Wednesday, 28 August 2013

(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?

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

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

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

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

that she raised that at what she called a consultants meeting, which may have been what consultants called a sisters' meeting, but she had been raising it with paediatricians, not with surgeons.

A. I don't know who Sister Millar raised that with. I wasn't present at that time, I don't think.

Q. So would consultant surgeons have met with the consultant paediatricians?

A. Not on a formal basis, no, there was no committee.

Q. The system of communication seems to be very loose and not structuralised?

A. I think there is a structure in that the two clinical directors would have met in the clinical directors' meeting, but there were open lines of communication between ourselves and the medical paediatric consultants.

THE CHAIRMAN: Does it depend then on how serious the issue is? If it's a passing thing that can be done paediatrician to surgeon, but if there's an issue such as this where the nurses are saying, "Look, we have trouble getting surgeons", and in a sense it's not a criticism of any individual surgeon because they have other responsibilities, but it's a simple reflection of the fact that paediatricians are inevitably around Ward 6 and surgeons are inevitably not around Ward 6.

Looking at it from this stance, is that an issue, if the nurses raise that with the paediatricians, how might you expect that to be followed forward to see if there's a way round it? Would you expect that to go from the paediatric clinical director to surgical clinical director, or what can you suggest as a way to explore that?

A. I think it certainly could have been done that way, but I think it's much more likely that the nursing staff, if they'd had a difficulty with getting surgical staff, would have raised it with one of the surgeons or directly with Mr Bateson.

THE CHAIRMAN: Right.

MR STEWART: With hindsight, would it have been better to have a formal system where people brought their individual issues to the right people within a minuted formalised structure?

A. I'm not sure that that would necessarily be the best way. From my experience in working in Altnagelvin, there were very open lines of communication between nursing staff, surgical staff and paediatric medical staff, and I think any of those issues could have been raised in that informal form and hopefully would have been able to be sorted out.

Q. Why wouldn't it be better to formalise it and minute it?

A. I wasn't saying that it would be better one way or the other, I just think that the informal method seemed to be working at that stage, and I'm not aware that there was any formal meeting between nursing staff, paediatric medical staff and surgical consultant staff.

THE CHAIRMAN: Does this issue depend on how serious the problem appears to be? The more serious it is, the more inclined one might be to go formal on it?

A. Possibly.

THE CHAIRMAN: You might start off trying to resolve it informally?

A. Yes, that's possible.

THE CHAIRMAN: And then by somebody like Sister Millar saying to somebody like you, "Look, we need to sort something out, we need to sort out something better here and you can discuss it with your colleagues", and if that's done and it doesn't work, and it is an issue of significance to the nursing staff, then it can be stepped up a bit?

A. More formally, yes.

THE CHAIRMAN: Right.

MR STEWART: You said in your most recent witness statement that:

"I do not recall what systems were in place in 2001 for quality assuring the safe provision of patient

care."

Did you really mean that? Can you not remember any systems for quality assuring patient care?

A. Well, there were a number of systems such as audit and the morbidity mortality meetings, and those sort of things. What I was really referring to is I don't remember those being formalised in a written format and I don't remember reading any of those -- reading any formal protocol for them. But certainly audit was in place and the morbidity mortality meeting was in place.

Q. I see. You were in a position where really you were dealing with your patients and you were the leader of a small specialty team. So in that context you have said that you would need for satisfied that anyone delivering clinical care was appropriately qualified and competent to do so.

A. Yes.

Q. I wonder, can we just look at that a bit to see how you went about satisfying yourself that the team were qualified and competent. First of all, you'd have to know who the patient was and what their condition was before you could go about working out the appropriateness of the member of the team dealing with the patient?

A. You wouldn't necessarily need to know the patients

per se, but you would need to know the potential condition that they had.

Q. It seems there was no protocol for ensuring that the on-call consultant was informed of patients admitted under their care. So if you weren't being informed of people admitted under your care, how could you possibly judge whether or not the team members looking after them were competent and capable to do so?

A. Yes, there wasn't -- there wasn't a protocol at that stage. They method of ascertaining the patients that were under your care after an evening after a period of on call was to start in the -- usually in the adult wards and work your way through the wards, and the nursing staff would inform you of any patients that had been admitted overnight under your care. You would see those patients. At the end of that ward round you would assess -- you would ask the team had they heard of any other patients that were admitted, you might well check in the other wards where those patients were likely to be admitted, or you might well send one of your members of the team to check on those wards and see if there were patients there.

Q. Why couldn't you simply telephone yourself, telephone the ward late in the evening to say, "Anybody admitted?"

A. Telephone the ward late in the evening?

Q. Yes.

A. That wasn't the protocol at that stage and, of course, telephoning the ward late in the evening wouldn't necessarily have captured all the patients. Your period of on call was from 9 am to 9 am.

Q. I know there was no protocol. I'm asking you why you couldn't have telephoned in to find out?

A. Well, one could have telephoned in, but again, as I said, that wouldn't have captured all of the patients.

Q. Could you alternatively have insisted that your junior medical staff inform you? Could they telephone you, leave a message on your answering machine, or mobile telephone?

A. You could insist that every time a patient was admitted that you were informed, but that wasn't the normal practice then, nor is it now.

Q. Well, given that you didn't always do the post-take ward round, shouldn't you have put in place a system to ensure that you knew if you weren't going to be at the ward round?

A. Well, my evidence is that I almost certainly did do a ward round that morning.

Q. No, I'm asking you whether or not, because you're not always doing a ward round, should you not have had a system?

A. I will have done a post-take ward round, I think, almost every time that I was on take.

Q. Well, we know, because we're looking at one particular instance, one day, that you didn't do it.

A. No, we know that I didn't see that particular patient.

Q. Yes. We'll come to that in a moment as to whether or not you were there and whether or not you knew about Raychel.

So if you have no system to find out if there's anybody there under your care, what system did you have to find out whether the doctors in your team were competent and qualified to look after the children?

