overstated it or maybe you picked it up wrong. I think he said it had improved but it's still a problem.

A. Right.

THE CHAIRMAN: Okay?

A. Okay. Thank you.

THE CHAIRMAN: Tomorrow morning, 10 o'clock, for Dr Nesbitt. Thank you.

(4.52 pm)

(The hearing adjourned until 10.00 am the following day)