

(10.00 am)

(Delay in proceedings)

(10.30 am)

THE CHAIRMAN: Good morning. Just before we start, Mr Stitt, I'm hoping that we don't continue with yesterday's exchanges. Just let me clear the air on one point. I said to you yesterday afternoon a line about your advocacy and I want to explain that perhaps more eloquently than I did at the time.

You and I have been doing cases against each other for more than 30 years. I haven't ever had a difficulty with your advocacy in the past and I don't have any difficulty with your advocacy in the inquiry.

My concern is this, that sometimes as advocates, as you and I know, and as every other barrister in this inquiry knows, we are instructed on behalf of our clients to advance contentions and lines which are not necessarily supported on a clear analysis of the evidence or a realistic analysis of the evidence. When that happens, it then falls to barristers, and in this case it falls to you, in some respects, to advance those lines on behalf of the trust.

I'm afraid that no matter how well you do it or no matter how well any other barrister in that situation

does it, those lines are still unpersuasive and those lines are still more pointedly against the weight of the evidence as it has been given to date. One example is the apparent notion which is held in the trust that there is or should be no concern about the privilege issue. Because the trust was able to claim privilege, and did so, I think there seems to be a view abroad that that's the end of the issue, and it's not. It might be the end of the issue in a case, but in the context of an inquiry it's not the end of the issue. I'm just picking that as one example.

For the record, I have stated over and over again in various respects that what Altnagelvin did after Raychel's death was positive, and certainly better than anything that was done in the Royal following the deaths of the children there, and I said that. You will remember that I was saying that during the hearings in February and March, long before there was a report from Dr Swainson, which is in some respects along the same lines.

So as we start in a few moments with Mr Gilliland, let me reaffirm that I will continue to listen to the evidence, which is going to unfold over the next three to four weeks. I will do that against the backdrop of what we've already heard over 21 days in February and

March on the clinical issues, which inevitably runs over into the governance issues in many respects, and I hope that we can get through it perhaps more concisely than in some ways we did yesterday.

MR STITT: I'm grateful for your observations, Mr Chairman. I too will be mindful of your various observations.

THE CHAIRMAN: Thank you. Mr Stewart?

MR QUINN: Mr Chairman, can I just make the point before the witness is called. You had indicated at the start of the week that there'd be some housekeeping issues that would be dealt with, and my solicitor reminded me yesterday that there is some ongoing doubt about the timetable and what weeks we're sitting. Perhaps, Mr Chairman, before lunch we could deal with that point.

THE CHAIRMAN: Well, we'll deal with it at some point today. I'm afraid I started a bit late for various reasons, so I'm anxious to get Mr Gilliland's evidence done now. We'll sort that out at some point today, whether it's at 4 o'clock, 4.30.

MR QUINN: That's fine.

THE CHAIRMAN: Mr Gilliland.

MR ROBERT GILLILAND (called)

Questions from MR STEWART

MR STEWART: Mr Gilliland, since your last appearance here

on 14 March, you have submitted a further witness statement, which is WS044/4, which you submitted on 5 July 2013. Are you content that the inquiry should adopt that as your formal evidence?

A. Yes.

Q. Thank you. If I might recap some of your evidence so that we may refocus on some of the issues in relation to the systems at Altnagelvin Hospital. It has been your evidence, first of all, that it was your responsibility as admitting consultant to oversee Raychel's care. You have also indicated that the admitting consultant is the individual with overall responsibility for ensuring that there was a system that would deliver care to the patient. Does that accord with your view still? Thank you.

In fact, what I'd like to do, if I may, for a short time is to examine with you whether those systems were in place and whether they were working at the time of Raychel's admission.

In your role within the hospital, to whom were you immediately accountable in line management terms?

A. In line management terms, I would have been immediately accountable to my clinical director and then to the medical director.

Q. And your clinical director was?

1 A. Paul Bateson.  
2 Q. Within the paediatrics directorate, was there a clinical  
3 director with responsibility for paediatrics?  
4 A. Yes, there would have been.  
5 Q. Can you recall who that was?  
6 A. No, I can't.  
7 Q. Was it a Dr Denis Martin?  
8 A. Yes, it could have been, because I think that  
9 directorate is joined with obstetrics and gynaecology.  
10 Q. Can you recall whether Dr Martin had anything to do with  
11 the paediatrics department?  
12 A. I wouldn't know one way or the other.  
13 Q. Because you were operating on child patients, you were  
14 part of the paediatric department, were you?  
15 A. No, no, we would have been part of the general surgical  
16 department and we would have had patients who were  
17 children.  
18 Q. The reason I ask you this is because your name appears  
19 as part of the complement of the Ward 6 team. WS323/1,  
20 page 39.  
21 This is a page from November 2000, benchmarking  
22 exercise, and it goes to Ward 6, and looks at it, this  
23 is the opening page of the report, and it describes what  
24 Ward 6 is, it gives the complement of nursing staff, and  
25 there it describes the identity of all the individual

1 consultants who might be attached to Ward 6, and there  
2 we have all the surgeons, including yourself.  
3 So that document would seem to indicate, in terms of  
4 Ward 6, that there is a team of individual specialists  
5 who can be drawn upon for the healthcare of children.  
6 A. I wouldn't interpret it that way. That simply is a list  
7 of the surgical consultants currently working in  
8 Altnagelvin at that time, all of whom would have had  
9 patients in the paediatric unit at one time or another,  
10 and you'll see that there are two orthopaedic  
11 consultants mentioned there as well, who would have had  
12 children in the paediatric ward.  
13 Q. Really what you're identifying is the fact that there  
14 are different disciplines coming together to work with  
15 children?  
16 A. Yes.  
17 Q. So it's a multidisciplinary area or treatment?  
18 A. Yes. The paediatric ward contained both surgical and  
19 medical patients.  
20 THE CHAIRMAN: In the same way, then, you could put in  
21 anaesthetists there? But they're not actually part of  
22 Ward 6, but from time to time they're involved in the  
23 care?  
24 A. Yes, they're involved in the care but they don't have  
25 ongoing patient responsibility, so therefore these are

1 the named consultants who would have had patients under  
2 their care in the paediatric unit.  
3 THE CHAIRMAN: Yes.  
4 MR STEWART: So within a multidisciplinary system,  
5 individuals are reporting, in line management terms, to  
6 different individuals?  
7 A. That would be correct.  
8 Q. Was there any structure within the paediatrics whereby  
9 people from each of these different disciplines could  
10 meet in multidisciplinary committees to iron out  
11 differences that might emerge between them?  
12 A. Not that I recall. The clinical directors would have  
13 met as a group, but I wasn't involved in any of those  
14 meetings, and I don't remember a joint meeting between  
15 surgery, orthopaedics and paediatrics, namely the people  
16 you have mentioned there.  
17 Q. Were there ever any meetings between the ward sisters,  
18 the nursing staff and the surgeons who operated on  
19 children?  
20 A. I don't recall a formal meeting between the sisters and  
21 consultants at that stage.  
22 Q. You leave open the possibility that there were informal  
23 meetings.  
24 A. Well, there were -- we would have talked to the sisters  
25 on the ward on a regular basis when we were up and down

1 to the ward, but I don't remember any meeting where  
2 everyone sat down around a table.  
3 Q. If there was an issue which the nurses had in relation  
4 to surgeons, where would they raise that, in what  
5 committee would they raise that issue?  
6 A. I don't think they would have raised it in a particular  
7 committee, I think they would have probably raised it  
8 directly to the clinical director.  
9 Q. Which clinical director?  
10 A. If it was a surgical issue, they would have raised it to  
11 Mr Bateson, if it was an issue to do with medical  
12 paediatrics they would have raised it to one of their  
13 own consultants or possibly to Dr Martin, but more  
14 likely to one of their own consultants.  
15 Q. So it's less likely they would go to their own clinical  
16 director?  
17 A. I would have thought because Dr Martin's responsibility  
18 was largely in obstetrics and gynaecology and the  
19 medical paediatric consultants were on their ward all of  
20 the time that the nursing staff would be able to iron  
21 out any difficulties directly with their own medical  
22 staff.  
23 Q. You see, Sister Millar had an issue, she had an issue  
24 with the difficulty getting surgical medical staff to  
25 come to attend to her children in Ward 6, and it's said

1 that she raised that at what she called a consultants  
2 meeting, which may have been what consultants called  
3 a sisters' meeting, but she had been raising it with  
4 paediatricians, not with surgeons.  
5 A. I don't know who Sister Millar raised that with.  
6 I wasn't present at that time, I don't think.  
7 Q. So would consultant surgeons have met with the  
8 consultant paediatricians?  
9 A. Not on a formal basis, no, there was no committee.  
10 Q. The system of communication seems to be very loose and  
11 not structuralised?  
12 A. I think there is a structure in that the two clinical  
13 directors would have met in the clinical directors'  
14 meeting, but there were open lines of communication  
15 between ourselves and the medical paediatric  
16 consultants.  
17 THE CHAIRMAN: Does it depend then on how serious the issue  
18 is? If it's a passing thing that can be done  
19 paediatrician to surgeon, but if there's an issue such  
20 as this where the nurses are saying, "Look, we have  
21 trouble getting surgeons", and in a sense it's not  
22 a criticism of any individual surgeon because they have  
23 other responsibilities, but it's a simple reflection of  
24 the fact that paediatricians are inevitably around  
25 Ward 6 and surgeons are inevitably not around Ward 6.

9

1 Looking at it from this stance, is that an issue, if the  
2 nurses raise that with the paediatricians, how might you  
3 expect that to be followed forward to see if there's  
4 a way round it? Would you expect that to go from the  
5 paediatric clinical director to surgical clinical  
6 director, or what can you suggest as a way to explore  
7 that?  
8 A. I think it certainly could have been done that way, but  
9 I think it's much more likely that the nursing staff, if  
10 they'd had a difficulty with getting surgical staff,  
11 would have raised it with one of the surgeons or  
12 directly with Mr Bateson.  
13 THE CHAIRMAN: Right.  
14 MR STEWART: With hindsight, would it have been better to  
15 have a formal system where people brought their  
16 individual issues to the right people within a minuted  
17 formalised structure?  
18 A. I'm not sure that that would necessarily be the best  
19 way. From my experience in working in Altnagelvin,  
20 there were very open lines of communication between  
21 nursing staff, surgical staff and paediatric medical  
22 staff, and I think any of those issues could have been  
23 raised in that informal form and hopefully would have  
24 been able to be sorted out.  
25 Q. Why wouldn't it be better to formalise it and minute it?

10

1 A. I wasn't saying that it would be better one way or the  
2 other, I just think that the informal method seemed to  
3 be working at that stage, and I'm not aware that there  
4 was any formal meeting between nursing staff, paediatric  
5 medical staff and surgical consultant staff.  
6 THE CHAIRMAN: Does this issue depend on how serious the  
7 problem appears to be? The more serious it is, the more  
8 inclined one might be to go formal on it?  
9 A. Possibly.  
10 THE CHAIRMAN: You might start off trying to resolve it  
11 informally?  
12 A. Yes, that's possible.  
13 THE CHAIRMAN: And then by somebody like Sister Millar  
14 saying to somebody like you, "Look, we need to sort  
15 something out, we need to sort out something better here  
16 and you can discuss it with your colleagues", and if  
17 that's done and it doesn't work, and it is an issue of  
18 significance to the nursing staff, then it can be  
19 stepped up a bit?  
20 A. More formally, yes.  
21 THE CHAIRMAN: Right.  
22 MR STEWART: You said in your most recent witness statement  
23 that:  
24 "I do not recall what systems were in place in 2001  
25 for quality assuring the safe provision of patient

11

1 care."  
2 Did you really mean that? Can you not remember any  
3 systems for quality assuring patient care?  
4 A. Well, there were a number of systems such as audit and  
5 the morbidity mortality meetings, and those sort of  
6 things. What I was really referring to is I don't  
7 remember those being formalised in a written format and  
8 I don't remember reading any of those -- reading any  
9 formal protocol for them. But certainly audit was in  
10 place and the morbidity mortality meeting was in place.  
11 Q. I see. You were in a position where really you were  
12 dealing with your patients and you were the leader of  
13 a small specialty team. So in that context you have  
14 said that you would need for satisfied that anyone  
15 delivering clinical care was appropriately qualified and  
16 competent to do so.  
17 A. Yes.  
18 Q. I wonder, can we just look at that a bit to see how you  
19 went about satisfying yourself that the team were  
20 qualified and competent. First of all, you'd have to  
21 know who the patient was and what their condition was  
22 before you could go about working out the  
23 appropriateness of the member of the team dealing with  
24 the patient?  
25 A. You wouldn't necessarily need to know the patients

12

1 per se, but you would need to know the potential  
2 condition that they had.  
3 Q. It seems there was no protocol for ensuring that the  
4 on-call consultant was informed of patients admitted  
5 under their care. So if you weren't being informed of  
6 people admitted under your care, how could you possibly  
7 judge whether or not the team members looking after them  
8 were competent and capable to do so?  
9 A. Yes, there wasn't -- there wasn't a protocol at that  
10 stage. They method of ascertaining the patients that  
11 were under your care after an evening after a period of  
12 on call was to start in the -- usually in the adult  
13 wards and work your way through the wards, and the  
14 nursing staff would inform you of any patients that had  
15 been admitted overnight under your care. You would see  
16 those patients. At the end of that ward round you would  
17 assess -- you would ask the team had they heard of any  
18 other patients that were admitted, you might well check  
19 in the other wards where those patients were likely to  
20 be admitted, or you might well send one of your members  
21 of the team to check on those wards and see if there  
22 were patients there.  
23 Q. Why couldn't you simply telephone yourself, telephone  
24 the ward late in the evening to say, "Anybody admitted?"  
25 A. Telephone the ward late in the evening?

13

1 Q. Yes.  
2 A. That wasn't the protocol at that stage and, of course,  
3 telephoning the ward late in the evening wouldn't  
4 necessarily have captured all the patients. Your period  
5 of on call was from 9 am to 9 am.  
6 Q. I know there was no protocol. I'm asking you why you  
7 couldn't have telephoned in to find out?  
8 A. Well, one could have telephoned in, but again, as  
9 I said, that wouldn't have captured all of the patients.  
10 Q. Could you alternatively have insisted that your junior  
11 medical staff inform you? Could they telephone you,  
12 leave a message on your answering machine, or mobile  
13 telephone?  
14 A. You could insist that every time a patient was admitted  
15 that you were informed, but that wasn't the normal  
16 practice then, nor is it now.  
17 Q. Well, given that you didn't always do the post-take ward  
18 round, shouldn't you have put in place a system to  
19 ensure that you knew if you weren't going to be at the  
20 ward round?  
21 A. Well, my evidence is that I almost certainly did do  
22 a ward round that morning.  
23 Q. No, I'm asking you whether or not, because you're not  
24 always doing a ward round, should you not have had  
25 a system?

14

1 A. I will have done a post-take ward round, I think, almost  
2 every time that I was on take.  
3 Q. Well, we know, because we're looking at one particular  
4 instance, one day, that you didn't do it.  
5 A. No, we know that I didn't see that particular patient.  
6 Q. Yes. We'll come to that in a moment as to whether or  
7 not you were there and whether or not you knew about  
8 Raychel.  
9 So if you have no system to find out if there's  
10 anybody there under your care, what system did you have  
11 to find out whether the doctors in your team were  
12 competent and qualified to look after the children?  
13 A. Well, their qualifications will have been checked at the  
14 time of their interview. All of the doctors will have  
15 been through a selection and interview process that will  
16 have ensured that they were qualified to do the job that  
17 they were being appointed to do.  
18 As I've said in my written evidence, competence is  
19 an ongoing assessment, and one fairly quickly becomes  
20 aware of the level of competence of individual doctors  
21 whilst working with them. It's a global assessment  
22 that is ongoing and that is how most doctors' competence  
23 is assessed.  
24 Q. Is it not correct to say that children, as patients,  
25 behave differently from adults and some experience of

15

1 paediatrics, looking after children, is very useful?  
2 A. Yes. It's always useful to have experience when dealing  
3 with any particular patient.  
4 Q. In relation to your team, you didn't do the post-take  
5 ward round and your registrar didn't do the post-take  
6 ward round, but an SHO, Dr Zafar, did.  
7 A. Yes.  
8 Q. What sort of experience of paediatrics did he have?  
9 A. Mr Zafar had not done any paediatrics before he came to  
10 us, but he had been with us for four months at that  
11 stage.  
12 Q. He gave evidence on 1 March of this year as to what his  
13 paediatric experience was, and we can call up the  
14 transcript for 1 March 2013, page 143 and 144.  
15 143, line 25.  
16 "Question: Does that mean not only was Altnagelvin  
17 your first position where you had anything to do with  
18 paediatric patients, but actually you may not have had  
19 very many paediatric patients before Raychel; would that  
20 be fair?  
21 "Answer: Yes."  
22 So there's a doctor who is delegated as part of your  
23 team to attend upon Raychel and he doesn't look as  
24 though he's got much experience at all.  
25 A. Well, I think he's had considerable experience of

16

1 looking after patients. He had done 18 months general  
2 surgery in Russia, 30 months attachment in the  
3 United Kingdom, and he had a lot of experience as  
4 a cardiac surgeon, both at SHO and registrar level.  
5 I would have thought he would be fairly competent to  
6 work out if a patient was progressing normally or if  
7 a patient was sick.  
8 Q. You can see that he didn't have paediatric experience,  
9 which was the point I was making to you.  
10 A. Yes, but I think it is, you know -- the issue here is  
11 whether someone is progressing normally and  
12 satisfactorily, whether someone is well or someone is  
13 not well, and I think someone of Mr Zafar's experience  
14 who had his FRCS qualification and a significant amount  
15 of experience would be able to tell whether a patient  
16 was progressing normally or whether they were not.  
17 Q. Did he have his FRCS qualification?  
18 A. Yes.  
19 Q. I'll stand to be corrected on that. I think he had  
20 parts 1 and 2.  
21 A. I believe that he had the AFRCRS, which, as far as I can  
22 recall, was the equivalent.  
23 Q. Very well. In relation to the rest of the team of  
24 doctors, part of your team, who went to attend upon  
25 Raychel during the day of 8 June, they were all junior

17

1 house officers, pre-registration house officers.  
2 A. Yes, that's correct.  
3 Q. So they hadn't even finished their basic medical  
4 training.  
5 A. They had finished their basic medical training but they  
6 were not fully registered with the GMC.  
7 Q. I'm sure some of those young doctors are very able and  
8 talented young doctors, but I'm sure others of them,  
9 like other junior lawyers, maybe are not to be relied  
10 upon. Would that be fair?  
11 A. I think there's a range of ability in all grades of  
12 doctors.  
13 Q. Indeed some junior doctors really have to be really led  
14 by the nursing staff?  
15 A. That would be a common practice.  
16 Q. Is it correct that after Raychel's death, in fact  
17 juniors were taken away from Ward 6?  
18 A. I can't remember the exact timing of that, but there was  
19 at that stage in any case a move towards not allowing  
20 pre-registration house officers to be in certain  
21 specialties.  
22 Q. How long had that move been gathering pace for?  
23 A. I think it had been gathering pace in different  
24 specialties at different times. They were removed from  
25 Accident & Emergency departments around 1994 --

18

1 1984/1985. I don't think they were doing neurosurgery  
2 for a number of years before that.  
3 Q. Yes. And in paediatrics?  
4 A. I'm not sure the time frame.  
5 THE CHAIRMAN: I think I have to say it was described to us  
6 as a consequence of Raychel's death, unless I'm  
7 mistaken. The reliance -- the move away from  
8 pre-registration doctors to slightly more senior doctors  
9 was intimated to us to be a consequence of Raychel's  
10 death rather than something that was in train anyway.  
11 Is that not how you remember it?  
12 A. Is this in Altnagelvin or across --  
13 THE CHAIRMAN: In Altnagelvin.  
14 A. I don't remember for certain.  
15 THE CHAIRMAN: I'm not saying -- it might have been in the  
16 air but was hastened by Raychel's death, but -- I'm  
17 subject to correction -- it was described to us in  
18 February and March as a consequence of Raychel's death.  
19 A. I don't remember for certain if that was the specific  
20 incident that caused that change.  
21 MR STEWART: That sort of idea that juniors should be taken  
22 away from certain specialties, would that have found  
23 expression in the BMJ, for example? Is that where we  
24 would go to look and find out how long that notion had  
25 been abroad for?

19

1 A. I don't know that one would necessarily be able to find  
2 it within the BMJ. There's almost certainly some  
3 literature out there about that, but I wouldn't know for  
4 sure where one would go to find that.  
5 Q. So if some juniors really couldn't be relied upon and  
6 they would look to nursing staff for a steer, then the  
7 nursing staff are the fallback position, the safety net.  
8 Would you, as the individual responsible for the system  
9 of care, have to reassure yourself that the nursing  
10 staff were competent and fit?  
11 A. Well, again, I presume that the nursing staff also had  
12 been through a selection and interview process, which  
13 determined that they were fit to do that job, but  
14 I would have had no method per se of being able to  
15 formally assess the performance of any member of the  
16 nursing staff.  
17 Q. But you're making a number of assumptions there, aren't  
18 you? You're assuming that people, because they have  
19 a qualification, are competent. You're assuming that  
20 nurses by the very fact that they're there are  
21 competent?  
22 A. Yes.  
23 Q. The whole system is running on a system of assumptions?  
24 A. I think there's is a certain amount of truth in that.  
25 One has to assume if someone -- if a member of the

20

1 medical staff comes to you with a certain amount of  
2 training, a certain amount of experience, that they have  
3 a number of competencies, and that has to be simply  
4 assumed. It still is today.

5 Q. In 2001, all doctors were subject to the GMC's Good  
6 Medical Practice guidelines, setting out duties and  
7 responsibilities of doctors. Paragraph 37 of the Good  
8 Medical Practice guidelines deals with leading teams.  
9 It appears at 314-014-016.

10 I know that you would be familiar with this at the  
11 time. The penultimate bullet point says:

12 "If you lead a team, you must ensure that: regular  
13 reviews and audit of the standards and performance of  
14 the team are undertaken and any deficiencies are  
15 addressed."

16 So it looks as though the GMC were charging you with  
17 the obligation to review and audit the performance  
18 standards of your team and address deficiencies.

19 What did you do in order to comply with that  
20 obligation?

21 A. Well, we carried out a number of audits, but they were  
22 largely audits into patient care rather than audits into  
23 the performance of a team or of individuals within that  
24 team.

25 Q. Yes.

21

1 A. I'm not sure that I can recall ever having been involved  
2 in either personally or elsewhere, of an audit that  
3 looked at performance. Performance of junior staff is  
4 usually assessed globally, and there are now more formal  
5 methods of reporting that to the individual and  
6 reporting it to the training -- those who were  
7 responsible for their training.

8 THE CHAIRMAN: If you take the penultimate bullet point that  
9 Mr Stewart has just asked you about, in effect are you  
10 saying that that is something which isn't really adhered  
11 to?

12 A. No.

13 THE CHAIRMAN: Or is it adhered to but in some sort of  
14 informal way?

15 A. No, I think specifically I was focusing on the point of  
16 audit, and I'm not quite sure how one would audit the  
17 standards of a particular individual. But regular  
18 reviews of individuals were carried out at that time.  
19 All of the registrars went through a formal record of  
20 in-training assessment, which was carried out at the end  
21 of their six-month attachment. Those forms are  
22 forwarded to the deanery.

23 The JHos -- sorry, the pre-registration house  
24 officers also went through a formal process where they  
25 had to be signed off as being satisfactory and having

22

1 completed their year satisfactorily before they would be  
2 registered with the GMC.

3 I don't think at that stage that there was a formal  
4 process in place for SHOs, but that came in very shortly  
5 afterwards. So there were regular reviews of  
6 performance, both formally and informally, and a review  
7 of progress could simply be if someone had been on call  
8 the night before and they had not made a correct  
9 assessment of a patient, then that would be informally  
10 reviewed in the morning and would be used as a learning  
11 point. But the formal reviews were usually reserved for  
12 the end of attachments.

13 MR STEWART: Was there any documentary trail left by any of  
14 the reviews and audits that you mentioned?

15 A. There would be a documentary trail left of the JHO  
16 sign-offs and of the record of in-training assessments  
17 of all of the registrars.

18 Q. You use the phrase they "Oh, they would have been  
19 assessed globally", which is sort of rather  
20 a broad-brush type of description. Presumably in order  
21 to assess people, you have to have standards against  
22 which to assess them? You have to have a benchmark  
23 against which to judge their performance?

24 A. That benchmark is what one would expect from a person  
25 in that grade and if they're progressing normally.

23

1 Q. Now, there are guidelines and recommendations published,  
2 and there were then, for example, the NCEPOD  
3 recommendations, which this inquiry has already focused  
4 on. Your evidence was that you weren't aware of these,  
5 or "not that I recall".

6 To what extent was it possible to properly assess  
7 performance if you weren't using a benchmark,  
8 recommendation from outside the hospital?

9 A. I think those are probably two separate issues. The  
10 review of a performance of an individual doctor would be  
11 based on what one would expect their performance to be.  
12 And having gone through a surgical training scheme  
13 oneself, one would know what the level of performance of  
14 an individual doctor would be at. CEPOD was making  
15 a recommendation about practice, not necessarily about  
16 the review or training of any particular individual.

17 Q. Surely if you're reviewing performance in any given  
18 case, it's very useful to know what the practice ought  
19 to have been?