A. Well, their qualifications will have been checked at the time of their interview. All of the doctors will have been through a selection and interview process that will have ensured that they were qualified to do the job that they were being appointed to do.

As I've said in my written evidence, competence is an ongoing assessment, and one fairly quickly becomes aware of the level of competence of individual doctors whilst working with them. It's a global assessment that is ongoing and that is how most doctors' competence is assessed.

Q. Is it not correct to say that children, as patients, behave differently from adults and some experience of

paediatrics, looking after children, is very useful?

A. Yes. It's always useful to have experience when dealing with any particular patient.

Q. In relation to your team, you didn't do the post-take ward round and your registrar didn't do the post-take ward round, but an SHO, Dr Zafar, did.

A. Yes.

Q. What sort of experience of paediatrics did he have?

A. Mr Zafar had not done any paediatrics before he came to us, but he had been with us for four months at that stage.

Q. He gave evidence on 1 March of this year as to what his paediatric experience was, and we can call up the transcript for 1 March 2013, page 143 and 144.

143, line 25.

"Question: Does that mean not only was Altnagelvin your first position where you had anything to do with paediatric patients, but actually you may not have had very many paediatric patients before Raychel; would that be fair?

"Answer: Yes."

So there's a doctor who is delegated as part of your team to attend upon Raychel and he doesn't look as though he's got much experience at all.

A. Well, I think he's had considerable experience of

looking after patients. He had done 18 months general surgery in Russia, 30 months attachment in the United Kingdom, and he had a lot of experience as a cardiac surgeon, both at SHO and registrar level. I would have thought he would be fairly competent to work out if a patient was progressing normally or if a patient was sick.

Q. You can see that he didn't have paediatric experience, which was the point I was making to you.

A. Yes, but I think it is, you know -- the issue here is whether someone is progressing normally and satisfactorily, whether someone is well or someone is not well, and I think someone of Mr Zafar's experience who had his FRCS qualification and a significant amount of experience would be able to tell whether a patient was progressing normally or whether they were not.

Q. Did he have his FRCS qualification?

A. Yes.

Q. I'll stand to be corrected on that. I think he had parts 1 and 2.

A. I believe that he had the AFCRS, which, as far as I can recall, was the equivalent.

Q. Very well. In relation to the rest of the team of doctors, part of your team, who went to attend upon Raychel during the day of 8 June, they were all junior

house officers, pre-registration house officers.

A. Yes, that's correct.

Q. So they hadn't even finished their basic medical training.

A. They had finished their basic medical training but they were not fully registered with the GMC.

Q. I'm sure some of those young doctors are very able and talented young doctors, but I'm sure others of them, like other junior lawyers, maybe are not to be relied upon. Would that be fair?

A. I think there's a range of ability in all grades of doctors.

Q. Indeed some junior doctors really have to be really led by the nursing staff?

A. That would be a common practice.

Q. Is it correct that after Raychel's death, in fact juniors were taken away from Ward 6?

A. I can't remember the exact timing of that, but there was at that stage in any case a move towards not allowing pre-registration house officers to be in certain specialties.

Q. How long had that move been gathering pace for?

A. I think it had been gathering pace in different specialties at different times. They were removed from Accident & Emergency departments around 1994 --

1984/1985. I don't think they were doing neurosurgery for a number of years before that.

Q. Yes. And in paediatrics?

A. I'm not sure the time frame.

THE CHAIRMAN: I think I have to say it was described to us as a consequence of Raychel's death, unless I'm mistaken. The reliance -- the move away from pre-registration doctors to slightly more senior doctors was intimated to us to be a consequence of Raychel's death rather than something that was in train anyway. Is that not how you remember it?

A. Is this in Altnagelvin or across --

THE CHAIRMAN: In Altnagelvin.

A. I don't remember for certain.

THE CHAIRMAN: I'm not saying -- it might have been in the air but was hastened by Raychel's death, but -- I'm subject to correction -- it was described to us in February and March as a consequence of Raychel's death.

A. I don't remember for certain if that was the specific incident that caused that change.

MR STEWART: That sort of idea that juniors should be taken away from certain specialties, would that have found expression in the BMJ, for example? Is that where we would go to look and find out how long that notion had been abroad for?

A. I don't know that one would necessarily be able to find it within the BMJ. There's almost certainly some literature out there about that, but I wouldn't know for sure where one would go to find that.

Q. So if some juniors really couldn't be relied upon and they would look to nursing staff for a steer, then the nursing staff are the fallback position, the safety net. Would you, as the individual responsible for the system of care, have to reassure yourself that the nursing staff were competent and fit?

A. Well, again, I presume that the nursing staff also had been through a selection and interview process, which determined that they were fit to do that job, but I would have had no method per se of being able to formally assess the performance of any member of the nursing staff.

Q. But you're making a number of assumptions there, aren't you? You're assuming that people, because they have a qualification, are competent. You're assuming that nurses by the very fact that they're there are competent?

A. Yes.

Q. The whole system is running on a system of assumptions?

A. I think there's is a certain amount of truth in that. One has to assume if someone -- if a member of the

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

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

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

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

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

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

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

Q. Yes.

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

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

A. No.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

more formally at the end when one would sit down and review their progress and say whether or not they were fit to progress to the next stage of training. But CEPOD was doing something different, it was talking about practice within a hospital setting.

THE CHAIRMAN: In very crude summary terms, CEPOD is talking about improving practice; is that fair?

A. CEPOD is looking at what has happened before --

THE CHAIRMAN: Yes.

A. -- and is making recommendations as to what should happen in practice, based on that.

THE CHAIRMAN: Yes, but it's saying, "This might be the way things have been done before, but we can do them a bit better by adding X, Y and Z to A, B and C ".

A. That is what they're trying to do.

THE CHAIRMAN: Let me take it out of Altnagelvin and away from you. Let's suppose that you have a hospital where there is a consultant who's okay -- right? -- but that's the level of his or her performance, it's okay, and that consultant is then reviewing at the end of six months the performance of a junior doctor to decide whether that doctor is okay to go on to the next stage. What confidence can people have in that assessment or review of the junior doctor if the person who's conducting the review is okay, hasn't had any major disasters but is

just not very good and isn't up to date with recommendations about what current practice should be or what better practices should be?

A. Well, I see the point you're trying to make, but that has been the system that has been in place for some time.

THE CHAIRMAN: Yes. And that's, I think, why Mr Stewart was asking you about benchmarking. It might be why the GMC refer not just to a review but to audit, because audit suggests something a bit more formal.

A. It does. It suggests there's a standard to which you can be audited against.

THE CHAIRMAN: But your evidence is that neither in Altnagelvin or elsewhere are you familiar with audits. You're familiar with reviews in different styles, formal and informal, but you're not really familiar with auditing the performance of a team?

A. I'm not really familiar with auditing the performance of a team in that way. The audits that I've been involved in have largely been on patient care and, therefore, they would be -- well, I suppose they would be looking at the performance of individuals within that team.

THE CHAIRMAN: In fact, this isn't talking about occasional audit, this is talking about regular audit.

A. Yes. And we were certainly involved in regular patient

care audit.

THE CHAIRMAN: Right.

MR STEWART: Mrs Brown, the risk management coordinator of Altnagelvin, has told us that professional leads within the hospital were responsible for implementing the NCEPOD recommendations. So I take it that within your own specialty, you'd have been responsible for implementing NCEPOD recommendations?

A. No, I wouldn't. I wouldn't have been described as the professional lead. I don't think that's who she would be referring to.

Q. Who do you think she was referring to?

A. I think she'd be referring to the clinical director.

THE CHAIRMAN: Mr Bateson?

A. Yes.

THE CHAIRMAN: Or whoever was the clinical director at any time because --

A. He was the clinical director at that time.

THE CHAIRMAN: Yes.

MR STEWART: In relation to the multidisciplinary nature of what was going on in Ward 6 in 2001, you have described the sort of meetings that were available for nurses to meet with paediatricians and so forth. A problem in Raychel's case was that none of the specialties seemed to really know who was responsible for the prescription

and supervision of IV. The nurses had perhaps stepped into the breach and were simply overriding whatever doctors wanted with the ward protocol. That's something that you hadn't picked up?

A. No, I hadn't.

Q. Does it surprise you now with hindsight that you hadn't picked it up?

A. Well, to a certain extent it surprises me that none of the surgeons and, as far as I know, none of the anaesthetists were aware -- sorry, none of the consultant anaesthetists were aware that that is what was happening.

Q. Would a multidisciplinary meeting have been exactly the sort of thing which would have brought out issues such as this?

A. I'm not sure whether it would have been because the only way that we would have known that that was happening would have been if it had been questioned as to whether that was happening, and I don't think anyone was aware of it in order to raise the question.

Q. Because just going back to the GMC Good Medical Practice again, paragraph 36 of it, which is at 314-014-015, it's the preceding paragraph. This is about working in teams.

Paragraph 36:

"Healthcare is increasingly provided by multidisciplinary teams. Working in a team does not change your personal accountability for your professional conduct and the care you provide. When working in a team, you must ..."

And we go down to the fourth bullet point:

"Make sure that your patients and colleagues understand your professional status and specialty, your role and responsibilities in the team and who is responsible for each aspect of patients' care."

I'm assuming that you were aware of this back in 2001?

A. Yes.

Q. Given that you were obliged to ensure, you must ensure that everyone in your team knows who's responsible for what, and that's a multidisciplinary problem. What measures were put in place in Altnagelvin to make sure that people from different disciplines dealing with paediatric patients knew what each was supposed to be doing?

A. As I have said in my written evidence before, my understanding of the fluid prescription standard practice was for the anaesthetist to prescribe the fluids overnight if the child had been operated on at night and then, whenever the next fluid prescription was

required, that that would be the responsibility of a member of the surgical team. That was my understanding because that would have been standard practice, as I understood it, and indeed I think that would be standard practice, as a number of witnesses from Altnagelvin and some of the expert witnesses have also confirmed.

In normal practice, however, the nursing staff would -- if an IV prescription had run out, they would ask one of the paediatric medical staff, usually a member of the junior staff, to prescribe rather than have the patient wait for a long period of time for a continuation of IV fluids. That, it appears, seemed to be fairly standard practice at that time, as confirmed by some of the experts.

Q. So is your answer that there was no attempt made to ensure that people from different disciplines knew who was responsible for what?

A. No, it was -- there was no formal protocol that I am aware and, as I've said, I think before, there didn't seem to be any problem with what was happening and, therefore, the protocol was simply not questioned.

THE CHAIRMAN: But what emerged afterwards is that there was this debate -- well, there were two issues, really, Mr Gilliland. One is uncertainty about who is

responsible for prescribing post-operative fluid, and that's one issue. And, secondly, the notion that you somehow revert to the preoperative fluid prescription. You weren't aware of either of those and you're concerned about both of those?