20 A. It's useful to know what -- well, again, I think we're  
21 talking at two slightly different situations here. On  
22 the one hand we're talking about regular review of the  
23 performance of individuals within a team, which, as I've  
24 tried to explain, I think, is something that one would  
25 do informally throughout a six-month attachment and then

24

1 more formally at the end when one would sit down and  
2 review their progress and say whether or not they were  
3 fit to progress to the next stage of training. But  
4 CEPOD was doing something different, it was talking  
5 about practice within a hospital setting.  
6 THE CHAIRMAN: In very crude summary terms, CEPOD is talking  
7 about improving practice; is that fair?  
8 A. CEPOD is looking at what has happened before --  
9 THE CHAIRMAN: Yes.  
10 A. -- and is making recommendations as to what should  
11 happen in practice, based on that.  
12 THE CHAIRMAN: Yes, but it's saying, "This might be the way  
13 things have been done before, but we can do them a bit  
14 better by adding X, Y and Z to A, B and C".  
15 A. That is what they're trying to do.  
16 THE CHAIRMAN: Let me take it out of Altnagelvin and away  
17 from you. Let's suppose that you have a hospital where  
18 there is a consultant who's okay -- right? -- but that's  
19 the level of his or her performance, it's okay, and that  
20 consultant is then reviewing at the end of six months  
21 the performance of a junior doctor to decide whether  
22 that doctor is okay to go on to the next stage. What  
23 confidence can people have in that assessment or review  
24 of the junior doctor if the person who's conducting the  
25 review is okay, hasn't had any major disasters but is

25

1 just not very good and isn't up to date with  
2 recommendations about what current practice should be or  
3 what better practices should be?  
4 A. Well, I see the point you're trying to make, but that  
5 has been the system that has been in place for some  
6 time.  
7 THE CHAIRMAN: Yes. And that's, I think, why Mr Stewart was  
8 asking you about benchmarking. It might be why the GMC  
9 refer not just to a review but to audit, because audit  
10 suggests something a bit more formal.  
11 A. It does. It suggests there's a standard to which you  
12 can be audited against.  
13 THE CHAIRMAN: But your evidence is that neither in  
14 Altnagelvin or elsewhere are you familiar with audits.  
15 You're familiar with reviews in different styles, formal  
16 and informal, but you're not really familiar with  
17 auditing the performance of a team?  
18 A. I'm not really familiar with auditing the performance of  
19 a team in that way. The audits that I've been involved  
20 in have largely been on patient care and, therefore,  
21 they would be -- well, I suppose they would be looking  
22 at the performance of individuals within that team.  
23 THE CHAIRMAN: In fact, this isn't talking about occasional  
24 audit, this is talking about regular audit.  
25 A. Yes. And we were certainly involved in regular patient

26

1 care audit.  
2 THE CHAIRMAN: Right.  
3 MR STEWART: Mrs Brown, the risk management coordinator of  
4 Altnagelvin, has told us that professional leads within  
5 the hospital were responsible for implementing the  
6 NCEPOD recommendations. So I take it that within your  
7 own specialty, you'd have been responsible for  
8 implementing NCEPOD recommendations?  
9 A. No, I wouldn't. I wouldn't have been described as the  
10 professional lead. I don't think that's who she would  
11 be referring to.  
12 Q. Who do you think she was referring to?  
13 A. I think she'd be referring to the clinical director.  
14 THE CHAIRMAN: Mr Bateson?  
15 A. Yes.  
16 THE CHAIRMAN: Or whoever was the clinical director at any  
17 time because --  
18 A. He was the clinical director at that time.  
19 THE CHAIRMAN: Yes.  
20 MR STEWART: In relation to the multidisciplinary nature of  
21 what was going on in Ward 6 in 2001, you have described  
22 the sort of meetings that were available for nurses to  
23 meet with paediatricians and so forth. A problem in  
24 Raychel's case was that none of the specialties seemed  
25 to really know who was responsible for the prescription

27

1 and supervision of IV. The nurses had perhaps stepped  
2 into the breach and were simply overriding whatever  
3 doctors wanted with the ward protocol. That's something  
4 that you hadn't picked up?  
5 A. No, I hadn't.  
6 Q. Does it surprise you now with hindsight that you hadn't  
7 picked it up?  
8 A. Well, to a certain extent it surprises me that none of  
9 the surgeons and, as far as I know, none of the  
10 anaesthetists were aware -- sorry, none of the  
11 consultant anaesthetists were aware that that is what  
12 was happening.  
13 Q. Would a multidisciplinary meeting have been exactly the  
14 sort of thing which would have brought out issues such  
15 as this?  
16 A. I'm not sure whether it would have been because the only  
17 way that we would have known that that was happening  
18 would have been if it had been questioned as to whether  
19 that was happening, and I don't think anyone was aware  
20 of it in order to raise the question.  
21 Q. Because just going back to the GMC Good Medical Practice  
22 again, paragraph 36 of it, which is at 314-014-015, it's  
23 the preceding paragraph. This is about working in  
24 teams.  
25 Paragraph 36:

28

1 "Healthcare is increasingly provided by  
2 multidisciplinary teams. Working in a team does not  
3 change your personal accountability for your  
4 professional conduct and the care you provide. When  
5 working in a team, you must ..."  
6 And we go down to the fourth bullet point:  
7 "Make sure that your patients and colleagues  
8 understand your professional status and specialty, your  
9 role and responsibilities in the team and who is  
10 responsible for each aspect of patients' care."  
11 I'm assuming that you were aware of this back in  
12 2001?  
13 A. Yes.  
14 Q. Given that you were obliged to ensure, you must ensure  
15 that everyone in your team knows who's responsible for  
16 what, and that's a multidisciplinary problem. What  
17 measures were put in place in Altnagelvin to make sure  
18 that people from different disciplines dealing with  
19 paediatric patients knew what each was supposed to be  
20 doing?  
21 A. As I have said in my written evidence before, my  
22 understanding of the fluid prescription standard  
23 practice was for the anaesthetist to prescribe the  
24 fluids overnight if the child had been operated on at  
25 night and then, whenever the next fluid prescription was

29

1 required, that that would be the responsibility of  
2 a member of the surgical team. That was my  
3 understanding because that would have been standard  
4 practice, as I understood it, and indeed I think that  
5 would be standard practice, as a number of witnesses  
6 from Altnagelvin and some of the expert witnesses have  
7 also confirmed.  
8 In normal practice, however, the nursing staff  
9 would -- if an IV prescription had run out, they would  
10 ask one of the paediatric medical staff, usually  
11 a member of the junior staff, to prescribe rather than  
12 have the patient wait for a long period of time for  
13 a continuation of IV fluids. That, it appears, seemed  
14 to be fairly standard practice at that time, as  
15 confirmed by some of the experts.  
16 Q. So is your answer that there was no attempt made to  
17 ensure that people from different disciplines knew who  
18 was responsible for what?  
19 A. No, it was -- there was no formal protocol that I am  
20 aware and, as I've said, I think before, there didn't  
21 seem to be any problem with what was happening and,  
22 therefore, the protocol was simply not questioned.  
23 THE CHAIRMAN: But what emerged afterwards is that there was  
24 this debate -- well, there were two issues, really,  
25 Mr Gilliland. One is uncertainty about who is

30

1 responsible for prescribing post-operative fluid, and  
2 that's one issue. And, secondly, the notion that you  
3 somehow revert to the preoperative fluid prescription.  
4 You weren't aware of either of those and you're  
5 concerned about both of those?  
6 A. Yes, there certainly was concern about both of those.  
7 They didn't emerge until after Raychel's death.  
8 THE CHAIRMAN: The curious thing to me is all of the nurses  
9 who have given evidence in effect have said this was  
10 well-established, in fact it was so well-established  
11 that as Raychel came out of surgery, I think it was  
12 Mr Zafar who was going to prescribe Hartmann's and was  
13 advised against it.  
14 A. Dr Gund.  
15 THE CHAIRMAN: And Dr Gund was going to advise Hartmann's  
16 and was advised against it.  
17 A. By Dr Jamison.  
18 THE CHAIRMAN: Yes.  
19 A. That's correct. Dr Gund, I think, was going to  
20 prescribe Hartmann's at 80 ml an hour, and I think  
21 Dr Jamison advised him that what would happen would be  
22 that the -- when patient went back to the ward they  
23 would be recommenced at No. 18 Solution at the rate that  
24 had been prescribed beforehand, and that would be simply  
25 recommenced.

31

1 THE CHAIRMAN: That does take you aback, doesn't it?  
2 A. It does. It does. And I have to say that I was not  
3 aware of it and it would appear none of my surgical  
4 colleagues were aware of it, nor indeed Dr Nesbitt,  
5 according to his memo.  
6 THE CHAIRMAN: But it also appears to have been something  
7 which wasn't just a fluke in Raychel's case, this seems  
8 to have been an established practice.  
9 A. Yes, this is an established practice.  
10 MR STEWART: It was established practice that the  
11 consultants didn't know about. Would it be fair to  
12 suggest the consultants had simply relinquished control  
13 over it?  
14 A. No, I don't think that's the reason that we weren't  
15 aware of it. It would have been very difficult to have  
16 been aware of it because it would be rare for a child  
17 post-surgery to require a significant period of ongoing  
18 fluids. Plus, if a child had gone to theatre during  
19 daylight hours, by the time they were seen on the ward  
20 round the following morning by a consultant or a member  
21 of his team, it would be very likely that the fluids  
22 would have been discontinued by that stage and,  
23 therefore, there would have been no reason to go back  
24 and check exactly who had prescribed and what had been  
25 prescribed.

32



1 Similarly, in the morning, for example, a child such  
2 as Raychel who had gone to theatre late in the evening,  
3 by the following morning the assumption would be that  
4 the fluids would be discontinued through the day as her  
5 oral intake increased and, therefore, there wouldn't  
6 have been an impetus to check on the fluid prescription.  
7 Q. You seem to be suggesting that it really requires  
8 a tragedy before flaws in the system are in fact  
9 highlighted?  
10 A. I think flaws in the systems are often highlighted by  
11 a tragedy.  
12 Q. But in this case, I would suggest to you from the  
13 evidence that there doesn't appear to have been any  
14 systems in place before, and nobody in charge of any  
15 systems in place before, in order to look at the various  
16 aspects of intermultidisciplinary care?  
17 A. There was an established practice, but there was no  
18 formal written protocol.  
19 Q. And, of course, at that time not only were you looking  
20 after and leading your specialty team, you were also  
21 involved in education.  
22 A. Yes.  
23 Q. Heavily involved. It's one of your key interests. And  
24 you were both undergraduate and postgraduate surgical  
25 tutor at the time.

33

1 A. Yes.  
2 Q. Did you give teaching sessions on fluid balance,  
3 electrolyte disturbance, electrolyte management?  
4 A. My recollection of the third year teaching is that there  
5 was informal bedside teaching every day and, as fluid  
6 management is often an integral part of surgical  
7 management, there would have been informal discussions  
8 about fluid management around the bedside. But that  
9 would have been dependent on each individual who was  
10 conducting that ward round or bedside teaching.  
11 I also believe that there was a tutorial, one of the  
12 eight tutorials that third years did that dealt with  
13 fluid balance. But, again, I think that was  
14 predominantly in adults.  
15 Q. Of course, your practice encompassed adults and the  
16 elderly as well as children.  
17 A. It does.  
18 Q. And quite coincidentally, the 1999 NCEPOD report, which  
19 deals with extremes of age, and that's why we've been  
20 quoting it because it deals with the very young, it also  
21 deals with the elderly. The key points in their advice  
22 in relation to the elderly appear at 220-002-107.  
23 This is recommendations given by NCEPOD, 1999,  
24 in relation to the elderly, and it's in relation to  
25 fluid chart documentation. And, of course, the elderly

34

1 are also vulnerable to hyponatraemia as well as young  
2 girls; isn't that right?  
3 A. Yes.  
4 Q. The key points brought out by the 1999 NCEPOD  
5 recommendations are, second key point:  
6 "Doctors and nurses of all grades need to understand  
7 the clinical importance and ensure the accurate  
8 recording of fluid intake and output."  
9 Next bullet point:  
10 "Multidisciplinary review of the problem and  
11 development of good local working practices is required.  
12 Fluid charts are important documents that need to be  
13 retained."  
14 We can read on down, and it emphasises the  
15 importance of the -- the bottom three paragraphs on the  
16 right-hand side may be worth reading:  
17 "Management of fluid balance is a multidisciplinary  
18 exercise involving doctors, nurses and possibly other  
19 ward staff responsible for providing oral fluid intake  
20 for patients. This is akin to drug therapy where it is  
21 the responsibility of doctors to prescribe drugs and the  
22 responsibility of nurses to give the drugs and chart  
23 their administration. However, it is clear that fluid  
24 management is not perceived as having the same  
25 importance or status as drug therapy. Clinical audit

35

1 and governance should provide a framework for  
2 multidisciplinary review of the problem, be responsible  
3 for the development of good local working practices and  
4 oversee their implementation. Fluid excess or deficit  
5 can contribute to serious post-operative morbidity and  
6 doctors and nurses of all grades need to understand the  
7 clinical importance of fluid intake and output and  
8 ensure its accurate recording. Its importance is equal  
9 to the accurate recording of drug administration and  
10 this should be recognised."  
11 Now, if that advice had been taken on board  
12 generally in Altnagelvin, and especially for Raychel,  
13 things might have been different.  
14 A. In terms of the fluid recording?  
15 Q. In terms of the outcome for Raychel.  
16 THE CHAIRMAN: Yes, in terms of the fluid recording, which  
17 affects the outcome. Fluid recording includes vomiting,  
18 doesn't it?  
19 A. It does.  
20 THE CHAIRMAN: I don't want to go back over February  
21 and March again, but we know that the records are  
22 inadequate and there are vomits which were not recorded,  
23 and there's fluid intake which isn't recorded.  
24 A. I wasn't aware that there was fluid intake.  
25 THE CHAIRMAN: There was some oral fluids taken, not

36

1 recorded. Now, small amounts --  
2 A. Small amounts. Sips, was it?  
3 THE CHAIRMAN: It was, yes. But the point about it is, as  
4 I understand it, Mr Gilliland, that because Raychel was  
5 supposed to be on a route so that by the afternoon,  
6 after her operation, she would be expected to be --  
7 she'd be sipping more and more and then eating at some  
8 point late afternoon. When she reaches that stage and  
9 that's not happening, that's the point, and she has  
10 vomited a number of times, that's the point when  
11 somebody should come along, and one of the points of  
12 reference is an accurate fluid balance chart.  
13 A. Mm-hm.  
14 THE CHAIRMAN: So the fluid balance chart wasn't accurate  
15 but here's a report, I suspect it's not the only report,  
16 which says that the importance of fluid balance is as  
17 significant or can be as significant as drugs.  
18 A. Yes. I think that's right, and there are still ongoing  
19 changes being made to fluid balance charts. A new one  
20 has been introduced within the Ulster within this last  
21 month in an attempt to continuously improve the  
22 recording.  
23 THE CHAIRMAN: Is that an ongoing recognition of the  
24 importance of fluid --  
25 A. It's an ongoing recognition of the importance, yes.

37

1 THE CHAIRMAN: I think the concern is that the younger  
2 doctors, particularly doctors Devlin and Curran, really  
3 didn't appreciate the picture of when there's an issue  
4 about whether they were too raw to be of much assistance  
5 to Raychel when they were called or, maybe to raise the  
6 bar a bit, whether they should have at least recognised  
7 there was enough going wrong to bring in somebody more  
8 senior.  
9 A. Yes.  
10 THE CHAIRMAN: But part of the problem there may be that  
11 they don't seem to have appreciated what her fluid  
12 balance was or checked what her fluid balance was.  
13 A. My understanding of the evidence that I've read is that  
14 Dr Devlin did not check that. My understanding of  
15 Dr Curran's evidence was that he had made an assessment  
16 of Raychel and, therefore, I assumed that he had looked  
17 at the fluid balance chart.  
18 THE CHAIRMAN: Yes, but the problem is if the chart isn't an  
19 accurate recording in the first place. Even if you  
20 refer to it, in fact if it's not kept accurately it  
21 might become misleading.  
22 A. Yes, it could well become misleading. And also, as  
23 we've identified before, there's a great deal of  
24 difficulty in assessing the amount of vomit. The system  
25 in place at that stage would really mean that a junior

38

1 house officer or indeed any doctor coming along to see  
2 Raychel for the first time would be dependent on  
3 a first-hand account of the amount of vomiting that was  
4 really going on.  
5 THE CHAIRMAN: Yes. But in terms of the issue that  
6 Mr Stewart was asking you about, the concern in terms of  
7 governance is whether this training and this message was  
8 being given sufficiently to the doctors and nurses in  
9 Altnagelvin.  
10 A. Yes. Well, in terms of the PRHOs, a lot of their  
11 training would have been as medical students before they  
12 came to us. I believe there was some formal lectures on  
13 fluid balance given to the PRHOs, and there would have  
14 been a lot of informal training on ward rounds about  
15 fluid balance because, as has already been pointed out,  
16 it is an integral part of everyday work on a surgical  
17 ward.  
18 THE CHAIRMAN: Sorry, when you say informal training, I know  
19 why you're saying that's not a formal lecture, but in  
20 a sense accompanying the consultant on a ward round is  
21 actually part of formal training, isn't it?  
22 A. Well, I would have viewed that as informal.  
23 THE CHAIRMAN: Okay.  
24 A. But, yes, that is where a lot of that training would go  
25 on every day.

39

1 THE CHAIRMAN: Okay, thank you.  
2 MR STEWART: The question is, why did you take no steps to  
3 incorporate NCEPOD recommendations into your teaching?  
4 A. Why did I not take steps to specify the importance of  
5 fluid balance? Well --  
6 Q. No, why did you not take steps to incorporate NCEPOD  
7 recommendations into the teaching, your teaching?  
8 A. Which specific NCEPOD recommendations?  
9 Q. I have just read them out to you, these 1999 ones. Why  
10 did you take no steps to incorporate the 1999 NCEPOD  
11 recommendations into your teaching in your role as both  
12 undergraduate and postgraduate surgical tutor?  
13 A. I don't think that I would have specifically referred to  
14 these recommendations. Fluid balance is an important  
15 part of surgical training and, as I've already said to  
16 the chairman, there was a lot of informal training on  
17 the wards with regards fluid balance.  
18 Q. For the third time, why did you take no steps to  
19 incorporate the NCEPOD recommendations into your  
20 teaching?  
21 A. I'm sorry, I don't quite ...  
22 Q. Okay. You're a surgical tutor.  
23 A. Yes.  
24 Q. These are surgical recommendations which are national  
25 and important --

40

1 A. Yes.  
2 Q. -- and various experts have expressed their view on just  
3 how important they are. And you didn't know about them,  
4 you weren't aware of them and, accordingly, you weren't  
5 introducing them into your teaching. I'm asking you,  
6 why not?  
7 THE CHAIRMAN: I am sorry, Mr Gilliland wasn't aware of  
8 them. That's an answer to why he didn't incorporate  
9 them into the training. That's an answer. The other  
10 issue is, whether he was aware of them or not, the  
11 training which was given to the junior surgeons  
12 effectively incorporated them if he was emphasising the  
13 significance of fluid balance and recording.  
14 MR STEWART: Yes.  
15 THE CHAIRMAN: So there's two --  
16 MR STEWART: Perhaps even a third limb, which is: what  
17 enquiries did you make of relevant recommendations in  
18 order to consider whether or not they should be  
19 incorporated?  
20 A. Yes. As I've said in my evidence, I wasn't particularly  
21 aware of these particular recommendations. But  
22 nevertheless, these recommendations are not any  
23 different from what we would have recognised in normal  
24 practice. The issues with fluid balance charts, the  
25 importance of keeping an accurate record, that would be

41

1 reinforced often on ward rounds to members of the  
2 nursing staff, who keep those records, and the  
3 importance of fluid balance would be emphasised to  
4 members of the junior staff.  
5 Q. Very well. Sir, I don't know whether you might think  
6 this an appropriate ...  
7 THE CHAIRMAN: Okay, we will break. We'll break for a few  
8 minutes and be back in 10 minutes, Mr Gilliland.  
9 Thank you.  
10 (11.33 am)  
11 (A short break)  
12 (11.48 am)  
13 MR STEWART: Thank you, sir.  
14 Before our coffee, we touched upon the overall  
15 supervision and responsibility for surgical patients  
16 in the paediatric ward. I was reminded of a comment  
17 that Dr Scott-Jupp made in his report of what happens at  
18 his hospital. This was a hospital which, like  
19 Altnagelvin, had no resident paediatric surgeon, and  
20 a system had been developed whereby surgical patients  
21 would come under the care of the consultant  
22 paediatricians post-operatively rather than consultant  
23 surgeons. Have you come across that elsewhere?  
24 A. No.  
25 THE CHAIRMAN: Sorry, I was wrong. It's actually they come

42

1 under the primary care of the paediatricians from  
2 admission, even if they become surgical patients, and  
3 the point that Dr Scott-Jupp was making was this. This  
4 is not necessarily a criticism of what went on at  
5 Altnagelvin, because he said the practice isn't now  
6 universal in district hospitals like his, and it  
7 certainly universal, even less so, in 2001.  
8 He described it as the changing face of the system.  
9 It happened in his hospital from about five years ago.  
10 What it means is that a child like Raychel, even if  
11 she's brought in, and even if the appendicectomy goes  
12 ahead, she's a paediatric patient and both before and  
13 after the surgery, when she's on Ward 6, a paediatrician  
14 is primarily responsible for her care, but inevitably if  
15 she's a surgical patient there will be some input from  
16 the surgical team.  
17 How does that sound to you as an option?  
18 A. Well, I have no personal experience, I have never seen  
19 it happen before. I presume that --  
20 THE CHAIRMAN: Sorry. In the Ulster where you are now,  
21 there are paediatric surgeons, are there?  
22 A. There are adolescent patients between 13 and 16. There  
23 are no children under 13. They are admitted to  
24 a separate children's adolescent ward and they're looked  
25 after by the surgeons if they're under the surgeon's

43

1 name.  
2 THE CHAIRMAN: Okay. So might that include you, for  
3 instance?  
4 A. Yes.  
5 THE CHAIRMAN: Right. But is there a paediatric department  
6 in the Ulster?  
7 A. Yes, there's a medical paediatric department.  
8 THE CHAIRMAN: Right. So the idea that Dr Scott-Jupp is  
9 talking about, I'm just thinking of it as a way forward.  
10 Is that something that you see any attraction in?  
11 A. I'm not particularly sure that the paediatricians would  
12 be overly happy looking after surgical patients.  
13 THE CHAIRMAN: Right.  
14 A. So I'm not sure if that is something that would  
15 necessarily be brought in.  
16 THE CHAIRMAN: Okay. There was one other point which was  
17 mentioned in the context of Altnagelvin by, I think,  
18 primarily the nurses, and it was that the paediatric  
19 patients on Ward 6 would have an electrolyte test every  
20 24 hours.  
21 A. Yes.  
22 THE CHAIRMAN: And that was a standard procedure. But it  
23 clearly wasn't a standard procedure with the surgical  
24 patients.  
25 A. I think, again, this really refers to whether 24 hours

44

1 is strictly 24 hours or if, as Dr Scott-Jupp has said,  
2 it represents a standard period of time such as a day.  
3 I think if Raychel had been still on IV fluids the  
4 following morning, there is no doubt that her U&Es would  
5 have been checked, but it wouldn't have been checked on  
6 the morning when she was seen in the morning ward round  
7 by Mr Zafar at 8.30 because there would have been no  
8 need to check it at that stage, and it would have been  
9 anticipated that she would be off IV fluids in due  
10 course. That's why we've put our -- made changes in the  
11 monitoring process.

12 THE CHAIRMAN: Okay, thank you.

13 MR STEWART: If we may now turn directly to the  
14 circumstances of Raychel's case. You have told the  
15 inquiry that you believe that it was highly likely that  
16 you would have been informed on the morning of 8 June  
17 that she had been admitted overnight and had undergone  
18 the standard appendicectomy.

19 A. Yes.

20 Q. Can you explain again why you believe that it would have  
21 been likely that you would have been told?

22 A. Yes. Because it would have been my standard practice to  
23 ensure that all my patients had been seen. It would be  
24 my standard practice to enquire if there were any other  
25 patients.

45

1 Mr Zafar had gone to see Raychel early in the  
2 morning, probably before the main ward round had  
3 started, and I would presume that he would have come up  
4 and had spoken to me about it. I have no recollection  
5 of the event, but that would be my standard practice.

6 Furthermore, I think if I had not known about  
7 Raychel, I would have made some enquiries as to why  
8 I did not know about her and put some processes in place  
9 to ensure that that didn't happen again. But I have no  
10 recollection of making any such enquiries.

11 Q. Yes. I wonder, can we look, please, at a letter that  
12 you received from a Dr Clements of the Medical  
13 Protection Society. It appears at 022-042-103. This is  
14 where you're in correspondence with your professional  
15 indemnity insurers about this matter.

16 They write back to you, thanking you for your letter  
17 with the enclosed papers, making interesting paper, and  
18 they write:

19 "Bearing in mind that you did not actually see  
20 Raychel at all during her stay in hospital, I cannot see  
21 any special risk to yourself in this case ..."

22 And so forth. So you told them that you didn't see  
23 Rachel.

24 Did you also tell them that you hadn't been  
25 contacted about her case at all?

46

1 A. Not that I can recall.

2 Q. We go on to the third paragraph, Dr Clements writes:

3 "Whilst I understand that you will be asked to  
4 attend as a witness, I am not entirely sure that your  
5 evidence could be terribly extensive. My understanding  
6 is that you were not even contacted about the case at  
7 the time. Please correct me if I'm wrong."

8 Was he wrong?

9 A. I, again, do not have any recollection of the morning of  
10 8 June. I would be fairly certain that I would have  
11 been contacted about the case.

12 Q. Well, you seem to have allowed Dr Clements to understand  
13 that you're not even contacted about the case at the  
14 time.

15 A. I'm not sure where that understanding has come from.

16 Q. Did you then take steps to correct it as he asked you  
17 to?

18 A. Whether I did verbally or by telephone, I'm not sure.

19 Q. Did you tell Dr Fulton and others at the critical  
20 incident review that you were not informed of Raychel's  
21 admission under your name?