A. Yes, there certainly was concern about both of those. They didn't emerge until after Raychel's death.

THE CHAIRMAN: The curious thing to me is all of the nurses who have given evidence in effect have said this was well-established, in fact it was so well-established that as Raychel came out of surgery, I think it was Mr Zafar who was going to prescribe Hartmann's and was advised against it.

A. Dr Gund.

THE CHAIRMAN: And Dr Gund was going to advise Hartmann's and was advised against it.

A. By Dr Jamison.

THE CHAIRMAN: Yes.

A. That's correct. Dr Gund, I think, was going to prescribe Hartmann's at 80 ml an hour, and I think Dr Jamison advised him that what would happen would be that the -- when patient went back to the ward they would be recommenced at No. 18 Solution at the rate that had been prescribed beforehand, and that would be simply recommenced.

THE CHAIRMAN: That does take you aback, doesn't it?

A. It does. It does. And I have to say that I was not aware of it and it would appear none of my surgical colleagues were aware of it, nor indeed Dr Nesbitt, according to his memo.

THE CHAIRMAN: But it also appears to have been something which wasn't just a fluke in Raychel's case, this seems to have been an established practice.

A. Yes, this is an established practice.

MR STEWART: It was established practice that the consultants didn't know about. Would it be fair to suggest the consultants had simply relinquished control over it?

A. No, I don't think that's the reason that we weren't aware of it. It would have been very difficult to have been aware of it because it would be rare for a child post-surgery to require a significant period of ongoing fluids. Plus, if a child had gone to theatre during daylight hours, by the time they were seen on the ward round the following morning by a consultant or a member of his team, it would be very likely that the fluids would have been discontinued by that stage and, therefore, there would have been no reason to go back and check exactly who had prescribed and what had been prescribed.

Similarly, in the morning, for example, a child such as Raychel who had gone to theatre late in the evening, by the following morning the assumption would be that the fluids would be discontinued through the day as her oral intake increased and, therefore, there wouldn't have been an impetus to check on the fluid prescription.

Q. You seem to be suggesting that it really requires a tragedy before flaws in the system are in fact highlighted?

A. I think flaws in the systems are often highlighted by a tragedy.

Q. But in this case, I would suggest to you from the evidence that there doesn't appear to have been any systems in place before, and nobody in charge of any systems in place before, in order to look at the various aspects of intermultidisciplinary care?

A. There was an established practice, but there was no formal written protocol.

Q. And, of course, at that time not only were you looking after and leading your specialty team, you were also involved in education.

A. Yes.

Q. Heavily involved. It's one of your key interests. And you were both undergraduate and postgraduate surgical tutor at the time.

A. Yes.

Q. Did you give teaching sessions on fluid balance, electrolyte disturbance, electrolyte management?

A. My recollection of the third year teaching is that there was informal bedside teaching every day and, as fluid management is often an integral part of surgical management, there would have been informal discussions about fluid management around the bedside. But that would have been dependent on each individual who was conducting that ward round or bedside teaching.

I also believe that there was a tutorial, one of the eight tutorials that third years did that dealt with fluid balance. But, again, I think that was predominantly in adults.

Q. Of course, your practice encompassed adults and the elderly as well as children.

A. It does.

Q. And quite coincidentally, the 1999 NCEPOD report, which deals with extremes of age, and that's why we've been quoting it because it deals with the very young, it also deals with the elderly. The key points in their advice in relation to the elderly appear at 220-002-107.

This is recommendations given by NCEPOD, 1999, in relation to the elderly, and it's in relation to fluid chart documentation. And, of course, the elderly

are also vulnerable to hyponatraemia as well as young girls; isn't that right?

A. Yes.

Q. The key points brought out by the 1999 NCEPOD recommendations are, second key point:

"Doctors and nurses of all grades need to understand the clinical importance and ensure the accurate recording of fluid intake and output."

Next bullet point:

"Multidisciplinary review of the problem and development of good local working practices is required. Fluid charts are important documents that need to be retained."

We can read on down, and it emphasises the importance of the -- the bottom three paragraphs on the right-hand side may be worth reading:

"Management of fluid balance is a multidisciplinary exercise involving doctors, nurses and possibly other ward staff responsible for providing oral fluid intake for patients. This is akin to drug therapy where it is the responsibility of doctors to prescribe drugs and the responsibility of nurses to give the drugs and chart their administration. However, it is clear that fluid management is not perceived as having the same importance or status as drug therapy. Clinical audit

and governance should provide a framework for multidisciplinary review of the problem, be responsible for the development of good local working practices and oversee their implementation. Fluid excess or deficit can contribute to serious post-operative morbidity and doctors and nurses of all grades need to understand the clinical importance of fluid intake and output and ensure its accurate recording. Its importance is equal to the accurate recording of drug administration and this should be recognised."

Now, if that advice had been taken on board generally in Altnagelvin, and especially for Raychel, things might have been different.

A. In terms of the fluid recording?

Q. In terms of the outcome for Raychel.

THE CHAIRMAN: Yes, in terms of the fluid recording, which affects the outcome. Fluid recording includes vomiting, doesn't it?

A. It does.

THE CHAIRMAN: I don't want to go back over February and March again, but we know that the records are inadequate and there are vomits which were not recorded, and there's fluid intake which isn't recorded.

A. I wasn't aware that there was fluid intake.

THE CHAIRMAN: There was some oral fluids taken, not

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

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

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

THE CHAIRMAN: Okay, thank you.
MR STEWART: The question is, why did you take no steps to incorporate NCEPOD recommendations into your teaching?
A. Why did I not take steps to specify the importance of fluid balance? Well --
Q. No, why did you not take steps to incorporate NCEPOD recommendations into the teaching, your teaching?
A. Which specific NCEPOD recommendations?
Q. I have just read them out to you, these 1999 ones. Why did you take no steps to incorporate the 1999 NCEPOD recommendations into your teaching in your role as both undergraduate and postgraduate surgical tutor?
A. I don't think that I would have specifically referred to these recommendations. Fluid balance is an important part of surgical training and, as I've already said to the chairman, there was a lot of informal training on the wards with regards fluid balance.
Q. For the third time, why did you take no steps to incorporate the NCEPOD recommendations into your teaching?
A. I'm sorry, I don't quite ...
Q. Okay. You're a surgical tutor.
A. Yes.
Q. These are surgical recommendations which are national and important --

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

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

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

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

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

THE CHAIRMAN: Okay, thank you.

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

A. Yes.

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

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

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

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

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

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

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

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

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

A. Not that I can recall.

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

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

Was he wrong?

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

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

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

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

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

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

A. Not that I can recall.

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

At the top you can read:

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

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

"The consultant in surgery..."

That I take to be you?

A. Yes.

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

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

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

A. Not at the time, no.

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

A. That is correct.

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

A. That is correct.

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

A. That is correct.

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

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

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

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

was mentioned. But it wasn't the sole reason for the phone call.

THE CHAIRMAN: Right. But then when he was under the impression that Raychel had been under somebody else's care, were you able immediately to say, "God, no, that's awful, she was under my care"?

A. No.

THE CHAIRMAN: If she was under your care, and if at that time you had known that she had been admitted, then why would you not be able to correct him immediately and say, "She wasn't under Mr X's care, she was under my care"?

A. If I'd known -- my expectation would have been that Raychel would have been discharged, so I would have had no concerns at that stage that this child would have been under my care.

MR STEWART: How do you know you'd have had no concerns?

A. Sorry?

Q. How would you have known to have no concerns?

A. My understanding was that it was a child who'd had a routine appendicectomy who was under my care, who was making adequate progress, and therefore I wouldn't have anticipated that this could have happened.

Q. A child's health can deteriorate very rapidly. This inquiry's heard that on a number of occasions. This is

the only appendicectomy, insofar as you would have been aware, in this ward, in fact the only surgical patient in this ward, and a death, which is extraordinarily rare. If you had known that she was under your care, you would have quizzed and made sure it wasn't your patient, if you weren't aware of her at all, or you might have just let it pass?

A. No, I think we had a very clear conversation about whose care this child was under, and I was assured that she was not under my care.

Q. And whose care was she under?

A. Actually was she under? She was under my care.

Q. Who did Mr Neilly think was her consultant?

A. Mr Neilly thought it was Mr Thompson.

Q. Mr Thompson?

A. Yes.

Q. How did he get that idea?

A. I have no idea.

THE CHAIRMAN: But the reason why you didn't correct him is because you didn't know he was talking about Raychel; is that right?

A. I didn't know the name of the child that he was talking about.

THE CHAIRMAN: So when he said this child was under Mr Thompson's care, you didn't say, "No, that's wrong,

she's under my care", because you didn't realise you were talking about Raychel?

A. That's correct.

THE CHAIRMAN: Despite the fact that Raychel was the only child, to your knowledge, who was on Ward 6 with an appendicectomy?

A. Well, there could have been other children on that ward under the care of other consultants. I wouldn't necessarily know about that.

THE CHAIRMAN: Well, if it wasn't Raychel, it could only possibly have been, what, one or two other children?

A. One would presume.

MR STITT: There is one element of confusion, sir, which I think has crept into the question unintentionally. We had established earlier that this witness subsequently became aware of the fact that there was only one child on the ward, one surgical child on the ward, but that's not the same as suggesting that this witness knew at that time that there was only one surgical child on the ward.

THE CHAIRMAN: Yes, but what he didn't know was that he, at least on Friday, had a surgical child on the ward, namely Raychel, and with an appendicectomy.

MR STITT: Yes, of course. But I'm just making that point, it's not as clear-cut that there was just one child so

it could only have been his patient if his patient had remained in longer than he'd expected.

MR STEWART: It's a fair point because there may have been admissions on the 8th.

Just to understand your rota, you were on call on Thursday 7th through to Friday 8th, from 9 pm to 9 am?

A. That's correct.

Q. And, then, would you have stayed in the hospital throughout the day of Friday the 8th?

A. Yes.

Q. So you then would have been in Altnagelvin right through to, what, 5 pm on Friday?

A. It's usually a little later than that.

Q. And possibly later. So you'd have been there all that time and I assume that you were not informed of any discharge of your patient?

A. No, but one would not normally be informed of a discharge.

Q. And then after you came to the end of your shift on Friday the 8th, Mr Neilly then came on call through to the morning of Saturday the 9th; is that correct?

A. I'm not sure exactly who was on call at that stage. You'll see in my original witness statement that I thought it was Mr Neilly, but there seems to have been some confusion about that because the blood tests that

were ordered I think were under the name of Mr Panasar, and so, I'm sorry, I'm not exactly sure who was on call at that stage.

Q. You're not exactly sure. Can we have a look at WS044/2, page 14. 23 (a):

"Who was the out-of-hours on-call consultant surgeon on the morning of 9 June 2001?"

And this is your response?

A. It is.

Q. And you reply Mr Neilly.

A. Yes.

Q. So it looks as though you do know who came after you.

A. That was who I presumed, but I understand there is some question about that.

Q. Why don't you write "I think it was Mr Neilly"?

A. Because at that time I felt sure that it was Mr Neilly.

Q. All right. Now, did you hear the evidence of Dr Makar when he gave evidence?

A. I did.

Q. On 13 March.

A. Yes.

Q. Can we please bring up pages 178 and 179 of the 13 March transcript.

Can I take you, please, to line number 10, page 178.