22 A. Not that I can recall.

23 Q. Can I ask that WS043/3, page 14, be shown? This is  
24 Dr Fulton's witness statement.

25 At the top you can read:

47

1 "In relation to the critical incident review  
2 meeting, please also confirm whether consideration was  
3 given to:

4 "(a) The overall leadership of the clinicians  
5 treating Raychel.

6 "The consultant in surgery..."

7 That I take to be you?

8 A. Yes.

9 Q. "... stated he was not informed of Raychel's admission  
10 under his name."

11 A. There's clearly a discrepancy in that. I fully see  
12 that. I again, I'm afraid, do not recall the events  
13 exactly.

14 Q. I think you accept that you weren't actually advised of  
15 her admission at the time of her admission.

16 A. Not at the time, no.

17 Q. And you weren't informed of her surgery at the time of  
18 her surgery?

19 A. That is correct.

20 Q. And you weren't informed of her seizure at the time of  
21 her seizure?

22 A. That is correct.

23 Q. And you weren't informed of her transfer to the Royal in  
24 Belfast at the time of her transfer?

25 A. That is correct.

48

1 Q. And you weren't informed of her death at the time of her  
2 death?  
3 A. That is also correct.  
4 Q. And you didn't see her?  
5 A. That's correct.  
6 Q. And in fact, you were on call on that night of the  
7 7th/8th; is that correct?  
8 A. I was on call the night of the 7th/8th, yes.  
9 Q. We've heard evidence from Dr Zafar that Raychel was the  
10 only surgical patient on the children's ward at that  
11 time.  
12 A. I presume that to be the case.  
13 Q. So, in fact, she's the only appendicectomy patient,  
14 I think, as well.  
15 A. On the children's ward?  
16 Q. Yes.  
17 A. Yes, so far as I know.  
18 Q. Can you confirm for me the death of a child  
19 post-appendicectomy is an exceptionally rare occurrence  
20 indeed?  
21 A. Yes.  
22 Q. Can I ask that your most recent witness statement -- in  
23 fact, it's not, it's your first one, it's WS044/1,  
24 page 4, be shown. This is down towards the bottom of  
25 the page and it's paragraph 4.

49

1 This is:  
2 "Describe your role and steps you took in relation  
3 to the investigation carried out at Altnagelvin  
4 following the death, to include ..."  
5 And you give an account of what happened.  
6 You say:  
7 "On the evening of Sunday 10 June I received a phone  
8 call from my colleague Mr Neilly. During that  
9 conversation he mentioned that there had been an  
10 unexpected death of a child following an appendicectomy.  
11 He had not been directly involved and was under the  
12 impression that the child had not been under my care,  
13 but under the care of another consultant."  
14 Now, can I ask you, when you received that call from  
15 Mr Neilly, what questions you asked?  
16 A. I will have asked what the circumstances were. My  
17 understanding is that Paul didn't recall the exact  
18 circumstances. I will have asked --  
19 THE CHAIRMAN: Just for the record, Paul is Paul Neilly?  
20 A. Sorry.  
21 THE CHAIRMAN: Thank you.  
22 A. I would have asked whose care the child was under.  
23 MR STEWART: Now, you see, if you had been informed of  
24 Raychel's admission, you would have known that you had  
25 a child appendicectomy patient in Ward 6.

50

1 A. Not on Sunday night. One would have expected that by  
2 that stage the child would have been at home.  
3 Q. Well, if you'd been informed of Raychel's admission, you  
4 would have had a child who was in Ward 6 only 24 hours  
5 or 48 hours beforehand, post-appendicectomy. You get  
6 a phone call from somebody saying, "You'll never guess,  
7 the most terrible and extraordinary thing has happened.  
8 A child has died in Ward 6 after an appendicitis  
9 operation". If you had known about it, you'd have  
10 quizzed him, would you not, lest it be your patient?  
11 A. I certainly did have a conversation as to exactly whose  
12 patient it was.  
13 Q. You'd want to find out exactly who she was, what  
14 happened, how it happened, when she was admitted, who  
15 did the operation, who was on the team, you'd want to  
16 know everything, wouldn't you, just in case it was your  
17 patient?  
18 A. Absolutely, and Mr Neilly didn't know those details, but  
19 he was fairly convinced that it was under the care of  
20 another consultant.  
21 THE CHAIRMAN: Why was he fairly convinced that Raychel was  
22 under the care of another consultant?  
23 A. I don't know. I don't know. But he, during the course  
24 of the conversation, said whose name he believed the  
25 child to be under.

51

1 THE CHAIRMAN: And was that investigated? Was it  
2 investigated whether Raychel was under the care of  
3 another named consultant?  
4 A. No, I think it wasn't specifically investigated, it was  
5 clear that she was under my name.  
6 THE CHAIRMAN: It wasn't clear to Mr Neilly.  
7 A. No, it wasn't clear, but I don't think he'd been  
8 directly involved as such.  
9 THE CHAIRMAN: Let's put this phone call in context.  
10 Mr Neilly is one of your colleagues.  
11 A. He is, or was.  
12 THE CHAIRMAN: Was a surgical colleague?  
13 A. Yes.  
14 THE CHAIRMAN: So was he ringing you to discuss this  
15 terrible news in the sense that this is awful, or was it  
16 more than that, was it as part of triggering an  
17 investigation or a review of what had happened?  
18 A. No, it wasn't for those reasons at all. Paul and I are  
19 friends and colleagues and we would often speak to each  
20 other, plus I had a major case in theatre the next day,  
21 the type of case that we would often do together. So  
22 I don't recall whether the phone call was simply to do  
23 with our friendship and association or whether it was to  
24 do with the case that was due to happen on Monday  
25 morning, but during the course of that conversation this

52

1 was mentioned. But it wasn't the sole reason for the  
2 phone call.  
3 THE CHAIRMAN: Right. But then when he was under the  
4 impression that Raychel had been under somebody else's  
5 care, were you able immediately to say, "God, no, that's  
6 awful, she was under my care"?  
7 A. No.  
8 THE CHAIRMAN: If she was under your care, and if at that  
9 time you had known that she had been admitted, then why  
10 would you not be able to correct him immediately and  
11 say, "She wasn't under Mr X's care, she was under my  
12 care"?  
13 A. If I'd known -- my expectation would have been that  
14 Raychel would have been discharged, so I would have had  
15 no concerns at that stage that this child would have  
16 been under my care.  
17 MR STEWART: How do you know you'd have had no concerns?  
18 A. Sorry?  
19 Q. How would you have known to have no concerns?  
20 A. My understanding was that it was a child who'd had  
21 a routine appendectomy who was under my care, who was  
22 making adequate progress, and therefore I wouldn't have  
23 anticipated that this could have happened.  
24 Q. A child's health can deteriorate very rapidly. This  
25 inquiry's heard that on a number of occasions. This is

53

1 the only appendectomy, insofar as you would have been  
2 aware, in this ward, in fact the only surgical patient  
3 in this ward, and a death, which is extraordinarily  
4 rare. If you had known that she was under your care,  
5 you would have quizzed and made sure it wasn't your  
6 patient, if you weren't aware of her at all, or you  
7 might have just let it pass?  
8 A. No, I think we had a very clear conversation about whose  
9 care this child was under, and I was assured that she  
10 was not under my care.  
11 Q. And whose care was she under?  
12 A. Actually was she under? She was under my care.  
13 Q. Who did Mr Neilly think was her consultant?  
14 A. Mr Neilly thought it was Mr Thompson.  
15 Q. Mr Thompson?  
16 A. Yes.  
17 Q. How did he get that idea?  
18 A. I have no idea.  
19 THE CHAIRMAN: But the reason why you didn't correct him is  
20 because you didn't know he was talking about Raychel;  
21 is that right?  
22 A. I didn't know the name of the child that he was talking  
23 about.  
24 THE CHAIRMAN: So when he said this child was under  
25 Mr Thompson's care, you didn't say, "No, that's wrong,

54

1 she's under my care", because you didn't realise you  
2 were talking about Raychel?  
3 A. That's correct.  
4 THE CHAIRMAN: Despite the fact that Raychel was the only  
5 child, to your knowledge, who was on Ward 6 with an  
6 appendectomy?  
7 A. Well, there could have been other children on that ward  
8 under the care of other consultants. I wouldn't  
9 necessarily know about that.  
10 THE CHAIRMAN: Well, if it wasn't Raychel, it could only  
11 possibly have been, what, one or two other children?  
12 A. One would presume.  
13 MR STITT: There is one element of confusion, sir, which  
14 I think has crept into the question unintentionally. We  
15 had established earlier that this witness subsequently  
16 became aware of the fact that there was only one child  
17 on the ward, one surgical child on the ward, but that's  
18 not the same as suggesting that this witness knew at  
19 that time that there was only one surgical child on the  
20 ward.  
21 THE CHAIRMAN: Yes, but what he didn't know was that he, at  
22 least on Friday, had a surgical child on the ward,  
23 namely Raychel, and with an appendectomy.  
24 MR STITT: Yes, of course. But I'm just making that point,  
25 it's not as clear-cut that there was just one child so

55

1 it could only have been his patient if his patient had  
2 remained in longer than he'd expected.  
3 MR STEWART: It's a fair point because there may have been  
4 admissions on the 8th.  
5 Just to understand your rota, you were on call on  
6 Thursday 7th through to Friday 8th, from 9 pm to 9 am?  
7 A. That's correct.  
8 Q. And, then, would you have stayed in the hospital  
9 throughout the day of Friday the 8th?  
10 A. Yes.  
11 Q. So you then would have been in Altnagelvin right through  
12 to, what, 5 pm on Friday?  
13 A. It's usually a little later than that.  
14 Q. And possibly later. So you'd have been there all that  
15 time and I assume that you were not informed of any  
16 discharge of your patient?  
17 A. No, but one would not normally be informed of  
18 a discharge.  
19 Q. And then after you came to the end of your shift on  
20 Friday the 8th, Mr Neilly then came on call through to  
21 the morning of Saturday the 9th; is that correct?  
22 A. I'm not sure exactly who was on call at that stage.  
23 You'll see in my original witness statement that  
24 I thought it was Mr Neilly, but there seems to have been  
25 some confusion about that because the blood tests that

56

1 were ordered I think were under the name of Mr Panasar,  
2 and so, I'm sorry, I'm not exactly sure who was on call  
3 at that stage.  
4 Q. You're not exactly sure. Can we have a look at WS044/2,  
5 page 14. 23 (a):  
6 "Who was the out-of-hours on-call consultant surgeon  
7 on the morning of 9 June 2001?"  
8 And this is your response?  
9 A. It is.  
10 Q. And you reply Mr Neilly.  
11 A. Yes.  
12 Q. So it looks as though you do know who came after you.  
13 A. That was who I presumed, but I understand there is some  
14 question about that.  
15 Q. Why don't you write "I think it was Mr Neilly"?  
16 A. Because at that time I felt sure that it was Mr Neilly.  
17 Q. All right. Now, did you hear the evidence of Dr Makar  
18 when he gave evidence?  
19 A. I did.  
20 Q. On 13 March.  
21 A. Yes.  
22 Q. Can we please bring up pages 178 and 179 of the 13 March  
23 transcript.  
24 Can I take you, please, to line number 10, page 178.  
25 "Question: Do you know how Mr Gilliland [a question

57

1 to Dr Makar] came to know that Raychel had died?  
2 "Answer: Now it's from my memory, I might be wrong,  
3 okay.  
4 "Question: Yes?  
5 "Answer: I think it was a confusion who was the  
6 consultant who look after Raychel at that time. From my  
7 memory, I think that it was another consultant who  
8 probably was on call. But a swap happened between the  
9 consultants and that's why Mr Gilliland was the actual  
10 on-call consultant other than what we thought is the  
11 consultant on call.  
12 "Question: Who did you think was the consultant?  
13 "Answer: I thought that probably Owen Thompson,  
14 I think, at that time.  
15 "Question: Sorry, let me be clear. I am  
16 distinguishing between the consultant who might have  
17 been on call at the time and Raychel's consultant?  
18 "Answer: The on-call consultant which we knew  
19 shortly, I don't know when, it was Mr Gilliland's  
20 on-call consultant, okay? And he would look after  
21 Raychel. But there's some confusion about Thursday, who  
22 was the actual consultant on call. I think it because  
23 of the rota, printed rota, had a name on it, which is  
24 different from what the admission and the A&E and the  
25 switchboard knows. So this made a little bit of

58

1 confusion at that time. But by -- this is as far as  
2 I remember from memory. Then after that, we knew for  
3 100 per cent sure that it was Mr Gilliland and  
4 Mr Gilliland who would look after Raychel."  
5 So here's somebody who's on the wards, part of your  
6 team, and he's told us about a confusion, and it looks  
7 as though there was a swap and Mr Thompson's name creeps  
8 in again. Can you explain that?  
9 A. No.  
10 Q. Did you swap your rota with Mr Thompson?  
11 A. I have no recollection of that whatsoever.  
12 Q. Did you do that from time to time?  
13 A. Occasionally if that was necessary.  
14 Q. Of course, if you did that, you had to make absolutely  
15 certain that everybody else knew you'd done that.  
16 A. Yes, one would let the on-call team know and let the  
17 switchboard know who was on call.  
18 Q. Because the last thing you'd want is any confusion?  
19 A. That is correct.  
20 Q. So if confusion arose, it was because the proper steps  
21 were not taken?  
22 A. I don't know why the confusion arose.  
23 Q. Could it be -- would you ever swap with another surgeon,  
24 swap your shift, and then for some reason forget about  
25 it? Could that ever happen?

59

1 A. Um, it could happen, but I don't think it ever has.  
2 Q. So if you swapped your shift, you forgot about it, you  
3 didn't turn up, well, perhaps other people could cover  
4 up for you? Does anybody say you were there?  
5 A. I was where, sorry?  
6 Q. Did anyone say that you were in Ward 6 at the time of  
7 the ward round in the morning?  
8 A. No, not that I'm aware of.  
9 Q. Is there any documentary evidence to show that you were  
10 there at that time?  
11 A. In Ward 6?  
12 Q. Yes, or in the hospital at that time.  
13 A. We haven't looked for that evidence.  
14 Q. Did this emerge as part of the critical incident review?  
15 A. No, it didn't.  
16 Q. It didn't? Can we have a look, please, at Dr Nesbitt's  
17 witness statement, WS035/2, page 15.  
18 At 18(b), this is in relation to the critical  
19 incident review meeting:  
20 "Please also confirm whether consideration was given  
21 to:  
22 "(b), the absence of the consultant responsible for  
23 Raychel's care from Raychel's care."  
24 And Dr Nesbitt responds:  
25 "Yes, there was a discussion about the fact that the

60

1 on-call consultant was not necessarily the consultant  
2 under whose name Raychel had been admitted and that  
3 there was a potential difficulty in letting that  
4 consultant know that his patient had died."  
5 What does that mean?  
6 A. I don't know. I don't remember that conversation.  
7 Q. It looks as though there's a discussion at the critical  
8 incident review that Dr Nesbitt at least remembers that  
9 Raychel was admitted under one consultant who wasn't  
10 necessarily the on-call consultant.  
11 A. That's indeed what it looks like, but my clear  
12 understanding was that she was under my care, which is  
13 why I took responsibility for it whenever I was informed  
14 on Monday morning that she was under my care.  
15 THE CHAIRMAN: You were at the critical incident review?  
16 A. I was. I simply just don't remember that conversation.  
17 THE CHAIRMAN: But this is a positive statement by  
18 Dr Nesbitt, who's recalling a discussion. He doesn't  
19 say, "I don't remember this", he's saying, "Yes, there  
20 was discussion about the consultant responsible for  
21 Raychel's care", and the discussion was about the fact  
22 that the on-call consultant wasn't necessarily the  
23 consultant under whose care Raychel had been admitted.  
24 A. That is exactly what he's saying. I simply don't  
25 remember that. I don't remember there being

61

1 a confusion, and I know that I certainly felt that I was  
2 the on-call consultant that night and responsible.  
3 MR STEWART: Because when a patient dies and there's  
4 a review meeting, surely the first question must be "Who  
5 was the consultant? What happened? Where were you?"  
6 A. Yes, I think those would be things that would be  
7 considered. That's why I was called to the meeting and  
8 that's why I was there.  
9 Q. Isn't that why Dr Nesbitt would remember if there was  
10 a confusion?  
11 A. I presume so, but I don't remember the conversation.  
12 THE CHAIRMAN: I will assume for now that since Dr Nesbitt  
13 remembers this conversation, the conversation took  
14 place. Okay?  
15 A. Yes.  
16 THE CHAIRMAN: That seems to be a fair assumption, doesn't  
17 it?  
18 A. It does.  
19 THE CHAIRMAN: Okay. So if that conversation took place,  
20 and if you were the on-call consultant and you were the  
21 consultant under whose care Raychel had been admitted,  
22 how could there be discussion about the fact that you  
23 weren't necessarily both people? How could such  
24 a discussion come about?  
25 A. I'm really unable to help you there.

62

1 THE CHAIRMAN: I have to say, Mr Gilliland, it seems to me  
2 that such a conversation can only have come about if  
3 there was actually confusion --  
4 A. Yes.  
5 THE CHAIRMAN: -- as to who the consultant was.  
6 A. Yes. I simply don't remember that. I remember fairly  
7 clearly my actions on the Monday morning. On the Monday  
8 morning I spoke to Mr Thompson and said to him, "Look,  
9 this is my information, this child has sadly died under  
10 your care and you probably need to try and look into  
11 this fairly quickly". At some point later that morning,  
12 sometime between the ward round and the start of my  
13 theatre list, I became aware that this child had  
14 definitely been under my care.  
15 THE CHAIRMAN: Sorry, if you're as sure as you can be that  
16 Raychel was under your care, why would you have gone to  
17 Mr Thompson on the Monday morning to say to him that "It  
18 looks as if this child has sadly died under your care?"  
19 A. Because that was what Mr Neilly told me on Sunday night.  
20 THE CHAIRMAN: Okay. Thank you.  
21 MR STEWART: Did you ask Mr Neilly why he thought it was  
22 Mr Thompson?  
23 A. Not that I recall.  
24 Q. Why not?  
25 A. I didn't say I didn't, I just don't recall whether

63

1 I asked him or not.  
2 Q. After Raychel died, you didn't contact her GP, did you?  
3 A. Not formally.  
4 Q. What did you do informally?  
5 A. Dr Ashenhurst and I had spoken about the case, about the  
6 tragedy, about the devastation that it had been for  
7 Mrs Ferguson.  
8 Q. When did you speak to Dr Ashenhurst?  
9 A. I think in the supermarket or something like that.  
10 Q. Quite some time after Raychel's death?  
11 A. It was some time afterwards.  
12 THE CHAIRMAN: You spoke to her because you bumped into her?  
13 A. Yes, it was an casual conversation.  
14 THE CHAIRMAN: Is that the normal way in which a consultant  
15 in charge of the care of a child who has died discusses  
16 what has happened with the GP? Because I have been led  
17 to understand that some communication with the GP can be  
18 important because a family often turns to a GP for  
19 information and for reassurance and for support with  
20 issues about stress and bereavement in the weeks and  
21 months which follow, and I've got the impression that  
22 the GP might typically expect more than to find out by  
23 bumping into the consultant in the supermarket.  
24 A. Yes, absolutely.  
25 THE CHAIRMAN: So this wasn't the normal way for the

64



1 consultant in charge to contact the GP?  
2 A. No, the normal way would be for a discharge letter to be  
3 released from the hospital, but that would be from the  
4 Children's Hospital for that's where she had passed  
5 away.  
6 THE CHAIRMAN: Right.  
7 MR STEWART: Can I indicate that the chairman's observations  
8 in fact are something which the Department of Health  
9 included in its Welfare of Children and Young People in  
10 Hospital guidance some considerable time ago, 1991, and  
11 that appears at 314-004-032.  
12 "Death of a child":  
13 "When a child dies, it is essential that  
14 parents/carers are helped to cope with the sense of loss  
15 and grief and also given practical assistance ..."  
16 Moving down to the final bullet point:  
17 "Advise to ensure that the family's GP is informed  
18 as soon as possible in the event of the death of a child  
19 so that, as necessary, the GP can help them cope with  
20 the medical effects of bereavement."  
21 And that, I think, gives force to the chairman's  
22 point that it is important to tell the GP for that very  
23 reason.  
24 A. For that very reason, yes.  
25 Q. And in fact, you at that time would have been subject to

65

1 the guidelines of the Royal College of Surgeons of  
2 England?  
3 A. Yes.  
4 Q. Yes. They produced guidelines for clinicians  
5 in relation to medical notes and records in 1994. It  
6 appears at 210-003-1048. That's the cover page. Does  
7 that seem familiar to you?  
8 A. I don't specifically recall, but it's a familiar cover  
9 page.  
10 Q. The advice they give in this document, which appears at  
11 page 1051, at the top, paragraph D, and this is  
12 in relation to details to be provided:  
13 "When a patient dies, similar documentation should  
14 be completed and sent to the patient's GP."  
15 And that documentation, if one reads back, I can  
16 tell you is a précis of the medical notes, a diagnosis  
17 and the name of the consultant in charge to be provided  
18 to the GP.  
19 Did you not think of doing that?  
20 A. I think D is referring to C, isn't it, the discharge  
21 summary? That would be the flimsy discharge summary  
22 that would be from the ward, and that would be on --  
23 Raychel wasn't discharged from our ward, she went to the  
24 Children's Hospital and then, I think, that letter  
25 should have come from there.

66

1 Q. Go back to paragraph B and we'll take up your point in  
2 one second, if we may. Paragraph B, which is the  
3 preceding page, 1050 --  
4 THE CHAIRMAN: Do you want the two together?  
5 MR STEWART: If we could, 1050 and 1051 beside:  
6 "Details on discharge.  
7 "B. For each patient there should be a discharge  
8 summary/letter which should be completed within 14 days  
9 of the patient's discharge. This should include  
10 a précis of the clinical notes, the full diagnosis, and  
11 the name of the consultant in charge. This should be  
12 sent to the GP, hospital or institution to which the  
13 patient is discharged."  
14 And then D, when a patient dies, similar  
15 documentation, i.e. that referred to in paragraph B,  
16 should be completed and sent.  
17 Was anything sent by Altnagelvin to Dr Ashenhurst,  
18 Raychel's doctor?  
19 A. Not that I'm aware.  
20 Q. In hindsight, do you think it should have been?  
21 A. Yes.  
22 Q. Because it would have been an appropriate thing if she  
23 knew exactly what the diagnosis was, what had happened,  
24 to be there for the family?  
25 A. Certainly it would be good practice to make sure that

67

1 the discharge summary is sent to the general  
2 practitioner.  
3 Q. Because you seemed to suggest a moment ago, if I picked  
4 you up correctly, that perhaps that was the  
5 responsibility of the Royal in Belfast.  
6 A. Well, in terms of the point that you were making about  
7 point C where they're talking about the front sheet must  
8 be completed at the time of discharge, I think that is  
9 referring to the immediate communication that happens  
10 with any general practitioner.  
11 Q. It doesn't really matter where your patient dies, it's  
12 what you do in respect of your patient?  
13 A. There's no doubt that a discharge summary would have  
14 been useful.  
15 THE CHAIRMAN: Just to be specific, it should have come from  
16 you to Dr Ashenhurst?  
17 A. It should have come from my team to Dr Ashenhurst.  
18 THE CHAIRMAN: It should have come from your team because  
19 you're the consultant in charge?  
20 A. Yes.  
21 MR STEWART: Did you get your team together after the  
22 dreadful news came through?  
23 A. I spoke to Mr Makar and Mr Zafar.  
24 Q. Did you get them together -- I mean, did you bring all  
25 those people whom you have responsibility together into

68

1 a room, and say, "Right, what happened?"  
2 A. No.  
3 Q. Why not?  
4 A. Because I'd already informed the medical director first  
5 thing on Monday morning and a critical incident meeting  
6 was being called, which I thought was the correct forum  
7 for exploring those issues.  
8 Q. But at the critical incident review, there weren't many  
9 members of your team there, were there?  
10 A. As far as I know, I was there, Mr Makar was there.  
11 I believe Mr Zafar was there.  
12 Q. Mr Zafar was not there.  
13 A. Was he not?  
14 Q. It was you and Mr Makar. You hadn't seen Raychel and  
15 Mr Makar had performed the surgery, which seemed to go  
16 all right, and that was the end of his involvement.  
17 A. Apart from seeing Raychel's father, I think, on the  
18 morning of the --  
19 Q. I don't think he examined Raychel in the morning --  
20 A. No, no.  
21 THE CHAIRMAN: He did visit on the morning.  
22 MR STEWART: Yes, I think he was in the ward but not  
23 actually examining Raychel on the --  
24 A. No, he didn't examine Raychel.  
25 MR STITT: He did make comment as to how he saw Raychel and

69

1 made comment as to how she had appeared to him.  
2 MR STEWART: I stand corrected. I'm grateful for that.  
3 But there was no member of your team there who might  
4 have been able to describe the care she received on the  
5 8th, her condition on the 8th or her deterioration from  
6 the 8th into the 9th.  
7 A. That's correct.  
8 Q. So you didn't get a group of your team together and nor  
9 did your team gather together anywhere, especially not  
10 in the critical incident review.  
11 A. That's correct.  
12 Q. Did you make any attempt to identify those members of  
13 your team who had been involved with Raychel on the 8th  
14 or the 9th?  
15 A. Well, yes, I was aware that Mr Makar had been involved.  
16 I was aware that Mr Zafar had been involved. I didn't  
17 make an attempt to identify the two JHOs who were  
18 involved.  
19 Q. Why not?  
20 A. I didn't think that that was specifically where the  
21 issue lay. It was clearly that that was where the issue  
22 lay, but my focus had been on the surgical treatment.  
23 Q. But it wasn't for you to work out where the issues lay,  
24 it was for you to identify your team next, bring them  
25 through for review so the review could identify where

70

1 the issue lay.  
2 A. I don't remember being asked to identify all the  
3 members, but perhaps I was, but I certainly didn't  
4 specifically go and find the two housemen who were  
5 involved.  
6 Q. You didn't volunteer them.  
7 THE CHAIRMAN: Sorry, to rule out. To identify so early  
8 where the issue lay must have been premature,  
9 Mr Gilliland, because the issue as it became must have  
10 become pretty clear, it wasn't about how the surgery was  
11 conducted. She didn't die because of any mistake that  
12 was made during the -- there wasn't anything left in her  
13 that shouldn't have been in her.  
14 A. No, that was fairly clear.  
15 THE CHAIRMAN: But after she came out of surgery, she  
16 remained under the care of the surgical team, and surely  
17 in what might initially appear to have been a very  
18 unusual and unexpected death, it was fundamental to  
19 involve any member of the surgical team who had been  
20 involved in her care?  
21 A. I must say, I didn't think of that. This was, I think,  
22 the first of these incidents that I'd ever been involved  
23 in and I simply didn't consider that.  
24 THE CHAIRMAN: At any later point, did you speak to  
25 Dr Devlin or Dr Curran about this?