"Question: Do you know how Mr Gilliland [a question

to Dr Makar] came to know that Raychel had died?

"Answer: Now it's from my memory, I might be wrong, okay.

"Question: Yes?

"Answer: I think it was a confusion who was the consultant who look after Raychel at that time. From my memory, I think that it was another consultant who probably was on call. But a swap happened between the consultants and that's why Mr Gilliland was the actual on-call consultant other than what we thought is the consultant on call.

"Question: Who did you think was the consultant?

"Answer: I thought that probably Owen Thompson, I think, at that time.

"Question: Sorry, let me be clear. I am distinguishing between the consultant who might have been on call at the time and Raychel's consultant?

"Answer: The on-call consultant which we knew shortly, I don't know when, it was Mr Gilliland's on-call consultant, okay? And he would look after Raychel. But there's some confusion about Thursday, who was the actual consultant on call. I think it because of the rota, printed rota, had a name on it, which is different from what the admission and the A&E and the switchboard knows. So this made a little bit of

confusion at that time. But by -- this is as far as I remember from memory. Then after that, we knew for 100 per cent sure that it was Mr Gilliland and Mr Gilliland who would look after Raychel."

So here's somebody who's on the wards, part of your team, and he's told us about a confusion, and it looks as though there was a swap and Mr Thompson's name creeps in again. Can you explain that?

A. No.

Q. Did you swap your rota with Mr Thompson?

A. I have no recollection of that whatsoever.

Q. Did you do that from time to time?

A. Occasionally if that was necessary.

Q. Of course, if you did that, you had to make absolutely certain that everybody else knew you'd done that.

A. Yes, one would let the on-call team know and let the switchboard know who was on call.

Q. Because the last thing you'd want is any confusion?

A. That is correct.

Q. So if confusion arose, it was because the proper steps were not taken?

A. I don't know why the confusion arose.

Q. Could it be -- would you ever swap with another surgeon, swap your shift, and then for some reason forget about it? Could that ever happen?

A. Um, it could happen, but I don't think it ever has.

Q. So if you swapped your shift, you forgot about it, you didn't turn up, well, perhaps other people could cover up for you? Does anybody say you were there?

A. I was where, sorry?

Q. Did anyone say that you were in Ward 6 at the time of the ward round in the morning?

A. No, not that I'm aware of.

Q. Is there any documentary evidence to show that you were there at that time?

A. In Ward 6?

Q. Yes, or in the hospital at that time.

A. We haven't looked for that evidence.

Q. Did this emerge as part of the critical incident review?

A. No, it didn't.

Q. It didn't? Can we have a look, please, at Dr Nesbitt's witness statement, WS035/2, page 15.

At 18(b), this is in relation to the critical incident review meeting:

"Please also confirm whether consideration was given to:

"(b), the absence of the consultant responsible for Raychel's care from Raychel's care."

And Dr Nesbitt responds:

"Yes, there was a discussion about the fact that the

on-call consultant was not necessarily the consultant under whose name Raychel had been admitted and that there was a potential difficulty in letting that consultant know that his patient had died."

What does that mean?

A. I don't know. I don't remember that conversation.

Q. It looks as though there's a discussion at the critical incident review that Dr Nesbitt at least remembers that Raychel was admitted under one consultant who wasn't necessarily the on-call consultant.

A. That's indeed what it looks like, but my clear understanding was that she was under my care, which is why I took responsibility for it whenever I was informed on Monday morning that she was under my care.

THE CHAIRMAN: You were at the critical incident review?

A. I was. I simply just don't remember that conversation.

THE CHAIRMAN: But this is a positive statement by Dr Nesbitt, who's recalling a discussion. He doesn't say, "I don't remember this", he's saying, "Yes, there was discussion about the consultant responsible for Raychel's care", and the discussion was about the fact that the on-call consultant wasn't necessarily the consultant under whose care Raychel had been admitted.

A. That is exactly what he's saying. I simply don't remember that. I don't remember there being

a confusion, and I know that I certainly felt that I was the on-call consultant that night and responsible.

MR STEWART: Because when a patient dies and there's a review meeting, surely the first question must be "Who was the consultant? What happened? Where were you?"

A. Yes, I think those would be things that would be considered. That's why I was called to the meeting and that's why I was there.

Q. Isn't that why Dr Nesbitt would remember if there was a confusion?

A. I presume so, but I don't remember the conversation.

THE CHAIRMAN: I will assume for now that since Dr Nesbitt remembers this conversation, the conversation took place. Okay?

A. Yes.

THE CHAIRMAN: That seems to be a fair assumption, doesn't it?

A. It does.

THE CHAIRMAN: Okay. So if that conversation took place, and if you were the on-call consultant and you were the consultant under whose care Raychel had been admitted, how could there be discussion about the fact that you weren't necessarily both people? How could such a discussion come about?

A. I'm really unable to help you there.

THE CHAIRMAN: I have to say, Mr Gilliland, it seems to me that such a conversation can only have come about if there was actually confusion --

A. Yes.

THE CHAIRMAN: -- as to who the consultant was.

A. Yes. I simply don't remember that. I remember fairly clearly my actions on the Monday morning. On the Monday morning I spoke to Mr Thompson and said to him, "Look, this is my information, this child has sadly died under your care and you probably need to try and look into this fairly quickly". At some point later that morning, sometime between the ward round and the start of my theatre list, I became aware that this child had definitely been under my care.

THE CHAIRMAN: Sorry, if you're as sure as you can be that Raychel was under your care, why would you have gone to Mr Thompson on the Monday morning to say to him that "It looks as if this child has sadly died under your care"?

A. Because that was what Mr Neilly told me on Sunday night.

THE CHAIRMAN: Okay. Thank you.

MR STEWART: Did you ask Mr Neilly why he thought it was Mr Thompson?

A. Not that I recall.

Q. Why not?

A. I didn't say I didn't, I just don't recall whether

I asked him or not.

Q. After Raychel died, you didn't contact her GP, did you?

A. Not formally.

Q. What did you do informally?

A. Dr Ashenhurst and I had spoken about the case, about the tragedy, about the devastation that it had been for Mrs Ferguson.

Q. When did you speak to Dr Ashenhurst?

A. I think in the supermarket or something like that.

Q. Quite some time after Raychel's death?

A. It was some time afterwards.

THE CHAIRMAN: You spoke to her because you bumped into her?

A. Yes, it was an casual conversation.

THE CHAIRMAN: Is that the normal way in which a consultant in charge of the care of a child who has died discusses what has happened with the GP? Because I have been led to understand that some communication with the GP can be important because a family often turns to a GP for information and for reassurance and for support with issues about stress and bereavement in the weeks and months which follow, and I've got the impression that the GP might typically expect more than to find out by bumping into the consultant in the supermarket.

A. Yes, absolutely.

THE CHAIRMAN: So this wasn't the normal way for the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

being run by somebody much more senior and much more familiar with these processes than myself. I simply wouldn't have considered --

Q. But you're the consultant surgeon and this was your patient.

A. I appreciate that.

Q. Because other surgeons happen to be elevated to the position of medical director doesn't place them in a role of authority over you in that way. You have to make suggestions of your own.

A. Yes. I certainly wouldn't have considered inviting the Children's Hospital doctors.

Q. You mentioned a moment ago being invited or having the opportunity to meet with Mr and Mrs Ferguson or Mrs Ferguson at a meeting that was arranged in early September 2001.

A. Mm-hm.

Q. Who invited you to go along to that?

A. I don't actually remember.

Q. Was it Dr Fulton?

A. Again, I don't remember.

Q. You did discuss your non-attendance with Dr Fulton.

A. I did.

Q. And what features of your non-attendance did you discuss with Dr Fulton?

A. The ones that I've outlined.

THE CHAIRMAN: "I don't know the family. I don't really think I have anything to contribute and there are others going who will be able to contribute more"? Sorry, is that the gist of what you would --

A. Yes.

THE CHAIRMAN: -- been saying to them, "I don't know the family, I don't really think I have anything to contribute and there are others going who will be able to contribute more"?

A. That would be a summary of it.

MR STEWART: Did he ask you if you had already made contact with the Fergusons?

A. Not that I recall. This was -- as far as I recall, this was an informal meeting. I believe I was in theatre at the time and we had a conversation close to the theatre block.

Q. And did you say to him, "Well, you know, I know my duty under paragraph 23 of the code, but I think on this occasion I just don't think" --

THE CHAIRMAN: No, he didn't.

MR STEWART: Did Dr Fulton remind you of your duty under paragraph 23?

A. No, not under paragraph 23.

Q. Did he remind you of any of your duties?

A. I think it was Dr Fulton's position that he felt that I should be there.

Q. And at that stage, Dr Fulton was -- he's still the medical director?

A. He was medical director, yes.

Q. So your medical director thinks you should be there?

A. Yes.

Q. So why didn't you take his advice?

A. Because, for the reasons that I've outlined already.

Q. I see. Could I suggest to you that perhaps you were motivated again by the fact that you didn't want to have to meet with this family in these really excruciatingly difficult circumstances?

A. I think those circumstances would have been very difficult and I think, as I've said already, no one would relish a meeting like that, no one would necessarily want to have to go through that sort of a meeting. But there were other reasons for not attending.

Q. Were you perhaps defensive because of possible litigation? We've looked at your letter earlier on in relation to inquest evidence with your professional indemnity insurers. Were you worried about litigation?

A. I don't know that I was particularly concerned about litigation at that stage.

Q. Were you defensive in case it might emerge?

A. I don't specifically recall.

Q. After the critical incident review, were you asked to make a statement for the risk management coordinator like everybody else?

A. Sorry, I will need to be reminded. I don't recall.

Q. Well, a number of the individuals involved volunteered statements to her immediately after the meeting.

A. Mm-hm.

Q. You didn't.

A. No.

Q. Did you ask your team to proffer their statements to her?

A. No, not that I recall.

Q. And so she had to write to you five months after the critical incident review, in November, to ask you to furnish her with a statement.

A. Yes.

Q. But you are at that time a fairly key player in the Altnagelvin response to this death. You're a key player in terms of the response going forward to the inquest, aren't you?

A. Yes.

Q. Because you were the consultant, and when documents like the post-mortem report come in, it's sent off straight

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

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

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

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

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

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

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

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

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

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

THE CHAIRMAN: Okay.

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

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

Mr Stitt, do you have any questions?

Questions from MR STITT

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

THE CHAIRMAN: Yes.

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

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

And the sentence continues:

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

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

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

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

THE CHAIRMAN: Yes. Thank you very much.

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

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

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

(The witness withdrew)

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

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

Okay? Thank you very much.

(1.08 pm)

(The Short Adjournment)

(2.00 pm)

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

MR STEWART: Sister Millar, please.

MRS ELIZABETH MILLAR (called)

Questions from MR STEWART

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

A. Yes.

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

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

Q. 35?

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

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

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

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

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

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

A. No.

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

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

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

THE CHAIRMAN: Okay.

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

THE CHAIRMAN: Right.

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

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

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

THE CHAIRMAN: Okay.

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

This is about education and your job responsibilities.