71

1 A. Not that I can recall.  
2 THE CHAIRMAN: So at no point did it strike you that what  
3 they did or didn't do was worth at least investigating,  
4 pinning down and seeing whether more might have been  
5 done? Even for their benefit as young doctors.  
6 A. Sure, sure. No, I didn't think about doing that because  
7 there was a critical incident review ongoing and  
8 I thought that people more senior and more used to  
9 dealing with that sort of situation who would be in  
10 charge of that process. I must say I didn't think about  
11 speaking to them directly.  
12 THE CHAIRMAN: Or suggesting that they should be brought  
13 into the critical incident review?  
14 A. I just didn't think about that.  
15 THE CHAIRMAN: Because the fact that they're not there on  
16 the first meeting on 12 June doesn't mean that they  
17 shouldn't be brought in as a result of a discussion on  
18 12 June.  
19 A. That's right.  
20 THE CHAIRMAN: The critical incident review is not a single  
21 meeting, however long it was.  
22 A. That's correct. There was a wide-ranging discussion,  
23 but I don't think -- certainly I don't recall  
24 a discussion about bringing those doctors into the  
25 review process.

72

1 THE CHAIRMAN: Okay. But the nurses are then saying at the  
2 review that they're frustrated, they have been troubled  
3 for some time about the lack of support they have from  
4 the surgical team; right?  
5 A. That's their evidence.  
6 THE CHAIRMAN: But surely in that context, the difficulty  
7 that they had tracking Dr Devlin or Dr Curran and  
8 bringing them in to do something, that must have struck  
9 you as being relevant?  
10 A. I must say, I don't think that it particularly struck me  
11 at that stage, and, as I've said, I wasn't necessarily  
12 the person in charge of that critical incident meeting  
13 at that time.  
14 THE CHAIRMAN: But this isn't a hierarchical thing. Surely  
15 at a critical incident review the important thing  
16 is that everybody who has something to contribute makes  
17 that contribution.  
18 A. Yes.  
19 THE CHAIRMAN: So the fact that you weren't in charge of the  
20 critical incident review is neither here nor there.  
21 A. I simply say that I didn't think about involving those  
22 doctors.  
23 MR STEWART: They've given evidence that they expected to be  
24 talked to. Dr Curran has told the inquiry that he  
25 expected to be talked to about it, and Dr Bhalla said

73

1 that he thought he should have been invited along to the  
2 review because he said he was the person from the  
3 surgical department who was present during the patient's  
4 critical time.  
5 A. That's correct.  
6 Q. Your juniors thought they were relevant people. It  
7 didn't occur to you?  
8 A. Certainly it wouldn't have occurred to me to have  
9 Mr Bhalla there. I don't know that there was anything  
10 specifically that he contributed at that stage. Her  
11 care was largely being looked after at that stage by  
12 a consultant paediatrician and a consultant  
13 anaesthetist, but I confess I didn't think about  
14 involving the JHOs.  
15 Q. Would it be fair to say because you prejudged the issues  
16 that might arise during the review and in your opinion  
17 Dr Curran wasn't required?  
18 A. No, I don't think that was the case. I think it's  
19 simply that I didn't think about involving them.  
20 THE CHAIRMAN: I think the reason that you are asked the  
21 question is because, on the approach that was taken, and  
22 excluding from the critical incident review or not  
23 thinking to include in the critical incident review  
24 people like Dr Curran, Dr Devlin, Dr Bhalla, you're  
25 restricting the surgical role to the conduct of the

74

1 surgery as opposed to Raychel's subsequent care on the  
2 ward when she is still under the care of the surgical  
3 team. So if you went in with a too narrow perspective  
4 of the role of the surgical team, you would focus on the  
5 surgery, which is why you have perhaps Dr Zafar there.  
6 But you don't expand the role of the surgical team to  
7 its full remit, which includes those from the surgical  
8 team who cared for her afterwards.  
9 A. Well, that was the main focus of the critical incident  
10 meeting, was her after care. There was a fairly  
11 preliminary discussion about her initial surgical care.  
12 The main focus was about her after care.  
13 THE CHAIRMAN: Surely all the more reason to bring in the  
14 people from the surgical team who were involved in her  
15 after care.  
16 A. I think you're probably -- absolutely correct, but  
17 I confess that I didn't think about doing that at the  
18 time, nor did I necessarily feel that it was my role to  
19 call the people to that meeting.  
20 MR STEWART: We can see from the agreed action plan, which  
21 was produced following the meeting, which is at  
22 022-108-336, that you were at paragraph 3 specifically  
23 actioned, tasked, to inform surgical junior staff to  
24 assess these results, that is U&E results, properly. So  
25 there we know that the junior staff were being

75

1 discussed, her issue of vomiting was being discussed,  
2 you were there at the meeting. You could have  
3 proffered, volunteered your team, because what doctors  
4 Curran and Devlin might have had to say about the  
5 child's vomiting or her response to medication or the  
6 notes and what they were told, all was relevant.  
7 A. All was relevant and I could have done that but  
8 I simply --  
9 Q. You sat through a review and didn't say, "Let's get hold  
10 of Devlin"?  
11 A. No, I didn't say that.  
12 Q. Why not?  
13 A. Because, as I've said, I simply didn't consider doing  
14 that.  
15 Q. You see, we're going back again to paragraph 37 of the  
16 GMC Good Medical Practice, this is about leading the  
17 teams. 314-014-016.  
18 We've been through this before. The penultimate  
19 bullet point again:  
20 "Regular reviews of the standards and performance of  
21 the team are undertaken and deficiencies addressed."  
22 This was an ideal opportunity to review the  
23 performance of your team when your patient dies.  
24 A. Yes.  
25 Q. Did you not think of fulfilling your obligation as

76

1 a doctor under the GMC code?  
2 A. Well, I thought that I was fulfilling my obligation by  
3 ensuring that the review was conducted by informing the  
4 medical director first thing on Monday morning of what  
5 had happened, and from that point on the critical  
6 incident review took place. I've absolutely been clear  
7 about the fact that I simply didn't think about asking  
8 either Dr Devlin or Dr Curran to that meeting and  
9 I wasn't responsible for the people who were called.  
10 THE CHAIRMAN: Sorry, Mr Gilliland, I just don't accept for  
11 the second or third time that you've said it that  
12 you are not responsible for the people who are called.  
13 Because I can't think for one second that if you had  
14 suggested at that meeting, "Since there are issues about  
15 the junior doctors and since the nurses have a general  
16 issue about the junior doctors, I think we should  
17 involve the junior doctors", I don't find it persuasive  
18 that you say, "I'm not responsible for the people who  
19 are called", because I would be astonished if anybody  
20 else who was involved in the review said that it would  
21 have been somehow inappropriate for you to suggest that  
22 other people be involved.  
23 A. That's true, but the nurses' issues were fully discussed  
24 at the review. It was open. The chairman of the review  
25 will have heard that, other doctors will have heard

77

1 that.  
2 THE CHAIRMAN: But apart from the nurses' general issue  
3 about the difficulty, for reasons which I understand  
4 about tracking down surgeons, because you have more  
5 responsibilities than Ward 6, but there must also have  
6 been issues about -- there must surely have been some  
7 discussion about how Raychel's condition had  
8 deteriorated to the extent that led to her death without  
9 anybody identifying, any doctor or nurse identifying,  
10 that something was going terribly wrong.  
11 A. There certainly were discussions about the fact that it  
12 wasn't identified.  
13 THE CHAIRMAN: Yes. And among the people who did not  
14 identify it were the two young doctors who were called  
15 in.  
16 A. Yes.  
17 THE CHAIRMAN: That's why it seems to me that they should  
18 have been part of the critical review team and why it  
19 must have been entirely open to anybody to  
20 suggest: we'll involve these people because they're  
21 involved in the care. Is there not another element to  
22 it? I mean, I have heard their evidence and their  
23 evidence is subject to the fact that in June 2001 they  
24 were both young, inexperienced doctors.  
25 A. Mm-hm.

78

1 THE CHAIRMAN: But let's set aside for the moment any issue  
2 about pointing the finger of blame at them. It would be  
3 entirely understandable if somebody like Dr Curran was  
4 beating himself up a bit afterwards about "Could I have  
5 done more? What if I had called for senior assistance  
6 when I came in at about midnight?" Part of speaking to  
7 him afterwards is a way of reassurance and support --  
8 A. And pastoral care.  
9 THE CHAIRMAN: Yes. But was that done? If it was done, it  
10 wasn't done by you.  
11 A. No.  
12 MR STEWART: So I take it that you didn't provide a list of  
13 surgical staff who were involved in this case for the  
14 consideration of the review meeting?  
15 A. Not that I can recall.  
16 Q. Did anyone ask you at the meeting to identify signatures  
17 in the notes to identify for the meeting who individuals  
18 might have been? Dr Zafar in particular.  
19 A. Again, I'm not sure if I was asked to identify those.  
20 Q. And in relation to the discussion referenced by  
21 Dr Nesbitt, which we looked at a moment ago about  
22 confusion as to who the on-call consultant was as  
23 opposed to the admitting consultant, did anyone say,  
24 "Let's have a look at the surgeons' rota and see who it  
25 was"?

79

1 A. I can't recall anyone doing that because I was there and  
2 I had -- as far as I was aware, this child was under my  
3 care and I don't think anyone would have thought to look  
4 at the rota.  
5 Q. Do you know what happened to the surgeons' rota, the  
6 actual piece of paper?  
7 A. I have no idea.  
8 Q. It's gone missing.  
9 A. I have no idea.  
10 Q. Did you think yourself about meeting with Mr and  
11 Mrs Ferguson, the Ferguson family?  
12 A. No, I didn't.  
13 Q. You knew at that time what your duty was under the GMC  
14 code? Perhaps I'll read it. It's 314-014-012.  
15 Paragraph 23 at the top:  
16 "If a child under your care has died, you must  
17 explain to the best of your knowledge the reasons for  
18 and the circumstances of the death to those with  
19 parental responsibility."  
20 It couldn't be clearer.  
21 A. No.  
22 Q. Did you know about that at the time?  
23 A. I wouldn't have been able to quote that directly at the  
24 time.  
25 Q. Well, did you understand the broad thrust of --

80

1 A. Yes.  
2 Q. -- what was expected of you as an obligation or duty?  
3 A. Yes, I would have expected the broad thrust of that.  
4 Q. Okay. For that reason did you -- I assume you decided  
5 not to fulfil that obligation, or did it simply not  
6 occur to you?  
7 A. Well, I wasn't given any opportunity during Raychel's  
8 time in hospital after she became unwell. I wasn't  
9 called to her at that stage. She had died elsewhere.  
10 There were other doctors who were dealing with her at  
11 that time and I would have assumed would have spoken to  
12 Raychel's parents. I was the named consultant, but the  
13 issues did not appear to be specifically related to  
14 surgery, and there were other doctors who were there who  
15 were explaining to Mr And Mrs Ferguson to the best of  
16 their ability what was happening.  
17 Q. So you made assumptions that other people were talking  
18 to them and --  
19 A. Well, the assumptions were based on the information that  
20 I knew at that stage, that doctors McCord and Nesbitt  
21 had attended Raychel that night.  
22 Q. Well, could you not have explained those circumstances  
23 to the Fergusons?  
24 A. I don't know that I would have needed to explain those  
25 circumstances to the Fergusons because they were there,

81

1 they met doctors McCord and Nesbitt.  
2 Q. And how do you feel now about your failure to fulfil  
3 that obligation?  
4 A. I don't think I had any opportunity to speak to the  
5 Fergusons whilst Raychel was unwell and in Altnagelvin.  
6 Q. But you had the opportunity to make opportunity to meet  
7 with them after her death.  
8 A. I was given the opportunity on 3 September.  
9 Q. I'm really talking about in the immediate aftermath.  
10 They need to speak to her consultant. You didn't make  
11 yourself known to them, put yourself forward to them.  
12 Don't you think now, in hindsight, that was the proper  
13 thing to do?  
14 A. I'm not sure that I would have thought at that time or  
15 even now of contacting the family in those  
16 circumstances.  
17 Q. So you're saying that this, paragraph 23, did not apply  
18 to you?  
19 A. No. I think it does apply to me.  
20 THE CHAIRMAN: I accept, Mr Gilliland, there's a variety of  
21 ways and circumstances in which paragraph 23 can be put  
22 into action. There isn't a rule, you meet the family at  
23 10 o'clock in the morning the day after the death.  
24 You have to have some discretion. But if you accept  
25 that that paragraph applies to you, it seems that the

82

1 exercise of your discretion was not to meet them to  
2 explain anything to them at any time. Now, that doesn't  
3 seem to me to be what is expected of you by the GMC.  
4 A. Yes, I would not have -- I would not have and did not  
5 think about meeting the Fergusons after the death of  
6 Raychel.  
7 THE CHAIRMAN: You told me when you were here in March that  
8 you were invited to the meeting on 3 September.  
9 A. Yes.  
10 THE CHAIRMAN: But you didn't believe that it was  
11 appropriate for you to go because you'd never met them  
12 before and you thought that the explanations that they  
13 were entitled to receive could equally be given by  
14 others?  
15 A. Well, would be in fact probably better given by others.  
16 That was my feeling at that stage, yes. And I said at  
17 that stage that it was my belief that there wasn't any  
18 issue specifically around surgery, the conduct of the  
19 appendicectomy and so forth. But I understand that  
20 there were.  
21 THE CHAIRMAN: Again, I'm sorry, with respect, that's too  
22 narrow. It's not enough, from what we now know, to say  
23 there was no issue around surgery. There's an issue  
24 around the surgery about whether the surgery should have  
25 been carried out, but let's set that aside because

83

1 that isn't why Raychel died.  
2 A. No.  
3 THE CHAIRMAN: But there are issues. If there aren't issues  
4 around surgery there are issues about the care which she  
5 received, including care which she received from the  
6 surgical team for which you are responsible.  
7 A. Yes.  
8 THE CHAIRMAN: So why does that not give you an obligation  
9 to lead for the surgical team at the meeting with the  
10 family?  
11 A. Yes. Well, as I've said in March, I think it's on the  
12 transcript, that I now know that there were questions  
13 that needed to be asked and answered, and I was sorry  
14 that I was not there to answer them.  
15 MR STEWART: At that time were you aware that there was  
16 a view at the Children's Hospital in Belfast that there  
17 had been wrong fluids used and mismanagement of this  
18 case? Were you aware of that at the time?  
19 A. My recollection was that there was some concern or  
20 disquiet at the critical incident meeting that there had  
21 been criticism of the management and specifically of the  
22 fluids.  
23 Q. So there you are, you are the consultant in charge of  
24 Raychel's care who didn't see Raychel, she's dead, and  
25 there may be criticism of the care. Was your decision

84

1 not to meet Mr and Mrs Ferguson because, frankly, you  
2 didn't want to go there?  
3 A. No, I don't think that was the entire reason, but  
4 there's no doubt, and I'd be perfectly honest about it,  
5 those are very difficult and emotional meetings, as you  
6 would understand. So there was possibly some reluctance  
7 on my part for that reason, but there were other  
8 reasons, and, as I said, I'd never had the opportunity  
9 to form a relationship with either Mr and Mrs Ferguson  
10 or with Raychel, and I thought there would be others  
11 best placed who had already met them to explain what was  
12 happening.  
13 Q. But it isn't exactly those circumstances where the  
14 circumstances are difficult and have to be faced up to  
15 where it is a surgeon's responsibility to go forward and  
16 do what the GMC requires of them?  
17 A. It certainly is the responsibility of doctors to go and  
18 meet with that family.  
19 Q. Given that you knew there was criticism being made, did  
20 you take any steps at that stage to audit or review what  
21 had happened?  
22 A. Well, there was a review already taking place. I don't  
23 recall specifically creating or starting any particular  
24 audit.  
25 Q. What about a peer review?

85

1 A. By asking expert witnesses in?  
2 Q. Well, perhaps you could look at this document. It's  
3 220-002-023. This is again back to the 1999 NCEPOD  
4 recommendations, this time back with children again, and  
5 it's the third bullet point on the left:  
6 "Clinical recommendations."  
7 It's something as a surgeon you should know:  
8 "The death of any child occurring within 30 days of  
9 an anaesthetic or surgical procedure should be the  
10 subject of peer review irrespective of the place of  
11 death."  
12 Which seems entirely to fit the Altnagelvin  
13 position.  
14 In fact, the next bullet point goes on to emphasise  
15 again:  
16 "The events surrounding the perioperative death of  
17 any child should be reviewed in the context of  
18 multidisciplinary clinical audit."  
19 Did you at the time think that was a good idea or  
20 did you know it to be a good idea?  
21 A. I wouldn't have thought about doing an audit at that  
22 stage because I wasn't quite sure what one would audit.  
23 Death by dilutional hyponatraemia is such a rare  
24 occurrence that I'm not sure, at least I wasn't sure at  
25 that stage what form an audit would take, what benchmark

86

1 one would audit against.  
2 Q. Well, you could ask somebody and find out.  
3 THE CHAIRMAN: Sorry, but that suggests that you thought  
4 about it, you weren't sure what form the audit would  
5 take and, therefore, you didn't do it. Let's go back  
6 a step. Did you think about doing one at all?  
7 A. No, I didn't think about doing an audit.  
8 THE CHAIRMAN: And you weren't familiar with this  
9 recommendation from CEPOD?  
10 A. I'm not sure whether I was familiar with that  
11 recommendation, but again I'm not -- you know, in terms  
12 of an audit, I'm not quite sure what one would have  
13 audited or what benchmark one would have -- so I didn't  
14 consider it.  
15 THE CHAIRMAN: Let's go back to the peer review, then. The  
16 peer review doesn't have the same concern that you've  
17 just expressed over what exactly an audit might entail.  
18 A. Mm.  
19 THE CHAIRMAN: I have been told more times than I can  
20 possibly remember how rare it is for a child to die in  
21 hospital.  
22 A. Mm-hm.  
23 THE CHAIRMAN: And I presume you endorse that. That is  
24 exceptionally rare?  
25 A. Mm-hm.

87

1 THE CHAIRMAN: So when the death of a child occurs after  
2 a standard operation, that is quite a shocking event?  
3 A. It is.  
4 THE CHAIRMAN: And NCEPOD say -- in fact, surely that NCEPOD  
5 recommendation must have even more force in such  
6 circumstances?  
7 A. Yes, and that is exactly why I took the actions that  
8 I did on the Monday morning. I realised this was a very  
9 serious event, a very rare event, which is why  
10 I informed the medical director and, as you know, there  
11 was a critical incident review set up.  
12 THE CHAIRMAN: Who might you go to for a peer review?  
13 A. Again, I thought that that was the process that was  
14 being put in place. This was a review of everything  
15 that had happened to Raychel by peers within the  
16 hospital.  
17 MR STEWART: But you knew, for example, that the surgical  
18 team weren't there and you knew the Royal Belfast  
19 Hospital for Sick Children, which was making critical  
20 noises offstage, they weren't there either. How was it  
21 a review?  
22 A. I wouldn't have even dreamed of calling the  
23 Children's Hospital doctors to that meeting. That would  
24 not have entered my head at all. Remember, this is the  
25 first of these meetings that I have been at and it's

88

1 being run by somebody much more senior and much more  
2 familiar with these processes than myself. I simply  
3 wouldn't have considered --  
4 Q. But you're the consultant surgeon and this was your  
5 patient.  
6 A. I appreciate that.  
7 Q. Because other surgeons happen to be elevated to the  
8 position of medical director doesn't place them in  
9 a role of authority over you in that way. You have to  
10 make suggestions of your own.  
11 A. Yes. I certainly wouldn't have considered inviting the  
12 Children's Hospital doctors.  
13 Q. You mentioned a moment ago being invited or having the  
14 opportunity to meet with Mr and Mrs Ferguson or  
15 Mrs Ferguson at a meeting that was arranged in early  
16 September 2001.  
17 A. Mm-hm.  
18 Q. Who invited you to go along to that?  
19 A. I don't actually remember.  
20 Q. Was it Dr Fulton?  
21 A. Again, I don't remember.  
22 Q. You did discuss your non-attendance with Dr Fulton.  
23 A. I did.  
24 Q. And what features of your non-attendance did you discuss  
25 with Dr Fulton?

89

1 A. The ones that I've outlined.  
2 THE CHAIRMAN: "I don't know the family. I don't really  
3 think I have anything to contribute and there are others  
4 going who will be able to contribute more"? Sorry, is  
5 that the gist of what you would --  
6 A. Yes.  
7 THE CHAIRMAN: -- been saying to them, "I don't know the  
8 family, I don't really think I have anything to  
9 contribute and there are others going who will be able  
10 to contribute more"?  
11 A. That would be a summary of it.  
12 MR STEWART: Did he ask you if you had already made contact  
13 with the Fergusons?  
14 A. Not that I recall. This was -- as far as I recall, this  
15 was an informal meeting. I believe I was in theatre  
16 at the time and we had a conversation close to the  
17 theatre block.  
18 Q. And did you say to him, "Well, you know, I know my duty  
19 under paragraph 23 of the code, but I think on this  
20 occasion I just don't think" --  
21 THE CHAIRMAN: No, he didn't.  
22 MR STEWART: Did Dr Fulton remind you of your duty under  
23 paragraph 23?  
24 A. No, not under paragraph 23.  
25 Q. Did he remind you of any of your duties?

90

1 A. I think it was Dr Fulton's position that he felt that  
2 I should be there.  
3 Q. And at that stage, Dr Fulton was -- he's still the  
4 medical director?  
5 A. He was medical director, yes.  
6 Q. So your medical director thinks you should be there?  
7 A. Yes.  
8 Q. So why didn't you take his advice?  
9 A. Because, for the reasons that I've outlined already.  
10 Q. I see. Could I suggest to you that perhaps you were  
11 motivated again by the fact that you didn't want to have  
12 to meet with this family in these really excruciatingly  
13 difficult circumstances?  
14 A. I think those circumstances would have been very  
15 difficult and I think, as I've said already, no one would  
16 would relish a meeting like that, no one would  
17 necessarily want to have to go through that sort of  
18 a meeting. But there were other reasons for not  
19 attending.  
20 Q. Were you perhaps defensive because of possible  
21 litigation? We've looked at your letter earlier on  
22 in relation to inquest evidence with your professional  
23 indemnity insurers. Were you worried about litigation?  
24 A. I don't know that I was particularly concerned about  
25 litigation at that stage.

91

1 Q. Were you defensive in case it might emerge?  
2 A. I don't specifically recall.  
3 Q. After the critical incident review, were you asked to  
4 make a statement for the risk management coordinator  
5 like everybody else?  
6 A. Sorry, I will need to be reminded. I don't recall.  
7 Q. Well, a number of the individuals involved volunteered  
8 statements to her immediately after the meeting.  
9 A. Mm-hm.  
10 Q. You didn't.  
11 A. No.  
12 Q. Did you ask your team to proffer their statements to  
13 her?  
14 A. No, not that I recall.  
15 Q. And so she had to write to you five months after the  
16 critical incident review, in November, to ask you to  
17 furnish her with a statement.  
18 A. Yes.  
19 Q. But you are at that time a fairly key player in the  
20 Altnagelvin response to this death. You're a key player  
21 in terms of the response going forward to the inquest,  
22 aren't you?  
23 A. Yes.  
24 Q. Because you were the consultant, and when documents like  
25 the post-mortem report come in, it's sent off straight

92

1 to you, you're copied into it immediately; isn't that  
2 right?  
3 A. I don't remember being -- seeing the post-mortem report.  
4 Q. All right. I can bring the documents through to you if  
5 you like.  
6 A. Sorry, I do not remember being furnished the post-mortem  
7 report immediately it was published. I certainly  
8 remember seeing it after or in and around the time of  
9 the inquest.  
10 Q. So you send a statement in at the end of 2001, beginning  
11 the 2002, to the RMCO.  
12 Can we please see page 022-055-153? This is a note  
13 prepared by Mrs Brown. I think she may have sent this  
14 to the coroner, indicating the statements she was  
15 getting for further submission to him.  
16 You appear at the top:  
17 "Mr Gilliland, consultant surgeon. Mr Gilliland did  
18 not see Raychel\*."  
19 And the asterisk means: I've received statements  
20 from these staff and they've returned for minor  
21 amendments.  
22 Do you remember what amendments you were asked to  
23 make to your statement?  
24 A. No.  
25 Q. Can we look at page 022-053-050? This is a letter from

93

1 you to Dr Clements of January 2002. It's in relation to  
2 your statement. Presumably it's the same statement that  
3 you presented to the RMCO, and you write to him:  
4 "Thank you for your letter."  
5 And you tell Dr Clements:  
6 "I have amended my statement in accordance with your  
7 advice."  
8 So did you make amendments in consequence of what  
9 your Medical Protection Society advised you to do?  
10 A. I presume so.  
11 Q. Did you add things or delete things?  
12 A. I have no recollection of that whatsoever.  
13 Q. Were they minor amendments or were they rather more  
14 substantive?  
15 A. I have no recollection whatsoever.  
16 Q. Were they things like punctuation and ambiguity or were  
17 they things that it was felt you ought to include for  
18 the sake of completeness?  
19 A. I'm sorry, I can't help you further.  
20 Q. Did you feel at any stage uneasy that you didn't have  
21 control of your own statement?  
22 A. No, not specifically. I think whenever one is asked to  
23 write such a statement, it's fairly standard to send  
24 that statement off to one's Medical Protection Society.  
25 Q. This statement, of course, was for Her Majesty's

94

1 coroner, wasn't it?  
2 A. Yes.  
3 Q. And that's a slightly more serious thing than just  
4 making a statement for an internal hospital committee or  
5 something, isn't it?  
6 A. Yes. It's an important statement.  
7 Q. Because -- can we go to paragraph 32 of the GMC Good  
8 Medical Practice, 314-014-014.  
9 Paragraph 32, this is about your co-operation with  
10 inquiries and so forth:  
11 "Similarly, you must assist the coroner by  
12 responding to enquiries and by offering all relevant  
13 information to an inquest into a patient's death."  
14 What I'm concerned about is that you may have been  
15 offering all relevant information in relation to  
16 Raychel's death but perhaps somebody, perhaps  
17 Dr Clements or somebody else, was suggesting that you  
18 don't do that.  
19 A. I don't think that happened.  
20 Q. In which case you would have a conflict with your  
21 obligation and duty as a doctor, wouldn't you?  
22 A. Sorry, I missed that.  
23 Q. If you were being asked to take something out of  
24 a statement which you had previously and initially  
25 thought relevant, you would then have a conflict with

95

1 your duty under paragraph 32?  
2 A. You would.  
3 Q. Can you recall grappling with any such conflicts?  
4 A. No.  
5 Q. In the approach to the inquest, were you called to  
6 pre-inquest consultation meetings?  
7 A. Again, I have no specific recollection of that meeting,  
8 whether I was there or not.  
9 Q. I see. Thank you.  
10 Thank you, sir, I have no further questions.  
11 THE CHAIRMAN: Mr Quinn?  
12 Questions from MR QUINN  
13 MR QUINN: There is one issue I want to raise, Mr Chairman.  
14 Could we have WS333/1, which is the GP's statement.  
15 THE CHAIRMAN: Yes.  
16 MR QUINN: Could I have pages 2 and 3 put together, please?  
17 THE CHAIRMAN: 333/1 and pages?  
18 MR QUINN: 2 and 3 of that reference.  
19 THE CHAIRMAN: They're about to come up. Thank you very  
20 much. (Pause).  
21 And your point is?  
22 MR QUINN: The first point I want to ask is arising out of  
23 question 3.  
24 I want to ask him about the last few lines, which  
25 read:

96



1 "Fortunately, child death in general practice is  
2 rare and since Raychel anaesthetist death we have had as  
3 a practice only one, and we were telephoned by  
4 a consultant to inform us."

5 I would like to ask, sir, whether or not this  
6 witness thinks it would be good practice for  
7 a consultant to phone the general practitioner  
8 personally and inform her rather than meet her in  
9 a supermarket and casually mention that he was the  
10 consultant in charge of Raychel.

11 THE CHAIRMAN: I take it you agree that must be a better  
12 practice?

13 A. It is a better practice, and I must say I have  
14 telephoned quite a number of general practitioners about  
15 deaths of their patients.

16 MR QUINN: Why did he not do it on this occasion?

17 A. Because on this occasion, again, Raychel had died  
18 elsewhere and I simply didn't think to do so.

19 THE CHAIRMAN: Okay.

20 MR QUINN: I have nothing further arising after the answer  
21 I got, Mr Chairman.

22 THE CHAIRMAN: Thank you. Before I come to Mr Stitt, are  
23 there any other questions from the floor? No?

24 Mr Stitt, do you have any questions?

25 Questions from MR STITT

97

1 MR STITT: I have one matter to bring up. It's not in the  
2 form of a question of the witness. Can I put it to you  
3 and will you decide if it's worthy of consideration?

4 THE CHAIRMAN: Yes.

5 MR STITT: If this document could be called up, WS035/2, 15.  
6 This is the document which is the statement from  
7 Dr Nesbitt. We have dealt with subsection B of  
8 section 18. There has been considerable questioning,  
9 reasonable questioning, from Mr Stewart relating to this  
10 confusion in relation to a named consultant as opposed  
11 to the consultant on call.

12 I would just ask -- my point is this, sir. I don't  
13 quite see what the complication is. If it reads, yes,  
14 there was discussion about the fact that the on-call  
15 consultant was not necessarily the consultant under  
16 whose care Raychel had been admitted and that there was  
17 potential difficulty in letting that consultant -- now,  
18 if you say that consultant is the -- lets assume that's  
19 the consultant under whose care Raychel had been  
20 admitted. Now, Raychel was admitted on 7 June and  
21 Raychel died on 10 June.

22 And the sentence continues:

23 "There was a potential difficulty in letting that  
24 consultant, the admitting consultant, know that this  
25 patient had died."

98

1 If that's the syntax, then there's one consultant  
2 who's the admission consultant under whom Raychel was  
3 admitted on the 7th, but there could be -- this could  
4 read that it could be potential difficulty in letting  
5 the admitting consultant know. That might not  
6 necessarily be the same consultant as the on-call  
7 consultant when Raychel died.

8 THE CHAIRMAN: Okay. Two points about this. One is that  
9 Mr Gilliland doesn't recall this conversation in any  
10 event. The second point is that Dr Nesbitt will be  
11 giving evidence. Shall we --

12 MR STITT: Maybe it's better left. I just thought --

13 THE CHAIRMAN: Yes. Thank you very much.

14 Mr Gilliland, that's your evidence concluded, so  
15 unless there's any issue that you wanted to cover that  
16 hasn't been covered, you're now free to leave.

17 A. Having read that last point, I think I now understand  
18 what that's about. That's about the time whenever  
19 Raychel became acutely unwell. I think that's what  
20 Dr Nesbitt is referring to, not necessarily whose name  
21 she was specifically under.

22 THE CHAIRMAN: Okay. We can clarify that with him when he  
23 comes. Thank you very much indeed.

24 (The witness withdrew)

25 THE CHAIRMAN: We'll break for lunch. What I'll do this

99

1 afternoon, Mr Quinn, we'll start at 2 o'clock so we'll  
2 get most of our lunchtime. We'll start at 2 o'clock  
3 with Ms Millar and we'll do any housekeeping,  
4 timetabling after her evidence is complete.

5 Okay? Thank you very much.

6 (1.08 pm)

7 (The Short Adjournment)

8 (2.00 pm)

9 THE CHAIRMAN: We'll hear from Sister Millar and then do  
10 some tidying up at the end.

11 MR STEWART: Sister Millar, please.

12 MRS ELIZABETH MILLAR (called)

13 Questions from MR STEWART

14 MR STEWART: Since last you were with us, you have provided  
15 a further witness statement, which has been given the  
16 number WS056/3, which you signed on 8 July of this year.  
17 Are you content that the inquiry should adopt that  
18 statement as part of your formal evidence?

19 A. Yes.

20 Q. Thank you. To recap on where you were, you were the  
21 senior paediatric nurse, ward sister, with many years'  
22 experience, 25 years of experience, working with  
23 children.

24 A. Yes. At the time Raychel died I had 35 years.

25 Q. 35?

100

1 A. Mm-hm.  
2 Q. And you've retired since?  
3 A. I retired almost three years ago.  
4 Q. Yes. I'm interested if we might for a moment explore  
5 how your job responsibilities were set out in 2001. We  
6 don't have a 2001 job description for you, but there is  
7 one which is dated 2004, and it appears at WS056/2,  
8 page 34.  
9 (Pause).  
10 The machines take time to warm up. (Pause).  
11 This is the cover page of the document, and it comes  
12 from you, and it's for the job described as paediatric  
13 unit manager. But it's 2004. This was your job in  
14 2004.  
15 Can you tell us whether or not your job  
16 responsibilities were very different in 2004 from how  
17 they'd been in 2001?  
18 A. Yes, they were different. In 2004 I had four areas  
19 under my responsibility.  
20 In 2001 I had three, with one more impending. At  
21 that time in 2001/2002, we were then developing the  
22 transitional care unit for children with life limiting  
23 conditions.  
24 Q. Yes.  
25 A. And I suppose the big change in my responsibility

101

1 between the late 90s/early 2000s and going on 2004 was  
2 the -- you know, clinical governance, setting of  
3 standards, auditing. It was still very much in its  
4 infancy, but we were striving to get our heads round it  
5 really, and so there was more responsibility into  
6 accountability and standard setting, as I say, and  
7 auditing.  
8 Q. Perhaps could we look at page 36 of this document, and  
9 we'll just perhaps identify those responsibilities which  
10 probably were in place in 2001. This is "Professional  
11 leadership".  
12 Number 2:  
13 "Exercise leadership and achieve high moral by sound  
14 staff management."  
15 I'm not sure I understand that.  
16 THE CHAIRMAN: "Morale".  
17 MR STEWART: Oh, "morale", thank you, sir:  
18 "... to achieve high morale by sound staff  
19 management. Promote good relationships and timely  
20 communication ..."  
21 Was that part of your 2001 remit?  
22 A. It would have been, yes.  
23 Q. And going on down 3 and 4:  
24 "To work regularly within the clinical setting to  
25 ensure that personal skills are maintained and

102

1 developed."  
2 That would have been part of your job in 2004.  
3 A. Yes.  
4 Q. As would 4, to maintain accurate up-to-date records?  
5 A. Yes.  
6 Q. 5, to update and improve knowledge of relevant research,  
7 changes in developments in nursing and professional  
8 knowledge and competence. That would have been broadly  
9 speaking part of your job in 2001?  
10 A. Yes.  
11 Q. Number 6, to attend study days and courses and to  
12 disseminate information and feedback appropriately.  
13 A. Yes.  
14 Q. What about number 7? Forming links with key workers in  
15 the clinical/community areas --  
16 A. Yes.  
17 Q. -- to a network of informed personnel.  
18 A. Yes.  
19 Q. And 8, individual performance review.  
20 A. Yes.  
21 Q. And maintaining personal records of professional  
22 development.  
23 A. Yes.  
24 Q. So really, much of this is really describing how you  
25 work in 2001.

103

1 Over the page, page 37, might be a bit different,  
2 maybe not. This is clinical governance and quality.  
3 The first point is:  
4 "To ensure compliance with the reporting of critical  
5 incidents, investigating accidents and incidences,  
6 preventing recurrence where possible and advising the  
7 clinical services manager as appropriate."  
8 That was part of your job in 2001?  
9 A. Yes. I would say that in the late 90s/early 2000s we  
10 probably weren't as good about reporting, say,  
11 incidences or adverse incidents as we were later on,  
12 2004, 2003, because at some stage the introduction of  
13 the adverse incident reporting was commenced. I cannot  
14 remember what year that was.  
15 Q. We can get the policy for you. It was certainly --  
16 pre-dated Raychel's --  
17 A. Yes, but we were working, we were striving to improve on  
18 our reporting of incidences.  
19 Q. Yes. And in fact, at number 2 there is the task to  
20 monitor, to be responsible for close monitoring of the  
21 reporting system and to initiate clinical audit in  
22 conjunction with risk management and advising the  
23 clinical services manager of areas of concern. Was that  
24 part of --  
25 A. Well, that in 2001, again, was very much in its infancy

104

1 and it was really after that that we began auditing and  
2 really looking very closely at incidents that may be  
3 recurring, such as adverse incidents with medicines and,  
4 you know, things like that. So recurrent incidences  
5 with medication, for instance, would raise concerns, and  
6 we would be looking to see, you know, maybe who was  
7 involved or what medications were involved and did we  
8 need extra training, or had the medication -- you know,  
9 calculating medications --

10 THE CHAIRMAN: I wonder, can you give me a practical example  
11 of how things changed. You weren't here yesterday.

12 A. No.

13 THE CHAIRMAN: Mr Stewart showed Mrs Noble on screen  
14 a letter which was sent by you and another nurse before  
15 Raychel's death, expressing concerns about staffing  
16 levels. Okay? And it went to Margaret Doherty. That's  
17 an example of an issue being raised at the nursing end  
18 of concern.

19 As governance then develops in the late 1990s and  
20 through the 2000s, how would something like that be  
21 dealt with differently as a governance issue, as you got  
22 more enhanced governance procedures in place? Would it  
23 still take the same format of writing a letter up the  
24 line to Margaret Doherty or would there be some  
25 different way of doing it?

105

1 A. No. I mean, prior to -- say in the 80s/90s, say, for  
2 instance, if you had problems with staffing, you know,  
3 it would be very difficult to get something immediate  
4 done.

5 THE CHAIRMAN: Okay.

6 A. In the beginning of the 2000s, we did an audit on  
7 workforce planning. Mary McKenna, who was the junior  
8 sister, she set up an audit looking at the amount of  
9 time nurses took, say, for instance, in the day going to  
10 theatre with the child, going to X-ray with the child,  
11 and she put all the data or the results of that  
12 together, and she was able to present that to our -- to  
13 me, plus our clinical services manager. But it was --  
14 you know, we had to be able to persuade the clinical  
15 services manager that we needed extra staff, so we had  
16 to be able to prove that -- we found that unless we were  
17 actually able to prove that we needed them, we didn't  
18 get them.

19 THE CHAIRMAN: Right.

20 A. But the letters that were written, you know -- we always  
21 experienced winter pressures, there wasn't a winter went  
22 by that we may have had 100 per cent occupancy, and then  
23 in the spring/summer months we might have gone down to  
24 45 -- 35 per cent occupancy. So we always ran into  
25 trouble in the winter time and there was -- we did have

106

1 problems recruiting children's trained nurses. We just  
2 couldn't get them at that stage.

3 We tried to recruit from the mainland UK and from  
4 the south of Ireland, but we had very little success.  
5 And then we then introduced the nursery nurses in 2002.  
6 But staffing issues were prior -- they were very  
7 difficult in the winter months.

8 THE CHAIRMAN: Okay.

9 MR STEWART: Yes. I will ask you in a moment, if I may,  
10 about those staffing issues. Can I just finish asking  
11 you one question about the document on the screen. In  
12 fact, if we go over the page to page 238. Sorry,  
13 page 38.

14 This is about education and your job  
15 responsibilities.

16 At paragraph 3 you are charged with ensuring all  
17 members of staff participate in the individual  
18 performance review programme on an annual basis and to  
19 advise the clinical services manager of  
20 training/educational requirements for staff.

21 Was that in place as part of your job in 2001?

22 A. It was, yes.

23 Q. So you will identify the training needs of individual  
24 members of staff?

25 A. Well, we were always looking at educational needs, but

107

1 there was very little money around back in the 80s and  
2 the 90s for nurse training. Medical staff, I think, had  
3 their quota given to them individually every year, but  
4 we didn't. From the early 2000s onwards, I think I --  
5 I've forgotten the dates, but we were made much more  
6 aware of our need to update training and looking at our  
7 area that we worked in as to what the needs were.

8 So for instance, if we had new equipment or some new  
9 management of patients, we were able to put in a request  
10 for training, but -- and through the individual  
11 performance, you know, and appraisal, each year. Now,  
12 I have to say that I didn't always get an appraisal done  
13 every year with all my staff. It may have taken every  
14 two years.

15 Q. Yes.

16 A. But through that, I tried to identify the training  
17 needs. I then put in my request to my clinical services  
18 manager. The money may not always have been there, but  
19 certainly within my last 10 years of training, 10 years  
20 of working, it became much easier to avail of education  
21 and training. Prior to that, it wasn't, and also the  
22 educational consortium wasn't in place, I think, at  
23 that -- it was just starting.

24 Q. My question is this. If you were responsible for  
25 identifying training needs of others and you yourself

108

1 had not received training in IV fluid management or  
2 electrolyte management, how could you identify the  
3 training needs of others in those areas that you  
4 yourself didn't know about?

5 A. Well, at that time IV fluids was very much the domain of  
6 the medical staff, the ordering of IV fluids or the  
7 prescribing of IV fluids. But the actual erecting of  
8 IV fluids and connecting a child up and monitoring the  
9 IV fluid, recording was -- it was done during a nurse's  
10 training, during student nurse training and during their  
11 placement on the wards.

12 Q. Because this inquiry has heard from Professor Hanratty  
13 on 20 March this year, and she was of the view that  
14 nurses should have had an understanding of intravenous  
15 fluids and the management of them.

16 A. No, we didn't.

17 Q. Thank you. Now to double back to the issue of staffing  
18 you were discussing. A series of letters passed between  
19 yourself and Staff Nurse McKenna and clinical services  
20 manager. I think you countersigned one of them.

21 It was clear that the children's unit was  
22 experiencing difficulties with staffing. The first  
23 letter appears at 321-051-002.

24 This is June of 2000, this is a year before Raychel  
25 came to you. This is Staff Nurse Mary McKenna writing

109

1 to Mrs Doherty, the clinical services manager:

2 "Further to our discussion on the difficulties we're  
3 experiencing at present providing adequate cover, I wish  
4 to make you aware of the number of patients."

5 And so on.

6 And over the page at 003, she concludes the letter  
7 with the peroration:

8 "We now feel we need to address the problem of  
9 staffing levels on the ward and reach a solution."

10 How long had this been a problem for? Or was it  
11 a problem, first of all, in your view, at that time?

12 A. Well, as I've said previously today, we experienced  
13 staffing difficulties every winter. It was very rare  
14 for any winter to go by that at some level we didn't  
15 experience staffing problems. Sometimes there was  
16 a high level of sickness amongst staff. We may have had  
17 a number of staff on maternity leave. You could have  
18 had six or seven on maternity leave. You may have had  
19 some highly dependent children and so there were  
20 problems during the winter months, but it wasn't  
21 unusual.

22 Q. This letter, you see, was written in June, just as  
23 Raychel was admitted in June. That's why I draw it to  
24 your attention. Were there staffing issues in June or  
25 the summer months?

110

1 THE CHAIRMAN: No, it's a year earlier.

2 MR STEWART: A year earlier, yes.

3 A. No, there weren't staffing levels during June when  
4 Raychel was admitted. There was a full quota of night  
5 duty, night staff on, and also our occupancy levels  
6 in June of that year when Raychel was admitted were --  
7 I think the Friday that I was on duty, I think we had  
8 20/21 children. Now, our bed complement is 43.

9 MR STEWART: You're jumping ahead of me a bit and we will  
10 perhaps analyse the situation during those days in  
11 a moment. But I want to sketch out what the background  
12 had been and whether problems were more wide reaching  
13 than just the winter months.

14 Another letter, this is the letter you  
15 countersigned, which is at 321-051-004 and 005.

16 This is coming back to the issue in February 2001.  
17 By getting you to countersign this letter to  
18 Mrs Doherty, were you attempting to emphasise the issue  
19 and give it added weight and authority?

20 A. No, I -- Mary McKenna was the junior sister at the time,  
21 and I think she had had a particularly bad day at some  
22 stage. I don't know whether it was this letter or the  
23 other, but I know she told me she'd written a letter.  
24 She'd had a particularly bad day because a child had had  
25 to be transferred to Belfast. And -- but I signed it

111

1 because I was obviously supporting her and --

2 Q. If you go to the top of the second page, you can see she  
3 says quite clearly:

4 "This situation today is not unique."

5 It wasn't just a single one-off bad day. You go on  
6 to say:

7 "It appears to be a repetitive cycle of events on  
8 the children's ward over the last number of weeks and  
9 months and the morale of staff is falling. The staff  
10 are mentally and physically exhausted, many from extra  
11 hours and they are now frustrated at little apparent  
12 improvement in the staffing situation."

13 In the next paragraph she writes:

14 "... we have brought our concerns forward [in the  
15 next paragraph she writes] by writing, but unfortunately  
16 have not found solutions..."

17 A. Yes. Well, that letter was written in February 2001,  
18 and as I've said, it was the winter months that threw up  
19 these problems. And once we got into the months of  
20 April, May, our occupancy levels would fall, and we  
21 didn't have these problems during the summer months,  
22 spring, late spring, summer months, but we definitely  
23 did experience them during the winter months. And it  
24 was after that that -- I think it was 2002 -- that we  
25 introduced the nursery nurses and we also got a number

112

1 of nurses from the Philippines.

2 Q. So I understand. I'm interested in how you hoped the  
3 system would work. You put the request, or the issue  
4 has been put in writing, it has now been reinforced in  
5 writing. What did you hope Mrs Doherty would do with  
6 this?

7 A. Well, first of all, I hoped that she would recognise  
8 that the problems were there, that we did have problems  
9 because sometimes, you know, you felt that nobody was  
10 listening. That was really the thing about writing the  
11 letters, we needed somebody to listen to us and to --  
12 because sometimes in the children's ward we felt a bit  
13 isolated. We were a children's area within a general  
14 district hospital.

15 Q. Yes.

16 A. We weren't the Children's Hospital in Belfast, who  
17 were -- you know, every ward had children. We were one  
18 floor, we had four areas on that floor, and you did feel  
19 a bit isolated at times. But we were quite a strong  
20 team and we stuck together, and without the goodwill of  
21 the nurses to do extra shifts and nights, it was very  
22 difficult at times.

23 Q. Where did nurses take their issues to? If you had  
24 a nursing issue, which committee would you take it to at  
25 that time?

113

1 A. We didn't have a committee. I mean, if nurses had  
2 a problem on the ward, they brought it to me. I would  
3 then take it to the clinical services manager, and then  
4 it would go to the director of nursing. But at that  
5 stage, in the late 90s/early 2000s, even though I -- you  
6 know, I was the ward manager, I had many years'  
7 experience and I did my best to vocalise my problems,  
8 you would -- I think ward managers struggled in getting  
9 their voices heard.

10 Q. How often did you meet with the director of nursing?

11 A. I didn't meet with her very often. She would come to  
12 the ward on maybe -- on occasions to do a round or to  
13 see --

14 Q. How often would that happen?

15 A. Maybe once a month.

16 Q. Once a month. How long did she spend on the ward?

17 A. Um ...

18 THE CHAIRMAN: When you say around, do you mean --

19 A. She would come to see how things were and she would have  
20 said, "Sister Millar, how are things?" or whatever. And  
21 if we had difficulties with staffing she would have  
22 come. I mean, we did experience some horrendous winters  
23 and she would have come to see us, plus also the  
24 chief executive later on.

25 MR STEWART: Would your meetings or discussions with her

114

1 about problems ever have been minuted?

2 A. No.

3 Q. So --

4 A. But I would have brought up these issues with the  
5 clinical services manager --

6 Q. Yes.

7 A. -- at the -- we had ward sisters' meetings every month  
8 with the clinical services manager and I would have  
9 brought staffing issues up, and they would have been  
10 minuted. But as I say, whether they went to the  
11 director of nursing, I can't say for definite.

12 Q. Can you make any comment about the assertion made in  
13 this letter by yourselves that morale is falling?

14 A. Well, obviously if you're under pressure and -- you  
15 know, you've saved 40 patients/45 patients and you're  
16 struggling with staffing, I mean, morale, yes, morale  
17 can fall, yes. I mean, during my many years of nursing,  
18 I went through many, many years of that. But certainly  
19 in the last 10 years or so of -- 12 -- of my career,  
20 things did improve dramatically.

21 Q. Morale is fantastically important for a team.

22 A. Yes, it is.

23 Q. Can you remember the director of nursing involving  
24 herself with the morale of her nurses?

25 A. Well, I -- Irene Duddy was director of nursing at the

115

1 time and she was a very approachable person. I found  
2 her very -- I mean, she was -- I remember her as the  
3 ward manager, so it wasn't as if I had a problem  
4 approaching her. But, you know, I didn't feel I could  
5 go directly to her. I went through my clinical services  
6 manager. I understood that was the way it should be.  
7 However, when she did visit the ward I was quite vocal  
8 in my concerns.

9 Q. Well, the concerns that are finding expression in this  
10 letter, especially the penultimate paragraph:

11 "We are now at the situation where we feel things  
12 may be unsafe as staff find it very difficult to cope  
13 with the condition we are finding ourselves in at  
14 present."

15 Would that fear of a lack of safety have been  
16 brought to the director of nursing?

17 A. Well, I mean, we wrote the letter to Mrs Doherty and  
18 I cannot say whether that letter went to Ms Duddy. But  
19 I do know that there was a concerted effort to recruit  
20 children's nurses after that and that -- without  
21 success. And then there was the recruitment of the six  
22 nurses from the Philippines and also the nursery nurses.  
23 And I think it did stem from, you know, the realisation  
24 that probably we weren't adequately staffed.

25 But can I just say that during the summer months,

116

1 I just want to reiterate that, and I would be very  
2 honest about that, if I had problems, we did not have  
3 problems during the summer months because at times in  
4 July or the end of June, we could have actually gone  
5 down to eight or ten patients.  
6 Q. I think there were 23. So I take it your evidence  
7 is that staffing levels played no part in the care given  
8 to Raychel?  
9 A. No, I don't, no.  
10 Q. In relation to the sort of issues that have arisen in  
11 this inquiry and the sort of forewarning there might  
12 have been in relation to them, do you remember  
13 a documentation audit being performed in 1999 and 2000  
14 in the hospital?  
15 A. Sorry, I can't hear you.  
16 Q. A documentation audit in 1999 and 2000. Do you remember  
17 an audit of records and documentation?  
18 A. No, I don't.  
19 Q. Can we call up document WS322/1, page 120? This is  
20 a discussion of the hospital management team, these are  
21 the minutes of it. It's Dr Parker informs the meeting  
22 that Mrs Witherow and himself:  
23 "... presented the results of this audit to member  
24 of the hospital management team in the recent meeting.  
25 Mrs Witherow said that she has attended the ward

117

1 We can go to the middle section where they conclude:  
2 "To improve scoring, the following areas need to be  
3 addressed."  
4 And the second bullet point is:  
5 "Some patients who were on intake/output charts had  
6 information missing. Seven incomplete out of 14."  
7 This is very relevant to what we're looking at. Do  
8 you remember this sort of information coming back to  
9 you?  
10 A. Yes, I think I do, yes. Mm-hm.  
11 Q. Whose responsibility would it have been to do something  
12 about this information?  
13 A. Well, this information would have been fed back to me.  
14 I mean, I was obviously involved, or Mary McKenna would  
15 have fed back the information --  
16 Q. Yes.  
17 A. -- and it would have been then, you know, sessions of  
18 informing staff that they need to improve on their -- on  
19 their documentation. That would have been passed on to  
20 staff.  
21 Q. Well, in this case we've heard of several deficiencies,  
22 as you know, and I think you have conceded in your  
23 earlier evidence, in relation to the fluid balance  
24 chart. So this seems to be eight months before,  
25 pointing out problems with the intake/outtake, something

119

1 sisters' meetings to discuss the action required  
2 in relation to nursing."  
3 Do you remember being told at a ward sisters'  
4 meeting about the audit and what was required of Ward 6?  
5 A. No.  
6 Q. Because you'd have been directly involved in that,  
7 wouldn't you?  
8 A. I would have been, yes. I mean, I can't remember.  
9 Q. Do you remember the benchmarking exercise that was  
10 undertaken in November 2000? It was called paediatric  
11 benchmarking.  
12 A. Yes. Well, I know that Mary McKenna was a member of the  
13 benchmarking team for Northern Ireland.  
14 Q. Yes. Was that part of the junior monitor exercise?  
15 A. No.  
16 Q. It was a different thing?  
17 A. Yes.  
18 Q. The benchmarking exercise, we can find that at WS323/1,  
19 page 42. That gives us the overview of the various  
20 hospitals taking part in it. It goes on then throughout  
21 the body of the report to focus on different parts of  
22 care given.  
23 At page 45, can I draw this to your attention, this  
24 is the patients' physical needs and it deals, amongst  
25 other things, with patients on IV fluids.

118

1 has to be done about it, something ought to be done  
2 about it, it's your job to look into that. What was  
3 done? Was anything done?  
4 A. Yes. Well, I do believe that we did ask staff to try  
5 and comply and be more fastidious in their  
6 documentation.  
7 Q. Was anything put in writing?  
8 A. No, not -- no, not that I can remember.  
9 Q. So insofar as this inquiry is concerned, it could have  
10 been that nothing was done? Nothing was in writing, the  
11 fluid balance chart is deficient in several respects in  
12 this case. How do we know that these suggestions and  
13 recommendations were actioned at all?  
14 A. Well, as I say, the staff were asked to improve on their  
15 documentation and I am not sure if there was a follow-up  
16 review done on that. I don't know.  
17 Q. I certainly haven't seen it if there was one.  
18 The same document deals with a number of other  
19 relevant matters, especially page 49, the bottom  
20 section. This is further evidence in relation to plans  
21 and so forth.  
22 The bottom paragraph:  
23 "It is also recommended that the core plans need to  
24 be revised to delete unnecessary material and add in new  
25 appropriate actions."

120

1 This is a care plan, and you'll see from the  
2 preceding bullet point that the problem identified  
3 is that nurses are not prescribing individualised care  
4 and individualising the care plans.  
5 Were any steps taken to focus on this area that  
6 could be improved?  
7 A. Yes. Well, I think that as far as I can remember,  
8 a member of staff was identified as being a coordinator  
9 for improving the care planning and checking up with the  
10 nurses, especially with new nurses that came on the  
11 ward.  
12 Q. And who was that?  
13 A. I can't remember.  
14 Q. Was any one individual within Ward 6, any nurse, tasked  
15 to go and make a regular check of the notes and records  
16 to ensure that they were compliant with the UKCC records  
17 guidance?  
18 A. Well, I know that Mary McKenna did check up on or do  
19 some audits on the fluid balance sheets at some stage,  
20 but it was after Raychel died. I know there were some  
21 audits done on that.  
22 Q. These recommendations, which are relevant, are before  
23 she comes into hospital, and that's why we're interested  
24 in them. And there's nothing in writing to indicate  
25 that they were heeded at all, is there?

121

1 A. Well, there's nothing in writing.  
2 Q. The junior monitor report was a different thing; is that  
3 correct? Was that a sort of a peer review type  
4 exercise?  
5 A. That was to do with the placement of students on the  
6 ward, the training of students and the education of  
7 students and the facilities that were available to them.  
8 Q. Did it also involve nurses from other hospitals coming  
9 in and seeing how you ran your ward and perhaps  
10 exchanging information?  
11 A. No.  
12 Q. Because Mrs Witherow did indicate that this happened.  
13 Can we go to WS329/1, page 8? At paragraph 7 (f),  
14 at the very top of the page she says -- I think this  
15 leads on from the preceding page:  
16 "I am aware that a system of peer review did take  
17 place in a number of wards where monitor was being used.  
18 Staff in the Sperrin Lakeland Trust and Altnagelvin,  
19 staff did cross over and review those facilities but  
20 I cannot say happened with the Ward 6 review."  
21 Do you recall any sort of interchange with other  
22 nurses from other hospitals?  
23 A. No, I can't remember.  
24 Q. Would you ever, in the course of your professional  
25 networking and going to meetings outside of the

122

1 hospital, have met up with nurses from the  
2 Sperrin Lakeland?  
3 A. Yes, very rarely, but at conferences or study days  
4 outside of Altnagelvin, say Belfast, or if they were  
5 held anywhere else, you would meet up with colleagues or  
6 other ward managers or specialist nurses and you would  
7 then get their views. But I didn't have an awful lot of  
8 contact with Sperrin Lakeland at that stage.  
9 Q. The loss of a child in a children's ward is a very  
10 shocking and profoundly memorable event, isn't it?  
11 Would that be the sort of thing that you would have  
12 talked about when you met colleagues from other  
13 hospitals?  
14 A. Um ... I don't remember discussing it with others  
15 outside of Altnagelvin. I personally can't remember.  
16 As I say, my contact with Sperrin Lakeland was very,  
17 very limited. I think there's much more contact now  
18 because they're all under the one -- Mary McKenna would  
19 be the nurse manager. But in those days, I rarely had  
20 any contact with Sperrin Lakeland.  
21 Q. When did you first hear that Raychel had died?  
22 A. When I returned on the Tuesday morning.  
23 Q. Mrs Doherty had heard about it before you?  
24 A. Yes. She must have had, because I left work about half  
25 5/6, on the Friday, and I returned on Tuesday morning,

123

1 so I presume that Mrs Doherty was on on the Monday. But  
2 I don't know. But I think she knew about it before me.  
3 Q. It seems that she did because she had got Sister Little  
4 to assist her in telephoning Staff Nurse Noble, noting  
5 down what she had to say, putting together a resume of  
6 what happened, looking at the notes, preparing, it  
7 seems, a little report.  
8 Were you involved in that early gathering up of  
9 information stage?  
10 A. No.  
11 Q. Are you surprised that they didn't phone you?  
12 A. Yes, I suppose I was, yes. I don't know if maybe I had  
13 been away for the weekend. I can't remember. But  
14 I certainly wasn't told. The first I knew was when  
15 I returned on the Tuesday morning.  
16 Q. Are the people you work with also your friends, like  
17 Margaret Doherty?  
18 A. Were they my friends?  
19 Q. Yes. Would you have phoned each other to exchange --  
20 A. No, no. No, I -- Margaret Doherty was very much my  
21 senior, no. I wouldn't have -- we -- I was able to  
22 speak to her, of course, but no, I wouldn't say we were  
23 friends, no.  
24 Q. Was Margaret Doherty in essence the director of  
25 paediatrics?

124

1 A. Yes.  
2 Q. And did Dr Denis Martin, who was the clinical director  
3 of women and children's care, was he really over at that  
4 side of things and not involved with Ward 6 and the  
5 paediatric department?  
6 A. Well, he was clinical director, as you say, for  
7 maternity and paediatrics, but he would have been very  
8 much in contact with Mrs Doherty. I mean, I knew him to  
9 see, but --  
10 THE CHAIRMAN: In the same way that the director of nursing  
11 would come through maybe once a month and be  
12 approachable and be interested in what was going on, did  
13 Dr Martin come through Ward 6 on any sort of regular  
14 basis?  
15 A. He came -- I remember him coming on at least two  
16 occasions when we were experiencing problems in the  
17 winter time, yes, he did.  
18 THE CHAIRMAN: In different years?  
19 A. Yes.  
20 THE CHAIRMAN: Right. And apart from coming in when you  
21 were experiencing -- you remember him twice in different  
22 years. Apart from that, do you remember him being in  
23 Ward 6 at all?  
24 A. No.  
25 THE CHAIRMAN: Thank you.

125

1 MR STEWART: So, really, to all intents and purposes,  
2 Margaret Doherty was the leader of the paediatrics?  
3 A. Yes.  
4 Q. And she reported to --  
5 A. Director of nursing.  
6 Q. She didn't report to the medical director? Well, we can  
7 ask her if you don't know.  
8 A. I don't know. I mean, she would have had contact with  
9 the director because they had meetings, I know,  
10 regularly. But I wasn't involved in any of those.  
11 Q. When you first heard of what had happened to Raychel,  
12 what was your first reaction?  
13 A. Well, disbelief.  
14 Q. Yes.  
15 A. Because, I mean, I had left on Friday evening --  
16 Friday -- late Friday afternoon, and I would -- I mean,  
17 when I heard first, I didn't -- I thought they weren't  
18 actually talking about the correct child because I would  
19 have never ever have expected that something like that  
20 would have happened.  
21 Q. Were there any other appendicectomy patients in the  
22 ward?  
23 A. I cannot say. I mean, I just can't remember.  
24 Q. Did you regard yourself as the leader of the nursing  
25 team that was looking after Raychel?

126

1 A. I did, yes. I mean -- well, I wasn't delivering care to  
2 Raychel, but I was -- in the morning time I was on the  
3 ward, and in my role as a nurse manager I would have  
4 responsibility.  
5 Q. So you heard the details of what had happened to her,  
6 how she suffered a collapse in the early hours of the  
7 morning, and did you think, "Why didn't any of you  
8 nurses spot this?" Wasn't your first reaction "What was  
9 happening to her when you were there?" Didn't you ask  
10 them --  
11 A. Well, I did ask that, yes.  
12 Q. You did?  
13 A. Yes.  
14 Q. Did you get the nurses involved into a group to find out  
15 what had happened?  
16 A. No, I didn't, because there was -- well, some of them  
17 were obviously on night duty, they had gone home, and  
18 I cannot remember whether any of them were there that  
19 day. I just can't offhand remember that. But I knew  
20 that there was a meeting scheduled. I was told when  
21 I came on duty that morning that there was a meeting  
22 scheduled for that afternoon to review what had  
23 happened.  
24 Q. What time was that meeting for?  
25 A. Well, I think it was -- I can't remember the exact time,

127

1 but I think it was 2 o'clock. Around -- it was  
2 afternoon.  
3 Q. Yes. Did you have anything else to do that day? Did  
4 you have any other meetings that day?  
5 A. No, I probably did the ward round that morning, but  
6 I had no further meetings that morning, no.  
7 Q. In the afternoon?  
8 A. No, I was at the meeting, the review meeting, in the  
9 afternoon.  
10 Q. And it took up the whole afternoon, did it?  
11 A. I cannot remember. It certainly took up a number of  
12 hours, but how long I cannot remember.  
13 Q. Did you think it might be useful for the review meeting  
14 if you were to bring along to it as much information as  
15 you could glean between the time you learned of this and  
16 the time the review meeting convened?  
17 A. Sorry, you'll have to ...  
18 Q. Did you think to have a quick investigation to get as  
19 much information together as possible for the review?  
20 A. No. No, because -- I mean, when I returned in the  
21 morning and heard what had happened, I mean, I didn't --  
22 nobody seemed to know what had happened. As I say,  
23 a lot of the staff that were on -- that had cared for  
24 Raychel weren't actually on that morning, and so it was  
25 very much, you know, scanty information, but obviously

128



1 everybody was shocked, and I cannot remember if I spoke  
2 to any of the paediatricians or -- but I -- as I say,  
3 I had very scanty information.  
4 Q. Because when you got to the meeting that afternoon, the  
5 nurses were very well represented, weren't they?  
6 A. I can't remember what nurses were there. Nurse Noble  
7 was there.  
8 Q. Yes.  
9 A. I think Nurse Bryce.  
10 Q. That's right.  
11 A. But I'm not sure who else.  
12 Q. It seems that apart from Mrs Doherty and Mrs Witherow,  
13 nurses Noble, yourself, Sister Millar, Gilchrist, Bryce  
14 and auxiliary nurse Lynch were all there.  
15 Did the meeting focus upon the nursing aspect of the  
16 care Raychel received?  
17 A. It focused -- the main focus was the documentation of  
18 the fluid balance sheet. The main focus -- the  
19 meeting -- I cannot remember very much about the  
20 meeting, I just -- I mean, there was a lot of  
21 discussion. It took off very slowly because everybody  
22 was -- you know, there was disbelief, shock, that this  
23 had happened.  
24 There was some murmurings about Solution No. 18  
25 initially and there was a rumour that -- maybe that it

129

1 was no longer being used in Belfast. Well, I found that  
2 very hard to believe, I remember at that time, because  
3 I thought, surely, you know -- I mean, I had used it for  
4 35 years and had experience of it, and I just found it  
5 unbelievable that this could be a problem.  
6 So there was a lot of discussion about a lot of  
7 different aspects. I just -- I do not remember the  
8 particular conversations about everything, but there was  
9 a lot of discussion took place. I know that there was  
10 focus on the documentation of the fluid balance sheet  
11 and, you know, the fact that it was felt that the  
12 urinary output and the vomits that Raychel had were --  
13 could have been better documented.  
14 Q. Yes.  
15 A. But there was, as I say, a lot of discussion, but  
16 I just -- I just cannot remember what was said.  
17 Q. You very helpfully told us the last time you gave  
18 evidence that the fluid balance chart was deemed to be  
19 unacceptable regarding intake of urine -- uptake of  
20 urine and vomit. You also, I think, accepted that  
21 electrolytes should have been taken, and you recognised  
22 that as a failure.  
23 Can I ask you about the vomiting. That was  
24 discussed at the meeting? Do you remember that?  
25 A. Yes. Well, I think the -- yes, I mean, there was

130

1 discussion around the vomiting, how much Raychel had  
2 vomited, and there was a difference of opinion between  
3 each nurse because each nurse would have been maybe had  
4 a different view on how much.  
5 Q. Yes.  
6 A. And it was felt that there may have been a problem with  
7 the documentation of the vomit.  
8 Q. Can I ask you about the vomit --  
9 THE CHAIRMAN: Just one point. When nurses have different  
10 views about vomiting, isn't that because the nurses  
11 aren't all there at the same time, so you might be there  
12 for a number of hours and another nurse might be there  
13 for a number of hours and you can only put the picture  
14 together --  
15 A. Well, I was more thinking about the amount of vomiting.  
16 You know, what I may think was a small amount of  
17 vomit -- that's really what I was ...  
18 THE CHAIRMAN: Thank you. On the plus or plus plus system,  
19 which wasn't unusual, your plus might be somebody else's  
20 plus plus.  
21 A. Yes, that's right, and that system at that time was  
22 being used in other hospitals.  
23 THE CHAIRMAN: Yes, yes, I understand that. I don't think  
24 the main issue about the vomiting is -- there's a bit of  
25 an issue about the plus or the plus plus, but there are

131

1 vomits which do not appear to have been recorded, and  
2 there certainly appears to have been a failure to  
3 appreciate the possible significance of coffee-ground  
4 vomiting later on on the Friday evening.  
5 A. Yes.  
6 MR STEWART: Can I ask, apart from the quantities of vomit,  
7 was there any discussion surrounding the protracted  
8 period over which the vomiting was suffered?  
9 A. No, not -- I think there was discussion around the --  
10 you know, there were three vomits documented during the  
11 day, at 10, 1 and 3, and there had been a small vomit or  
12 a vomit at 8 am. And there was some discussion around  
13 how that amount of vomiting would have caused the --  
14 a problem. Because it didn't seem to be hugely  
15 significant, and so I think there was some discussion  
16 about that, but I -- and, you know, was all the vomiting  
17 documented? And it -- the staff that were present, as  
18 far as I remember, were sure that they had documented  
19 the vomits that they were aware of.  
20 Q. On that point, Dr Fulton, who chaired that meeting, has  
21 given us a witness statement where he says that the  
22 nurses conceded they did not see all the vomiting,  
23 a witness statement in which he has said that the nurses  
24 told him that the Ferguson family had indeed informed  
25 them that she was continuing to vomit and they were

132

1 worried about it, and a statement in which he says that  
2 you pointed out the electrolytes should have been done  
3 in the afternoon of the 8th due to her continued  
4 vomiting. Do you remember any of that?  
5 A. No.  
6 Q. Can we go to WS043/3, page 15? This is all about the  
7 vomiting. Can we go to the preceding page as well?  
8 Page 14.  
9 He's describing it towards the bottom of page 14:  
10 "The extent, type and duration of vomiting suffered  
11 by Raychel on the 8th."  
12 He says:  
13 "This was described by the nurses who clearly  
14 believed it was due to prolonged post operative  
15 vomiting. They agreed that the vomiting was prolonged  
16 but not unusual after this type of surgery."  
17 Was it agreed that the vomiting was prolonged?  
18 A. I have no recollection of that being said.  
19 Q. "They did not believe the vomiting was excessive though,  
20 they said they may not have witnessed all the vomit."  
21 "They said they may not have witnessed all the  
22 vomit", is that right?  
23 A. Well, I have no memory of that, but, you know, it may --  
24 it may have happened that we did not witness, but  
25 anything that we did see, they were adamant that they

133

1 had documented it. But I cannot remember that  
2 conversation.  
3 Q. Okay:  
4 "The nursing method of recording vomit volume on  
5 a plus scale was questioned. It was decided this was  
6 too subjective and other methods of recording should be  
7 used. This was to include attempting to record and  
8 measure all vomiting, as well as urine. Sister Millar  
9 actioned the recording of all vomit and urine  
10 immediately. The nurses said that the Ferguson family  
11 told them during 8 June that they, the family, believed  
12 that Raychel's vomiting was repeated and severe."  
13 First of all, do you remember that being said to the  
14 review, to Dr Fulton?  
15 A. No, I don't.  
16 THE CHAIRMAN: If you just pause there. What that means  
17 is that the nurses were telling Dr Fulton on 12 June  
18 what the Ferguson family had been saying before Raychel  
19 died. Right? So this isn't the Fergusons coming along  
20 after Raychel has died and saying for the first time  
21 that the vomiting was repeated and severe, this is the  
22 nurses acknowledging that on the Friday, the family at  
23 that time was already making the point that her vomiting  
24 was repeated and severe. In other words, they were  
25 worried and concerned about her condition.

134

1 A. Yes.  
2 THE CHAIRMAN: Isn't that right?  
3 A. Yes.  
4 THE CHAIRMAN: Assuming that Dr Nesbitt's (sic) note is  
5 correct or his recollection is correct, that confirms  
6 that the Ferguson family were saying this about the  
7 vomiting before Raychel died.  
8 A. Mm. Yes. I mean, I can't remember that being said, but  
9 if it's in the minutes ...  
10 MR STEWART: Move down the page to paragraph (j), and that's  
11 asking about shortcomings in the frequency of assessment  
12 of the assay of Raychel's electrolytes.  
13 Dr Fulton says:  
14 "Sister Millar clearly stated that the blood  
15 electrolytes should have been checked in the afternoon  
16 because of the continued vomiting. She stated this was  
17 the responsibility of the doctors. There was total  
18 agreement on the need for regular electrolyte  
19 measurement while receiving IV fluids."  
20 Did you clearly state at the review meeting that  
21 electrolytes should have been checked in the afternoon  
22 because of the continued vomiting?  
23 A. I don't remember clearly stating that the electrolytes  
24 should have been done. Obviously, with hindsight, they  
25 should have been done, but I don't -- and I believe that

135

1 they should have been done, but I don't remember saying  
2 that.  
3 Q. Because this clearly implies that the vomiting was so  
4 bad that it necessitated electrolyte assessment.  
5 A. Mm-hm.  
6 Q. It's the acknowledgment of the severity of the vomiting.  
7 A. Yes. I don't remember saying that.  
8 THE CHAIRMAN: But it's consistent, isn't it --  
9 A. Yes.  
10 THE CHAIRMAN: I know it's a bit difficult for you to put  
11 yourself back into this meeting, but let's assume for  
12 the moment that Dr Fulton's recollection is correct.  
13 Then, if he correctly recalls you saying that the blood  
14 electrolytes should have been checked because of the  
15 continued vomiting, that would give an indication of the  
16 frequency and severity of the vomiting, wouldn't it?  
17 A. Yes.  
18 THE CHAIRMAN: Because you wouldn't have been saying that if  
19 it was just an occasional, small vomit.  
20 A. If I said it, which it's written there -- I don't  
21 remember saying it, but I presume his record is correct,  
22 I don't know -- yes, it would.  
23 THE CHAIRMAN: Thank you.  
24 MR STEWART: So at the critical incident review, you can  
25 recall that there were problems identified of

136

1 electrolytes and of the documentation, and you recall  
2 raising the issue of not being able to get doctors,  
3 surgeons, to come to attend to the patients on Ward 6,  
4 and you also expressed a sense that it was unfair that  
5 the responsibility for looking after these patients was  
6 having to be borne by the nursing staff.

7 Did you put any of those problems and issues into  
8 your witness statement that you provided for Mrs Brown  
9 after the review?

10 A. No, I didn't.

11 Q. Because you wrote that statement on 15 June --

12 A. Yes.

13 Q. -- which was just immediately after it. It appears at  
14 022-100a-313.

15 It comes right down, just very briefly and factually  
16 detailing your involvement with the patient:

17 "... and I went off duty shortly afterwards at 6 pm  
18 on the 8th."

19 Did you not think it might be relevant that the  
20 coroner should know, or that risk management should  
21 know, about these issues identified at review?

22 A. Yes. Well, they were at the review, the -- I mean, as  
23 far as I know, Therese Brown was at the meeting and I --  
24 that's why I voiced my concerns that she was there and  
25 I ... I mean, I was quite forthright in what I said.

137

1 So I would have presumed that she would have taken those  
2 on board.

3 Q. Well, why weren't you equally forthright and put it in  
4 writing?

5 THE CHAIRMAN: I'm sorry, there's two different areas about  
6 being forthright. The one area about being forthright  
7 that is recalled is you being forthright about the  
8 difficulty that you had -- that nurses had in contacting  
9 surgical staff and how you felt that this left a burden  
10 on the nursing staff, which was wrong. That's one area.

11 The second specific area is whether you were  
12 forthright at the meeting, as perhaps the note that you  
13 were looking at a few moments ago suggests you were,  
14 clearly saying at that blood electrolytes should have  
15 been checked in the afternoon because of the continued  
16 vomiting.

17 Now, why would you not refer in your statement about  
18 what happened to the failure to do the electrolytes  
19 in the afternoon, in view of the vomiting?

20 A. Well, as I said, I don't remember, you know, talking  
21 about the electrolytes at the meeting.

22 THE CHAIRMAN: I know you don't now, but if the meeting was  
23 on 12 June and you were preparing this statement -- this  
24 statement appears in its typed-up form on 15 June.  
25 You're unlikely to have forgotten over 72 hours that

138

1 week what had been discussed and agreed and debated  
2 at the meeting; isn't that right?

3 A. Yes.

4 THE CHAIRMAN: So if that's what happened, if that's an  
5 accurate note or if that's an accurate record or summary  
6 of the meeting, why doesn't any of it appear in your  
7 statement?

8 A. I have no explanation for that.

9 THE CHAIRMAN: Because what later happens is that a case is  
10 advanced to the coroner that it's disputed -- the  
11 vomiting issue is disputed and what is disputed  
12 is that -- and it's stated that the vomiting was neither  
13 prolonged nor severe. Now, the note that Mr Stewart has  
14 just taken you through says it was agreed at the  
15 critical incident review meeting that the vomiting was  
16 prolonged. So what appears to have been agreed at the  
17 critical incident review meeting by the nurses is then  
18 challenged by the nurses at the inquest.

19 How could that possibly come about? How could the  
20 nurses agree something on 12 June and then, on their  
21 behalf, on the trust's behalf, DLS writes to the coroner  
22 and says, "We are challenging that"? Do you understand  
23 my concern about how it comes about?

24 A. Yes, I do.

25 THE CHAIRMAN: And do you understand -- can you explain how

139

1 it could have come about? I mean, another example is if  
2 you have said that the continued vomiting means that the  
3 blood electrolytes should have been checked in the  
4 afternoon -- never mind 10, 11, midnight. If you say  
5 the continued vomiting means that the electrolytes  
6 should have been checked in the afternoon because of the  
7 continued vomiting, how could it be possibly disputed  
8 at the inquest that the vomiting was prolonged and  
9 severe?

10 Those are the two propositions that the coroner was  
11 written to and said were in dispute, "neither prolonged  
12 nor severe". I don't understand that and I'm asking  
13 you, can you help me understand that?

14 A. Well, as I say, I cannot remember mentioning  
15 electrolytes at that meeting. I mean, as far as I know,  
16 they were mentioned and that it was agreed that they  
17 should have been done, but I cannot -- I just cannot  
18 remember at the ...

19 THE CHAIRMAN: I understand how 10 years later you can't  
20 remember, and it's a concern about the critical incident  
21 review that this meeting wasn't recorded, and there's no  
22 end report from the critical incident review. But in  
23 June 2001, this appears to be what you were saying, and  
24 then the coroner's told that the nurses don't actually  
25 agree with that.

140

1 Now, whatever you recall now, 10 years later,  
2 I understand everybody's memory has faded in some  
3 respects, but I don't understand how this issue has --  
4 I was going to say it was resurrected, but I'm not sure  
5 it was ever an issue at all. I just don't understand  
6 how it became an issue before the coroner in light of  
7 what we're told about the critical incident review. I'm  
8 making that point to you because if you can help me with  
9 it, I'd like you to.  
10 A. Yes. I'm sorry, but I can't.  
11 THE CHAIRMAN: Okay.  
12 MR STEWART: Can I ask you in a similar vein to look,  
13 please, at WS056/1, page 9. This was the first witness  
14 statement you provided to this inquiry, and the third  
15 paragraph, you write and told this inquiry:  
16 "I am confident that Raychel received the highest  
17 standard of care from the nursing staff in Ward 6.  
18 Raychel's treatment and care was no different from any  
19 other child who required a surgical procedure."  
20 You've accepted to the inquiry that the fluid  
21 balance chart was deficient, that there were problems in  
22 this area and that area and so forth. How could  
23 you have brought yourself to tell the inquiry that  
24 you are confident that she received the highest standard  
25 of care?

141

1 A. Well, I mean, we did care for Raychel the same as  
2 we would care for any post-operative child. She did  
3 vomit, she was vomiting, but as I say, I've seen other  
4 children vomit more than that and not have  
5 a catastrophic event as Raychel had. I have been  
6 questioned on this before in my previous appearance --  
7 Q. I'm sorry.  
8 A. -- and I suppose, with hindsight now, and looking back,  
9 we could have done better.  
10 THE CHAIRMAN: Sorry. You're quite right to say that some  
11 of this was touched on when you were here last, but  
12 could I take you to the last paragraph:  
13 "All members of nursing staff were devastated ..."  
14 And I'm sure that's right, but would you look at the  
15 next sentence:  
16 "It was totally unexpected as she had been  
17 recovering very well on Friday the 8th."  
18 Now, if you told the critical incident review that  
19 she should have had her electrolytes taken on the  
20 afternoon because of her continued vomiting, that must  
21 be inconsistent with her recovering very well, mustn't  
22 it --  
23 A. Yes.  
24 THE CHAIRMAN: -- because you can't be recovering very well  
25 if you need your electrolytes taken because you're

142

1 vomiting so much?  
2 A. Mm-hm. No, I would agree that that sentence is not  
3 right.  
4 THE CHAIRMAN: I'm afraid what I have to then ask you,  
5 Mrs Millar, is this. How does it come to be written?  
6 How does it come to be written that you say in your  
7 statement that she's recovering very well when that  
8 simply wasn't the case? I mean, if she'd been  
9 recovering very well on the Friday, by some point on  
10 Friday afternoon -- as Friday went on, she would have  
11 been sipping more and more. The intravenous fluid would  
12 have been diminished and then stopped, and she would  
13 have started to eat; isn't that right? That was the  
14 expected recovery path, and that is a child who does  
15 that is recovering very well.  
16 A. Mm-hm.  
17 THE CHAIRMAN: A child who isn't sipping beyond one or two  
18 sips, a child who isn't eating, a child who's still on  
19 IV fluid and a child who gets two anti-emetics is not  
20 a child who's recovering very well.  
21 A. Mm-hm. No, I would agree with you.  
22 MR STEWART: Can I ask you, have you at all times, since  
23 2001, been aware of the UKCC code of professional  
24 conduct?  
25 A. Yes.

143

1 Q. And aware of the guidance in relation to it given by the  
2 UKCC Guidelines for Professional Practice of 1996?  
3 And paragraph 24 of that is about truthfulness:  
4 "Patients and clients have a legal right to  
5 information about their condition. Registered  
6 practitioners providing care have a professional duty to  
7 provide such information. A patient or client who wants  
8 information is entitled to an honest answer."  
9 Do you think that Mr and Mrs Ferguson have had  
10 honest answers?  
11 A. Um ... (Pause). Well, I -- I mean, it's very  
12 difficult. I agree that -- I mean, that sentence that  
13 I wrote, that it was totally unexpected, she had been  
14 recovering well, is wrong. But it's not -- I mean, why  
15 I wrote that, I -- you know, I have no answer for that.  
16 It wasn't trying to tell untruth. I don't know why  
17 I wrote that.  
18 THE CHAIRMAN: Let's put it another way. Let's suppose it's  
19 not telling untruths, it's not telling the truth.  
20 A. Mm-hm.  
21 THE CHAIRMAN: Let's move away for a moment about whether  
22 somebody's lying. That statement does not tell the  
23 truth about what happened to Raychel; is that right?  
24 A. Yes. But at the time, you know, it was -- I mean, it  
25 wasn't written in trying to, you know, tell an untruth.

144

1 But I would have to agree that she was not recovering  
2 well.  
3 THE CHAIRMAN: Okay.  
4 MR STEWART: After the critical incident review, there was  
5 an update prepared for the chief executive by Mrs Brown.  
6 Can I take you to that, it's 022-097-307.  
7 This you will see is dated 9 July 2001, and you will  
8 see in the middle section at paragraph 4 Mrs Brown  
9 writes:  
10 "A meeting has been held with Mrs Witherow [that's  
11 the clinical effectiveness coordinator] Mrs Doherty [who  
12 was the clinical services manager] Sister Millar, Sister  
13 Little, nursing staff and nursing auxiliary Ward 6 to  
14 discuss in detail the fluid balance management. The  
15 following has been agreed ..."  
16 That looks as though there was a meeting of the  
17 complement of nurses from Ward 6, doesn't it, or a large  
18 part of them anyway?  
19 A. Yes.  
20 Q. And it looks as though there was discussion about the  
21 fluid balance and a number of matters were agreed.  
22 A. Yes.  
23 Q. Is there any documentation relating to that? Was any  
24 documentation created as a result of that meeting of the  
25 nurses of Ward 6?

145

1 A. Do you mean minutes of the --  
2 Q. Minutes, notes, memoranda, records, agenda, attendance  
3 notes. Anything like that?  
4 A. No. As far as I know, that -- I cannot remember who was  
5 at that meeting, I just don't remember. I would presume  
6 that Mrs Witherow or Mrs Doherty would have taken notes.  
7 I cannot say.  
8 Q. And were you there? Do you remember?  
9 A. Was I there?  
10 Q. Yes.  
11 A. Well, my name is there, so I must have been there.  
12 Q. But you've got no recall of it otherwise; is that right?  
13 A. No.  
14 Q. Okay.  
15 THE CHAIRMAN: Can I just ask you, just to clarify, what  
16 does paragraph 4 (e) mean?:  
17 "Nursing staff to be proactive in advising medical  
18 staff regarding discontinuation of fluids."  
19 What were nurses going to tell the surgeons about?  
20 A. Well, I think it was about signing for the  
21 discontinuation of the fluid. On the back of the fluid  
22 balance sheet at that time there was no box as such that  
23 a doctor could sign that the IV fluid was to be  
24 discontinued. So we amended the fluid balance sheet  
25 that we were using at the time. There was a number of

146

1 amendments, minor amendments, and one of them was an  
2 area where the doctor could sign to say that he had  
3 discontinued the IV fluid.  
4 THE CHAIRMAN: So in effect what the nurses were going to do  
5 was make sure the doctor signed that?  
6 A. Yes.  
7 THE CHAIRMAN: You couldn't sign it but you wanted to do was  
8 to improve the record keeping by making sure that the  
9 doctors did what they were supposed to do.  
10 A. Yes.  
11 THE CHAIRMAN: And under (g), you were then to be involved  
12 in training the nursing staff --  
13 A. Well, it was informing them of the above decisions that  
14 had been made.  
15 THE CHAIRMAN: Well, you were to train them about (e)  
16 and (f), weren't you? So you were to train the nurses  
17 effectively to make sure they got the doctors to  
18 complete the forms properly.  
19 A. Yes.  
20 THE CHAIRMAN: In other words, there's limited value in the  
21 nurses completing the forms better if the doctors don't  
22 also complete the forms better.  
23 A. Yes.  
24 THE CHAIRMAN: And then at paragraph (f):  
25 "Nursing staff to be proactive in management of

147

1 fluids required after 4 pm. Refill bag not just  
2 automatically put up."  
3 A. Yes.  
4 THE CHAIRMAN: Do you remember Dr Butler in her evidence  
5 that she was passing through and she signed off a new  
6 bag which was given to Raychel around about midday or  
7 not long before? Is that what this paragraph (f) is  
8 referring to?  
9 A. No. Well, I think what that was -- that, you know, the  
10 doctors went off at 5 o'clock, the day doctors went off,  
11 and it was to make sure that before they went off that  
12 the fluids had been written up rather than calling  
13 somebody, you know, during the ...  
14 THE CHAIRMAN: Out of hours?  
15 A. Out of hours, yes. And also sometimes the same fluid  
16 would have been put up if we had difficulty getting  
17 a doctor. So we were to ensure that the fluids were  
18 written up before the changeover time for the medical  
19 staff.  
20 THE CHAIRMAN: Right. But for that to happen, would that  
21 mean that there would be a doctor coming back in before  
22 the end of the day shift just to check off what was  
23 happening on Ward 6?  
24 A. Well, we would -- we would call him back. We would --  
25 if they weren't coming back to write up a patient or,

148

1 you know, back to discharge a patient, we would actually  
2 bleep them to come back and write up the fluid before  
3 they went off at 5 or 5.30, 6, whatever time they went  
4 off. It was to ensure that we weren't calling doctors  
5 out of hours.  
6 THE CHAIRMAN: I'm sorry to interrupt, Mr Stewart, but can  
7 I take this on one step further? One of the actions  
8 that was taken on foot of the critical incident review  
9 was that you would no longer call on very junior  
10 doctors, like doctors Curran or Devlin, or people of  
11 their level of experience, that from then on it would be  
12 more senior doctors who were available to you?  
13 A. It would be an SHO or -- yes.  
14 THE CHAIRMAN: Did that work in practice?  
15 A. It mostly did work, but not always. But it mostly did.  
16 THE CHAIRMAN: I'm asking you because I can understand why  
17 that would be a lesson that was learnt from Raychel's  
18 death, but SHOs and registrars might be even busier than  
19 pre-registration doctors; is that right?  
20 A. Yes.  
21 THE CHAIRMAN: So although it's fine in principle and in  
22 theory to say for the children's purpose they need  
23 somebody more senior, that might not ease the problem of  
24 getting someone more senior along. So how was that  
25 largely achieved that you were able to get somebody

149

1 along?  
2 A. Well, I think the -- the doctors were aware after  
3 Raychel died as well that it was to be an SHO and  
4 registrars that wrote up fluid. And, I mean, I do  
5 remember that things did improve.  
6 THE CHAIRMAN: Was that maintained?  
7 A. It was mostly maintained, but there were times it wasn't  
8 always -- it wasn't 100 per cent but it was certainly  
9 a lot better than what it was.  
10 THE CHAIRMAN: Okay. Thank you.  
11 MR STEWART: So in short -- and thank you, sir -- that was  
12 a valuable meeting in terms of what was agreed, quite  
13 an important meeting in making sure that everybody was  
14 now agreed as to what their responsibilities were and  
15 what was to happen in the future?  
16 A. Yes.  
17 Q. Perhaps this might be a convenient moment to break for  
18 10 minutes?  
19 THE CHAIRMAN: Yes. We'll be back in 10 minutes.  
20 (3.27 pm)  
21 (A short break)  
22 (3.40 pm)  
23 THE CHAIRMAN: We won't be much longer, okay?  
24 A. Thank you.  
25 MR STEWART: Sister Millar, can I bring you to the meeting

150

1 with Mrs Ferguson on 3 September 2001 at the clinical  
2 education centre at Altnagelvin. You were there along  
3 with Staff Nurse Noble and Dr Nesbitt, Dr McCord,  
4 Mrs Burnside and the patient's advocate for and with the  
5 Altnagelvin Hospital.  
6 You explained part of what you remembered about that  
7 meeting the last time you gave evidence here on 1 March,  
8 and you explained that, insofar as you could remember,  
9 Dr Nesbitt was very open and he explained that there was  
10 a fault on the care of Raychel. And that was explained  
11 as meaning, by fault, that she should have had her  
12 electrolytes done.  
13 Is that correct, you remember giving that evidence?  
14 A. Yes, I do. I cannot remember in detail, you know, the  
15 explanation that Dr Nesbitt gave to Mrs Ferguson, but  
16 I do remember that it did evolve around the  
17 Solution No. 18 and I cannot be sure that the  
18 electrolytes were mentioned but I think they were. But  
19 I cannot -- I mean, I'm not -- I cannot remember what he  
20 said. But I do remember that I felt at the time that  
21 the explanation was ... Was ... I was satisfied that  
22 it was a good explanation.  
23 Q. Were you satisfied that it was an acceptance, an  
24 acknowledgment of fault?  
25 A. I was, yes.

151

1 Q. Can we go back then, please, again to the statement,  
2 your statement to this inquiry, WS056/1, page 9. This  
3 is the paragraph beginning:  
4 "I am confident ..."  
5 To ask you how it was you allowed yourself to make  
6 this statement, given that you'd been at a meeting with  
7 Mrs Ferguson where fault had been admitted by the  
8 hospital, you wrote:  
9 "I am confident that Raychel received the highest  
10 standard of care from the nursing staff. Her treatment  
11 and care was no different to any other child who  
12 required a surgical procedure."  
13 How could you write that having been at a meeting  
14 where fault was admitted?  
15 A. Well, at the meeting the fault was very much around the  
16 Solution No. 18 and -- I mean, it was recognised that  
17 there were deficiencies in the documentation. I can't  
18 remember if that was mentioned. I don't think it was.  
19 But it was very much around Solution No. 18. It  
20 wasn't -- it didn't highlight on the nursing care of the  
21 child --  
22 Q. Well --  
23 A. -- of Raychel.  
24 Q. Excepting only the fluid balance chart which you've just  
25 referred to is clearly --

152

1 A. Yes, well, that was -- that was nursing care.  
2 Q. So how did you bring yourself to express confidence that  
3 she'd received the highest standard of care and that  
4 that was no different to any other child? The two are  
5 inconsistent, I suggest. Did you write this statement  
6 all by yourself?  
7 A. Yes.  
8 Q. Did you receive any input from anybody else by way of  
9 amendment, correction, addition, augmentation?  
10 A. No.  
11 THE CHAIRMAN: I'm just a bit curious about this because  
12 I understand that when statements --  
13 A. I think the statements were checked.  
14 THE CHAIRMAN: That's what I was going to ask you. Because  
15 when statements are prepared for the coroner, I now see  
16 that the system is, as was explained to me yesterday by  
17 Mr Stitt, that they are read over for things like typos  
18 or grammatical errors, just to make sure the relevant  
19 issues have been addressed, and if that isn't the case,  
20 then they might be referred back to the person who's  
21 making the statement, not being told what to put in the  
22 statement but being suggested that they might improve it  
23 in some way. Okay?  
24 So when statements were being prepared for the  
25 inquiry -- let me personalise it to you, when you were

153

1 being asked by the inquiry for your response to these  
2 questions, did you prepare a response or, when you  
3 prepared a response, who did you send it to?  
4 A. I would have sent it to risk management.  
5 THE CHAIRMAN: Right. And did risk management then make  
6 suggestions or give you assistance in any way in how it  
7 might be improved, whether by typos or grammar or by any  
8 other way?  
9 A. Not that I can recall.  
10 THE CHAIRMAN: Okay. So all of these answers were, in  
11 effect, as per your original draft? What I have  
12 received from you is your first and only draft of the  
13 statement that you prepared for me?  
14 A. Yes.  
15 THE CHAIRMAN: Thank you very much.  
16 MR STEWART: Can I ask you why the deficiencies in the  
17 record keeping were not mentioned at the meeting with  
18 Mrs Ferguson on 3 September?  
19 A. Um ... I don't know. I have no explanation for that.  
20 Q. Could you have said more to Mrs Ferguson on that day?  
21 A. I felt I couldn't say any more. I think I said at  
22 the -- in February/March, when I appeared here that  
23 I found the meeting very difficult. The atmosphere was  
24 very, very difficult. Mrs Ferguson was distraught, as  
25 one would expect.

154

1 I felt Mrs Burnside spoke at, I think, at length.  
2 I cannot remember what she said. And Dr McCord --  
3 I mean, I was there to answer questions if questions  
4 were put to me. But the -- Mrs Burnside led the meeting  
5 and it was very much Dr Nesbitt and Dr McCord who spoke  
6 to Mrs Ferguson and her family.  
7 I did make an attempt to, you know -- I think I said  
8 that I hadn't expected anything like what had happened  
9 to Raychel and that I had seen other children, you know,  
10 vomit and actually vomit more than Raychel and they  
11 hadn't suffered any -- you know, the event that Raychel  
12 had. But I think that's all I said at that meeting. My  
13 recollection of it is not good.  
14 THE CHAIRMAN: Can I ask you this? I can understand how not  
15 just the family but the staff would have found that  
16 meeting very difficult because you're sitting down with  
17 the mother and family of a dead nine-year-old girl to  
18 try to explain to them what happened. It's not easily  
19 done, and part of the reason it's not easily done is  
20 because some things went wrong in the hospital which  
21 shouldn't have gone wrong in the hospital. Right?  
22 Before you went into that meeting, did you have any  
23 assistance or steer on how you would speak to the  
24 family, or were you just asked to come in at a certain  
25 time and a certain day because the Fergusons were coming

155

1 in?  
2 A. Yes, I was just told that there was a meeting with the  
3 Ferguson family on that date. It may have been --  
4 I have a feeling that -- I mean, I didn't know, it might  
5 have been only a day or the same day I knew about it,  
6 I wasn't given a huge prior notice to it, and would  
7 I attend. I didn't know why I was attending or what  
8 I was supposed to do or, if anything, or -- I just --  
9 I just was asked to attend.  
10 THE CHAIRMAN: Did you know who else was going to be there?  
11 A. No.  
12 THE CHAIRMAN: You said to me in March that one of your  
13 concerns, looking back on it, is that there were too  
14 many people there.  
15 A. Mm-hm.  
16 THE CHAIRMAN: And that can make a family feel a bit  
17 overwhelmed if there's a big table or big room full of  
18 people.  
19 A. Mm.  
20 THE CHAIRMAN: But you didn't have a clear idea about what  
21 your input was to be?  
22 A. No. No, I went over, I can't -- I actually can't  
23 remember whether it was in the MDEC or CEC, I can't  
24 remember clearly. I do remember that the room was very  
25 small and that I was sitting up against the door.

156

1 I don't remember Nurse Noble there, which I think she  
2 was. I remember Dr McCord, Dr Nesbitt, the patient's  
3 advocate person -- I can't remember her name --  
4 Mrs Burnside. And I remember a Dr Ashenhurst, the GP,  
5 because I know her.  
6 THE CHAIRMAN: Okay. Thank you.  
7 MR STEWART: Did the patient advocate do anything?  
8 A. I know she was in the background. I cannot remember if  
9 she said anything, but I think she was taking the  
10 minutes.  
11 Q. In relation to your observation that you weren't really  
12 sure about what you could contribute and what you were  
13 meant to contribute to the meeting, you had been part of  
14 the critical incident review, you were tasked with doing  
15 things in the agreed action plan. There in the update  
16 with the chief executive on 9 July, which we looked at  
17 just before our tea break. You'd been part of that  
18 meeting with the nurses. You were going to involve  
19 yourself in training the nurses in relation to some of  
20 those agreed objectives. You had a lot you could have  
21 told Mrs Ferguson about lessons learned, things put in  
22 place to stop a recurrence.  
23 Why didn't you tell her about those things?  
24 A. Dr Nesbitt and Dr McCord had spoken at length. They had  
25 been asked questions by the -- there were two ladies

157

1 with Mrs Ferguson, I can't remember who they were.  
2 I think one may have been her sister. A lot of what the  
3 recommendations about the electrolytes -- electrolytes  
4 was mentioned and the fact that they would review the --  
5 you know, that this management of the children was being  
6 reviewed, or was reviewed, and that there was going to  
7 be a change in management, that lessons had been  
8 learned. I mean, these are words that I remember but  
9 I cannot remember the exact conversation.  
10 It went on quite a lengthy time, and Mrs Ferguson  
11 was very, very upset, and I didn't feel that -- I felt  
12 that Dr Nesbitt had covered a large area and, I mean,  
13 I -- as I say, it was an extremely difficult meeting.  
14 When I went into that meeting I thought I would be  
15 able to speak to Mrs Ferguson face to face on her own or  
16 almost on her own. I did not expect that there were so  
17 many people in the room and that the atmosphere was so  
18 difficult. And when I -- I wrote, I remember that  
19 I felt that I was unable to give Mrs Ferguson the  
20 reassurance and the explanation. What I meant by  
21 reassurance was actually that I could have gone and  
22 comforted her. That's what I meant by that.  
23 Q. What explanation would you have given her, had you the  
24 opportunity at the time?  
25 A. And the explanation was that, you know, during the day,

158

1 that day that I had been on -- and yes, Raychel had  
2 vomited but she was up walking to the toilet with her  
3 father. You know, that, yes, I had -- whilst I had  
4 concern, I had no doubt that she would recover. I did  
5 not expect -- I mean, I did say that in a shortened  
6 sentence that I never expected, when I went off duty, to  
7 come back on the Tuesday and to hear of the catastrophic  
8 event that had occurred. But I just -- I mean, I wanted  
9 to talk to Mrs Ferguson, but mostly to comfort her and  
10 to say how sorry I was. But I just -- I just couldn't,  
11 it was very, very difficult.  
12 And I mean, I'd had many years of experience of  
13 nursing, but I had never experienced anything like this.  
14 I had never been involved in a child who had died in  
15 such circumstances. I just found it very difficult.  
16 THE CHAIRMAN: Can I ask you just on one separate issue on  
17 this. You have described now from coming back into work  
18 after Raychel had died right through to 3 September, and  
19 at no point has there been any reference to the director  
20 of nursing being involved in the reviews or exchanges or  
21 meetings. Do you remember Ms Duddy being involved in  
22 this period at all from June to September in anything to  
23 do with Raychel?  
24 A. No. No, just -- I think she was at the critical review  
25 meeting, but I don't remember anything after that.

159

1 THE CHAIRMAN: I'm subject to correction, but I don't think  
2 she was actually at the critical --  
3 A. I could be wrong.  
4 MR STEWART: The summer.  
5 THE CHAIRMAN: At the end of the summer or the start?  
6 MR STEWART: End of the summer, I think.  
7 THE CHAIRMAN: But in the various discussions -- I mean,  
8 because you said that you remember her coming round once  
9 or twice in separate winters when there were pressing  
10 issues about staffing, and here you have a pressing  
11 issue about a child's unexpected death. What I'm just  
12 exploring with you is, do you have any recollection of  
13 Mrs Duddy being involved in any of the discussions or  
14 proposals or reviews?  
15 A. No, I don't, no.  
16 THE CHAIRMAN: Thank you.  
17 MR STEWART: Do you have any recollection of anyone senior  
18 to you, after the critical incident review, gathering  
19 you and the other nurses together for further  
20 interviews?  
21 A. No.  
22 Q. Do you have any recollection of being interviewed  
23 yourself on any subsequent occasion?  
24 A. No.  
25 Q. Can I ask for document 160-163-003 to be shown? This is

160



1 part of a letter written on 29 March 2002, in which the  
2 solicitor acting on behalf of the Altnagelvin Trust puts  
3 to the coroner the Altnagelvin position.

4 The second paragraph down there:

5 "Another issue of concern to the trust is

6 Dr Sumner's conclusions on page 4 of his report in the  
7 comments numbered 2 and 5 that the deceased suffered  
8 very severe and prolonged vomiting. This conclusion is  
9 strongly disputed by the trust. The nurses who were  
10 caring for the deceased during the relevant period have  
11 been interviewed in detail about this matter and they  
12 are all of the opinion that the vomiting suffered by the  
13 deceased was neither severe nor prolonged."

14 You say to have no recollection of any interview  
15 with you --

16 A. No.

17 Q. -- about anything, let alone the vomiting?

18 A. No, I mean, we were asked to write statements --

19 Q. Yes.

20 A. -- and at the critical review meeting, I think, you  
21 know, there was discussion around Raychel's vomiting, as  
22 has been previously discussed.

23 Q. Yes.

24 A. But we weren't separately interviewed. I have no  
25 recollection of being separately interviewed or

161

1 interviewed individually, no.

2 THE CHAIRMAN: Or together?

3 A. No. I have no recollection of that.

4 MR STEWART: Have you any idea how the solicitor could have  
5 written to the coroner in these terms?

6 A. No, I don't.

7 THE CHAIRMAN: That doesn't really represent your view, does  
8 it, that the vomiting was neither severe nor prolonged?  
9 Your view is that you have seen children as bad who  
10 haven't died.

11 A. Mm-hm.

12 THE CHAIRMAN: But that's different from saying that the  
13 vomiting was neither severe nor prolonged.

14 A. Yes. As I have said before, Mr Chairman, I was not of  
15 the opinion that the vomiting was severe and prolonged.

16 We talked earlier about Dr Fulton's note or his minutes,  
17 where he said that the nurses were of the opinion that  
18 the vomiting was severe and prolonged. I have no  
19 recollection of that.

20 THE CHAIRMAN: Sorry, he says it was prolonged.

21 A. I think what may have been said was that it must have  
22 been prolonged to have caused the event that happened.

23 THE CHAIRMAN: Well, was it not prolonged? Because it  
24 started in the morning and was still going on very late  
25 at night, so it's prolonged, isn't it?

162

1 A. Yes, but --

2 THE CHAIRMAN: This was summarised very neatly yesterday  
3 afternoon. First of all, it's prolonged in the sense  
4 that it starts in the morning, quite early in the  
5 morning, and goes on intermittently all day, through the  
6 day, through the evening and into the night. So that's  
7 prolonged, isn't it?

8 Then in terms of its severity, you can debate, and  
9 we'll never end up with an answer to the debate about  
10 the difference between plus and plus plus, but when it  
11 gets to coffee-ground vomiting that's at least an  
12 indication of severity, isn't it?

13 A. Mm.

14 THE CHAIRMAN: So to take the view -- and I'm curious then  
15 that you're going back on this issue that you didn't  
16 think that her vomiting was either severe or prolonged.

17 A. Well, I didn't think it was severe, but --

18 THE CHAIRMAN: Well, is coffee-ground vomit not severe?

19 A. Yes, well, I suppose I was just talking about my time --  
20 my time on duty, which, you know, she vomited 10, 1 and  
21 3, and from what I saw of Raychel that day, that's all  
22 I can go on. Yes, I agree --

23 THE CHAIRMAN: I'm sorry, with respect, that can't be right,  
24 because for the nurses to have a view that the vomiting  
25 is neither severe nor prolonged, surely you have to look

163

1 at it overall. Because you can say, "Because I knew she  
2 vomited from 10 to 3, I don't think that's severe or  
3 prolonged vomiting", and somebody else can say, "Well,  
4 I saw her vomit four times between 4 o'clock and  
5 8 o'clock and that's not severe and prolonged", and  
6 somebody else can say, "I saw her vomit four times  
7 between half 7 and half 11, and that's not severe and  
8 prolonged", but when you add it all together that is  
9 severe and prolonged, isn't it?

10 A. Yes, I agree with that.

11 THE CHAIRMAN: So the fact that an individual nurse or  
12 a number of individual nurses do not say "I saw severe  
13 and prolonged vomiting" doesn't prevent anybody with  
14 a brain putting the length of time of the vomiting and  
15 the volume of vomiting ending up with coffee-ground  
16 vomiting into the category of prolonged and severe.  
17 Now, if that's wrong, please tell me.

18 A. No, I accept that. It goes into the evening and there's  
19 a coffee-ground vomit, obviously, yes, I agree, it is  
20 prolonged. But I suppose --

21 THE CHAIRMAN: And the coffee-ground vomiting is a sign, is  
22 it not --

23 A. Well --

24 THE CHAIRMAN: -- that it has become severe?

25 A. Yes. Mm-hm.

164

1 THE CHAIRMAN: I mean, there was some evidence that that is  
2 not the inevitable conclusion about a coffee-ground  
3 vomit, but certainly once you see -- the evidence was  
4 there was a coffee-ground vomit in itself alone is  
5 a sign for concern; isn't that right --  
6 A. Yes.  
7 THE CHAIRMAN: -- because it may indicate that something is  
8 seriously wrong?  
9 A. Yes. Well, it can be prolonged vomiting, but you can  
10 also get a coffee-ground vomit with one vomit --  
11 THE CHAIRMAN: Yes.  
12 A. -- because the severity of the vomit will maybe cause  
13 a little -- yes.  
14 THE CHAIRMAN: Okay.  
15 A. Yes.  
16 MR STITT: Mr Chairman, may I make hopefully a helpful  
17 observation? This line of questioning began with the  
18 letter from Donna Scott, the assistant director, of  
19 29 March 2002. The reference was made to the nurses  
20 being interviewed and they are maintaining that the  
21 vomiting was neither prolonged nor severe, which is  
22 obviously an important issue in this inquiry. And you,  
23 sir, through your questions, forensically have  
24 established from the witness that given certain points  
25 which you have put to her quite fairly that she would

165

1 agree that there's an element of severity and an element  
2 of prolongation.  
3 But might I respectfully remind the inquiry, if it's  
4 necessary, that her evidence on page 159 of the  
5 transcript was, before the questioning started, was that  
6 she was not of the opinion that the vomit was severe or  
7 prolonged.  
8 THE CHAIRMAN: Yes.  
9 MR STITT: That's a statement. It may be wrong for a number  
10 of reasons in terms of its technical assessment, but  
11 nonetheless she is stating what her opinion was.  
12 THE CHAIRMAN: The reason I went back over that over the  
13 last few minutes, Mr Stitt, was because it seemed to me  
14 to rather contradict the evidence that she gave before  
15 the break. And it also seems to me to ignore the  
16 evidence that we heard in February and March, and that's  
17 why I was anxious to go over with it and that is why I'm  
18 trying with the witness to put together the vomits from  
19 about 8 o'clock in the morning until late at night.  
20 MR STITT: Yes. I was on a slightly different point, and  
21 that was that it was being suggested to the witness that  
22 she could not recall being interviewed on any further  
23 occasions or on her own or with a group, which would  
24 tend to indicate that the statement in the letter was  
25 inaccurate that the nurses felt that the vomiting was

166

1 neither prolonged nor severe, and I'm simply saying that  
2 in terms of her answer, it is consistent,  
3 notwithstanding the answers which she's given to you.  
4 THE CHAIRMAN: But I'm not clear where the information on  
5 that letter comes from if she wasn't interviewed.  
6 MR STITT: Well, she can't remember being interviewed.  
7 I can't comment any further. It's not my place to do  
8 so, and you'll form your own view, sir, but this is  
9 2013.  
10 THE CHAIRMAN: Yes, but I'm sorry, I need a bit more than  
11 that, Mr Stitt. This was an issue which the trust was  
12 contesting. The basis for the contest is set out in  
13 this letter written by your instructing solicitor,  
14 I assume that the letter's written on instructions from  
15 the trust, and in light of what we have heard about  
16 what was agreed at the critical incident review we're  
17 trying to get to the root of the information contained  
18 in this letter.  
19 Now, if this witness wasn't -- effectively her two  
20 major contributions are her presence at the critical  
21 incident review and the statement she then wrote, which  
22 became her coroner's statement. If that's her  
23 contribution and she was not part of any subsequent  
24 interview on her own or with other nurses, at least so  
25 far as Sister Millar is concerned, where does this

167

1 information come from. That's what I'm trying to get  
2 at.  
3 MR STITT: I understand where you're trying to get to, and  
4 I for one certainly wouldn't want to stand in your way,  
5 Mr Chairman, but I am saying that her answer is not  
6 inconsistent with the letter, but your point is  
7 a different one.  
8 THE CHAIRMAN: Thank you.  
9 MR STEWART: Perhaps we can move to the evidence that you  
10 did give at the inquest. First of all, by way of  
11 background can we go, I wonder, to the transcript of  
12 your evidence for 1 March 2013, page 57.  
13 It's at line 11:  
14 "But there was always a difficulty in getting  
15 doctors. If I had two or three surgical children,  
16 I could spend more time with them than I would with  
17 maybe 15 or 20 medical children. So the amount of time  
18 wasted on trying to get doctors -- and it wasn't that  
19 they weren't answering their bleeps, it was they are in  
20 theatre, they were in clinics, they were in A&E, they  
21 were in outlying wards, there was an emergency going on  
22 in A&E, you know, it was very difficult to get them."  
23 The chairman:  
24 "So they seemed to be everywhere other than where  
25 you needed them?"

168

1 "Answer: Yes, I'm saying this, I said it at this  
2 meeting as far as I remember. I can't remember exactly  
3 what I said..."  
4 And you describe fully your frustration at getting  
5 the doctors.  
6 The evidence you gave at the inquest can be found at  
7 012-041-204. This is in the handwritten portion and you  
8 can see your signature at the foot of the page.  
9 The sentence beginning about five lines down:  
10 "The surgical team do a round in the morning and are  
11 available if required. It would not be unusual for them  
12 to return without being asked for."  
13 Can I suggest to you there seems to be a great  
14 difference between assuring the coroner on the one hand  
15 that the surgical team are indeed available if required  
16 and there was always difficulty getting them, the amount  
17 of time wasted on trying to get doctors, you know, it  
18 was very difficult to get them, seems to be two separate  
19 stories?  
20 A. No. There were problems with getting the medical staff,  
21 right? But they were to be available if they were  
22 needed. And --  
23 Q. I'm sorry, your evidence here was "are available if  
24 required", not "were to be". We're not in the  
25 hypotheticals, we're in the concrete, "are available if

169

1 required".  
2 A. If we required them, we would bleep them.  
3 THE CHAIRMAN: Yes, but the problem that you were expressing  
4 at the critical incident review was that you had great  
5 difficulty getting them.  
6 A. We did at times, yes, we did.  
7 THE CHAIRMAN: And we've already heard in Raychel's case  
8 that there was a specific problem in the afternoon  
9 getting a doctor, the first doctor along, Dr Devlin.  
10 A. Mm-hm.  
11 THE CHAIRMAN: So the delay -- and in fact, Dr Devlin wasn't  
12 actually responding to a bleep, he happened to be on  
13 Ward 6 doing something else and was grabbed and  
14 administered the anti-emetic; right? So he didn't  
15 respond to the bleep.  
16 There's nothing unusual about that because what you  
17 told the critical incident review, and the point was  
18 being emphasised, and you were being quite blunt about,  
19 was: the surgeons need to get their act together and  
20 provide us with a proper service for the children.  
21 Right?  
22 A. Yes.  
23 THE CHAIRMAN: But that's not what you told the coroner.  
24 You didn't tell the coroner anything like that. Why  
25 didn't you say to the coroner, without even having to go

170

1 into all the detail, "The surgical team do a round in  
2 the morning and if we need them otherwise, we sometimes  
3 have difficulty getting them but ultimately somebody  
4 always arrives?"  
5 The answer as noted -- and then you sign that at the  
6 end, the answer that you gave doesn't go down that route  
7 at all:  
8 "The surgical team do a round in the morning and are  
9 available if required."  
10 A. Yes. Well, I suppose that what I meant was that -- you  
11 know, that you would bleep them if you required them  
12 back. I suppose I wasn't thinking at that time of the  
13 difficulties that we had, but there were difficulties.  
14 THE CHAIRMAN: I'm sorry. In light of everything around  
15 Raychel's case, including the specific difficulty on the  
16 Friday afternoon in getting a doctor, and in light of  
17 the discussions afterwards in the critical incident  
18 review, and in light of the changed practices that you  
19 told me about when I asked you before the break, how  
20 could you not have been thinking about that when you  
21 were giving evidence to the coroner about Raychel?  
22 Let me spell this out to you, Sister Millar. It  
23 rather looks as though you didn't pull your punches  
24 in the hospital, in the critical incident review, but  
25 then you didn't speak quite so openly and frankly when

171

1 you were before the coroner. That's how it looks to me.  
2 Now, if that's not fair, please tell me why it's not  
3 fair.  
4 A. Well, I expect I should have expanded on that for the  
5 coroner, but I didn't.  
6 THE CHAIRMAN: Thank you.  
7 MR STEWART: If we go to the foot of this page where it says  
8 Mr McAlinden -- a question coming from counsel:  
9 "On sheet 37, the degree of vomiting shown is not  
10 that unusual based on my experience."  
11 So you're saying -- you're giving evidence about the  
12 degree of vomiting based upon the records. Did you tell  
13 the coroner that in fact the clinical incident review  
14 had recognised that there was poor documentation of the  
15 fluid balance in this case?  
16 A. Did I tell the coroner?  
17 Q. Yes.  
18 A. No. By that I didn't.  
19 Q. Can I ask in relation to the vomiting itself that  
20 we have a look at your evidence on the transcript from  
21 28 February, page 82?  
22 Line 10, you were asked by Mr Wolfe:  
23 "Could I ask you, Mrs Millar, did you actually  
24 physically see any of the vomit, any of the vomiting?  
25 "Answer: Yes, I saw the vomit at 10 o'clock ...

172

1 between 10 and 11 o'clock I was in the room. The  
2 paediatrician was doing the ward round. We noticed ...  
3 vomit bowl."

4 Can we go back now to 012-041-203. It's about six  
5 lines or seven lines from the bottom of the handwritten:

6 "I did not personally see any of the vomits."

7 A. Well, the vomit that I saw at 10 o'clock, I presumed  
8 that to be the 8 o'clock vomit, which was documented by  
9 the night staff whilst we were having the handover  
10 report. And I think if you look back at some of my  
11 statements, I said that -- that I understood that to be  
12 the 8 o'clock vomit that somebody hadn't removed. So  
13 I was -- the vomits that I was talking about to the  
14 coroner were the 10, the 1 and the 3 pm vomit. But back  
15 in March or February, when I appeared here, I -- I mean,  
16 I had to -- I couldn't say for definite whether it was  
17 the 8 o'clock or the 10 o'clock on questioning, but at  
18 that stage when I was absolutely sure that it was the  
19 8 o'clock vomit, and that had been documented by the  
20 night staff.

21 So it had been -- as I say, to me the vomits that  
22 were associated with me when I came on duty was the  
23 10 o'clock, 1 o'clock and the 3 o'clock, which I hadn't  
24 seen, but I had -- they had been described to me by the  
25 nurses that had been caring for Raychel.

173

1 Q. Did you tell the coroner that in the view, at least of  
2 the critical incident review, the vomiting had been  
3 prolonged?

4 A. No, I didn't.

5 MR STEWART: Thank you, sir. I have no further questions.

6 THE CHAIRMAN: Mr Quinn?

7 MR QUINN: Just one question.

8 THE CHAIRMAN: You don't have to.

9 Questions from MR QUINN

10 MR QUINN: I have one question the parents have asked me to  
11 ask. In your view, was there any difficulty with  
12 staffing levels at the time when Raychel was in  
13 hospital?

14 A. No.

15 MR QUINN: Thank you.

16 THE CHAIRMAN: I get the impression it's a winter issue  
17 rather than -- in some winters it's an issue, but  
18 in June -- in the spring and summer, it's not an issue.

19 A. No.

20 THE CHAIRMAN: Okay. Any questions before I come to  
21 Mr Campbell? Any questions?

22 Sister, thank you very much for coming again.

23 Unless there's anything more you want to say, that  
24 brings your evidence to a conclusion.

25 A. No.

174

1 THE CHAIRMAN: Thank you very much. You're free to leave.

2 A. Thank you.

3 (The witness withdrew)  
4 Housekeeping

5 THE CHAIRMAN: Just briefly, ladies and gentlemen, in terms  
6 of the questions that you were asking, Mr Quinn, about  
7 the timetable. I think everybody's been issued with  
8 a timetable up to and including Wednesday 11 September.  
9 Is that right?

10 MR QUINN: Yes.

11 THE CHAIRMAN: So we are sitting tomorrow and Friday. Then  
12 next week, we are sitting Monday the 2nd, Tuesday the  
13 3rd and Wednesday the 4th, and in the following week  
14 we are again sitting Monday to Wednesday. That's 9th,  
15 10th and 11th.

16 It looks likely that we will have to sit for  
17 a couple of days in the week of the 16th. It looks to  
18 be two days, hopefully not a third, but if needs be  
19 there will be a third, and that will finish the evidence  
20 in Raychel's case entirely in that week of Monday the  
21 16th.

22 As things stand, then, I understand we were to  
23 receive some information from DLS this afternoon from  
24 Craigavon Hospital, what is now the Western Trust. It's  
25 the Southern Trust, is it?

175

1 What we're aiming to do is to deal with Conor's case  
2 in the week beginning Monday, 14 October. But if we do  
3 Conor that week, we'll sit on the Monday, Wednesday,  
4 Thursday and Friday, not on the Tuesday.

5 So I'll confirm that as soon as I can. And then  
6 what we are trying to piece together are the final few  
7 weeks of the hearing, which involve the historic issues  
8 about the departmental witnesses such as Dr Campbell and  
9 others, and there might be around about two weeks of  
10 departmental evidence along those lines, and the final  
11 week will involve effectively presentations by the  
12 Belfast Trust and by the department to say how things  
13 have changed, what the current position is, and we are  
14 expecting in the next couple of weeks, I think -- and  
15 we've got a letter, Miss Rodgers, to say that the  
16 department's presentations are being prepared at the  
17 moment; is that right?

18 MISS RODGERS: Yes, the papers are still being gathered and  
19 they're put together, we hope to be in a position to  
20 serve them in the first week of September.

21 THE CHAIRMAN: Great. That's next week, by the way. I know  
22 the Belfast Trust is working along the same timetable,  
23 and on that basis, as I said before the summer, and  
24 there wasn't any adverse reaction or additional  
25 suggestions from the parties, that will be the final

176

1 week of the inquiry.  
2 What we're looking at to see is how tight we run  
3 those last weeks together, if it's two weeks of  
4 departmental witnesses and then a week of presentations  
5 at which the department and the Belfast Trust say what  
6 happens now, and we can then probe them by putting  
7 examples: well, if Raychel happened or Conor happened  
8 now or Adam happened now, how would things be different  
9 and the sort of episodes we've seen and queried over the  
10 last year, how would the new procedures allow that to be  
11 treated differently? That will be the way we conclude.  
12 The historical abuse inquiry needs to move in here.  
13 We are not going to be rushed out, but I think we are  
14 coming towards the end in any event, so it's a question  
15 of how quickly we can draw the last few pieces together.  
16 MR QUINN: Can I just clarify then? That means we're  
17 sitting next week for four days.  
18 THE CHAIRMAN: Three days, Monday, Tuesday, Wednesday.  
19 MR QUINN: Monday, Tuesday, Wednesday. Week commencing the  
20 9th, three days?  
21 THE CHAIRMAN: Yes, Monday, Tuesday, Wednesday.  
22 MR QUINN: And the week commencing the 16th?  
23 THE CHAIRMAN: It looks like it's definitely two days. We  
24 may need a third.  
25 MR QUINN: Does that mean, then, that the week commencing

177

1 the 23rd is free at the moment?  
2 THE CHAIRMAN: As is the week of the 30th. As is the week  
3 of the 7th.  
4 MR QUINN: So it's three weeks free?  
5 THE CHAIRMAN: Yes.  
6 MR QUINN: Then we're into the 14th. We sit the 21st and  
7 we're also sitting --  
8 THE CHAIRMAN: Well, that's the aim, but we're still  
9 waiting. In light of the evidence that was heard, which  
10 has been heard to date, apart from the presentations  
11 from the Belfast Trust and the department, we've asked  
12 for additional witness statements, and we're hoping to  
13 have those back in time for us to be able to sit through  
14 from 14 October. But that's the target, Mr Quinn.  
15 I can't yet confirm that. We have to look at how  
16 extensive those statements are, but as inevitably as all  
17 of these things happen, we're narrowing down the focus  
18 on more and more precise issues now.  
19 MR QUINN: But does it look as though we're going to sit  
20 some of the week of 20 October?  
21 THE CHAIRMAN: Probably.  
22 MR QUINN: Just for clarity on that point.  
23 THE CHAIRMAN: I'm sorry this is a little vague at the  
24 moment, but it depends on information coming back to us  
25 and how quickly we can get through that information in

178

1 a way that we can turn it round to present it publicly.  
2 MR QUINN: With respect, Mr Chairman, for some  
3 clarification, does that mean that we hope to finish on  
4 1 November at the latest, which is Friday, 1 November?  
5 THE CHAIRMAN: No, it wouldn't be because if we did the week  
6 of the 14th for Conor, the weeks of 21st and 28th for  
7 the historic issues involving the department, what the  
8 department knew or didn't know about what was going on  
9 at all of these different times, that would probably  
10 mean that the week of the 4 November would be the  
11 presentation week.  
12 I'm saying it's presentation, but it's on the basis  
13 that there's effectively agreement that people like the  
14 Permanent Secretary will lead a small team, who will  
15 come here. They will present papers or set out position  
16 papers and there will be two or three of them here who  
17 can be probed about how this works and how that works.  
18 MR QUINN: And the last issue I want to ask you about,  
19 Mr Chairman, is it likely that the coroner is to be  
20 recalled?  
21 THE CHAIRMAN: No, but I have written to the coroner and  
22 asked him if it's possible for him to give us an  
23 indication in light of what he has heard and his own  
24 evidence on how things might possibly change in the  
25 future.

179

1 MR QUINN: Yes, because that is a relevant issue that vexes  
2 the parents.  
3 THE CHAIRMAN: You will, of course, remember that while  
4 Mr Leckey is the senior coroner, he's not the head of  
5 the coronial service, it's Mr Justice Weir. Do you want  
6 me to ask Mr Justice Weir for a paper?  
7 MR QUINN: I might get there first!  
8 THE CHAIRMAN: If you want me to ask him for a written paper  
9 I'll do that. We've got a holding response from the  
10 coroner's office to say that our enquiry of him about  
11 how things might change in light of what he's heard is  
12 being taken forward, and we've got a holding answer on  
13 that. But I'm assuming something that you know this,  
14 Mr Quinn, but just so the families and everybody else  
15 knows it. Mr Leckey, the senior coroner who gave  
16 evidence here, is not the only coroner for Northern  
17 Ireland, and the head of the coronial service is a High  
18 Court judge called Mr Justice Weir, so Mr Leckey can't  
19 just write back to us and say, "I'm going to do five  
20 things differently in future", he needs to confer with  
21 the head of the service and the two other full-time  
22 coroners, and that's not just an overnight decision to  
23 be made.  
24 MR QUINN: Yes.  
25 THE CHAIRMAN: I'm hoping we get an answer. I just don't

180

1 know if and when we'll get an answer. Okay?  
2 Mr Stitt?  
3 MR STITT: On the coat tails, you were good enough to give  
4 us the likely length of this section. You ended up by  
5 saying there will probably be two days in the week  
6 commencing 16 September and might go into a third day.  
7 THE CHAIRMAN: Yes. Sorry, yes, we might go into a third  
8 day.  
9 MR STITT: When you say might be two days, is that Monday  
10 and Tuesday.  
11 THE CHAIRMAN: No, we have provisionally arranged witnesses  
12 for the Wednesday and the Thursday. Some of this is  
13 coming down to witness availability and there are some  
14 witnesses we had hoped to call before who aren't  
15 available, and unfortunately in the next couple of weeks  
16 there are a few days which, for different reasons,  
17 I can't be here. But at the moment it looks more like  
18 the Wednesday and Thursday. If we are going to need  
19 a third day at all, it will almost certainly be the  
20 Tuesday.  
21 MR STITT: Could I ask when we will get the list of which  
22 witnesses are proposed to be called?  
23 THE CHAIRMAN: Soon.  
24 MR STITT: Thank you.  
25 THE CHAIRMAN: Just give me one second. (Pause).

181

1 I can give you part of it now. Wednesday the 18th,  
2 the plan at the moment is to call Dr Taylor on Wednesday  
3 the 18th. Isn't that right?  
4 MR UBEROI: Yes, sir.  
5 THE CHAIRMAN: And Kay Doherty on the Wednesday. The  
6 proposal at present is to call Professor Swainson on  
7 Thursday the 19th.  
8 Now, there has been some previous legs in the  
9 inquiry when an expert witness wasn't called, so I will  
10 keep open Professor Swainson's attendance on the 19th  
11 and he will attend if required, and the parties can  
12 consider as the next couple of weeks go on whether we  
13 actually need to hear from Professor Swainson, because  
14 very often what has happened, as you'll recall it,  
15 these issues resolve themselves as the evidence goes  
16 along, and apart from that we have one day in the next  
17 couple of weeks when I'm concerned that we're too tight  
18 on witness time.  
19 Let me spell it out. I'm a bit concerned that  
20 Monday the 2nd, in which we have both Mrs Brown and  
21 Dr Crean, is too tight a day to do both witnesses, but  
22 I understand that neither witness is available to run  
23 into a second day. That might lead to a slight rejig,  
24 which is why I'm keeping open the possibility of Tuesday  
25 the 17th. But the next two days of this week, three

182

1 days next week and three days the following week are  
2 definites. Okay?  
3 MS GOLLOP: Sir, we don't all have a timetable up to  
4 September 11th.  
5 THE CHAIRMAN: If you wait for 10 minutes, you'll have one.  
6 Okay?  
7 MS GOLLOP: Thank you, sir.  
8 MR STITT: I'm just taking instructions, sir. If it's of  
9 some help, if you believe that the 2nd is too short  
10 a day, not a long enough day for the two proposed  
11 witnesses, Dr Nesbitt advises me that he remains  
12 available for Monday the 2nd, but he is out of the  
13 jurisdiction from the 9th onwards, and if there was  
14 going to be a decision, perhaps I respectfully suggest  
15 that Dr Crean be notified of the possibility of him  
16 doing the Tuesday and getting --  
17 THE CHAIRMAN: No. Sorry, I'm grateful to Dr Nesbitt for  
18 his flexibility. We've been given particular reasons  
19 why people aren't available to go into the Tuesday. If  
20 Dr Crean or Mrs Brown can't be taken on the Monday,  
21 then, as I understand it, neither of them is available  
22 on the Tuesday. So it actually wouldn't help to put  
23 Dr Nesbitt into the Monday.  
24 MR STITT: Yes, I see.  
25 THE CHAIRMAN: Look, it's just part of the witness

183

1 scheduling. We will definitely be sitting for three  
2 days next week, three days the week after, and what  
3 we'll tweak over the next few days is how we finish off  
4 in the fourth week.  
5 Okay. First we've got Ms McKenna and Ms Duddy.  
6 MR STEWART: The witness McKenna will be the shorter of the  
7 two.  
8 THE CHAIRMAN: And that leaves Dr Carson on Friday?  
9 MR STEWART: Yes.  
10 THE CHAIRMAN: 10 o'clock tomorrow. Thank you very much.  
11 (4.40 pm)  
12 (The hearing adjourned until 10.00 am the following day)  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

184

I N D E X

1  
2  
3 MR ROBERT GILLILAND (called) .....3  
4     Questions from MR STEWART .....3  
5     Questions from MR QUINN .....96  
6     Questions from MR STITT .....97  
7 MRS ELIZABETH MILLAR (called) .....100  
8     Questions from MR STEWART .....100  
9     Questions from MR QUINN .....174  
10 Housekeeping .....175  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25