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

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

A. It was, yes.

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

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

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

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

Q. Yes.

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

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

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

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

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

A. No, we didn't.

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

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

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

to Mrs Doherty, the clinical services manager:

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

And so on.

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

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

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

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

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

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

MR STEWART: A year earlier, yes.

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

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

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

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

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

because I was obviously supporting her and --

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

"This situation today is not unique."

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

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

In the next paragraph she writes:

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

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

of nurses from the Philippines.
Q. So I understand. I'm interested in how you hoped the system would work. You put the request, or the issue has been put in writing, it has now been reinforced in writing. What did you hope Mrs Doherty would do with this?
A. Well, first of all, I hoped that she would recognise that the problems were there, that we did have problems because sometimes, you know, you felt that nobody was listening. That was really the thing about writing the letters, we needed somebody to listen to us and to -- because sometimes in the children's ward we felt a bit isolated. We were a children's area within a general district hospital.
Q. Yes.
A. We weren't the Children's Hospital in Belfast, who were -- you know, every ward had children. We were one floor, we had four areas on that floor, and you did feel a bit isolated at times. But we were quite a strong team and we stuck together, and without the goodwill of the nurses to do extra shifts and nights, it was very difficult at times.
Q. Where did nurses take their issues to? If you had a nursing issue, which committee would you take it to at that time?

A. We didn't have a committee. I mean, if nurses had a problem on the ward, they brought it to me. I would then take it to the clinical services manager, and then it would go to the director of nursing. But at that stage, in the late 90s/early 2000s, even though I -- you know, I was the ward manager, I had many years' experience and I did my best to vocalise my problems, you would -- I think ward managers struggled in getting their voices heard.
Q. How often did you meet with the director of nursing?
A. I didn't meet with her very often. She would come to the ward on maybe -- on occasions to do a round or to see --
Q. How often would that happen?
A. Maybe once a month.
Q. Once a month. How long did she spend on the ward?
A. Um ...
THE CHAIRMAN: When you say around, do you mean --
A. She would come to see how things were and she would have said, "Sister Millar, how are things?" or whatever. And if we had difficulties with staffing she would have come. I mean, we did experience some horrendous winters and she would have come to see us, plus also the chief executive later on.
MR STEWART: Would your meetings or discussions with her

about problems ever have been minuted?
A. No.
Q. So --
A. But I would have brought up these issues with the clinical services manager --
Q. Yes.
A. -- at the -- we had ward sisters' meetings every month with the clinical services manager and I would have brought staffing issues up, and they would have been minuted. But as I say, whether they went to the director of nursing, I can't say for definite.
Q. Can you make any comment about the assertion made in this letter by yourselves that morale is falling?
A. Well, obviously if you're under pressure and -- you know, you've saved 40 patients/45 patients and you're struggling with staffing, I mean, morale, yes, morale can fall, yes. I mean, during my many years of nursing, I went through many, many years of that. But certainly in the last 10 years or so of -- 12 -- of my career, things did improve dramatically.
Q. Morale is fantastically important for a team.
A. Yes, it is.
Q. Can you remember the director of nursing involving herself with the morale of her nurses?
A. Well, I -- Irene Duddy was director of nursing at the

time and she was a very approachable person. I found her very -- I mean, she was -- I remember her as the ward manager, so it wasn't as if I had a problem approaching her. But, you know, I didn't feel I could go directly to her. I went through my clinical services manager. I understood that was the way it should be. However, when she did visit the ward I was quite vocal in my concerns.
Q. Well, the concerns that are finding expression in this letter, especially the penultimate paragraph:
"We are now at the situation where we feel things may be unsafe as staff find it very difficult to cope with the condition we are finding ourselves in at present."
Would that fear of a lack of safety have been brought to the director of nursing?
A. Well, I mean, we wrote the letter to Mrs Doherty and I cannot say whether that letter went to Ms Duddy. But I do know that there was a concerted effort to recruit children's nurses after that and that -- without success. And then there was the recruitment of the six nurses from the Philippines and also the nursery nurses. And I think it did stem from, you know, the realisation that probably we weren't adequately staffed.
But can I just say that during the summer months,

I just want to reiterate that, and I would be very honest about that, if I had problems, we did not have problems during the summer months because at times in July or the end of June, we could have actually gone down to eight or ten patients.

Q. I think there were 23. So I take it your evidence is that staffing levels played no part in the care given to Raychel?

A. No, I don't, no.

Q. In relation to the sort of issues that have arisen in this inquiry and the sort of forewarning there might have been in relation to them, do you remember a documentation audit being performed in 1999 and 2000 in the hospital?

A. Sorry, I can't hear you.

Q. A documentation audit in 1999 and 2000. Do you remember an audit of records and documentation?

A. No, I don't.

Q. Can we call up document WS322/1, page 120? This is a discussion of the hospital management team, these are the minutes of it. It's Dr Parker informs the meeting that Mrs Witherow and himself:

"... presented the results of this audit to member of the hospital management team in the recent meeting. Mrs Witherow said that she has attended the ward

sisters' meetings to discuss the action required in relation to nursing."

Do you remember being told at a ward sisters' meeting about the audit and what was required of Ward 6?

A. No.

Q. Because you'd have been directly involved in that, wouldn't you?

A. I would have been, yes. I mean, I can't remember.

Q. Do you remember the benchmarking exercise that was undertaken in November 2000? It was called paediatric benchmarking.

A. Yes. Well, I know that Mary McKenna was a member of the benchmarking team for Northern Ireland.

Q. Yes. Was that part of the junior monitor exercise?

A. No.

Q. It was a different thing?

A. Yes.

Q. The benchmarking exercise, we can find that at WS323/1, page 42. That gives us the overview of the various hospitals taking part in it. It goes on then throughout the body of the report to focus on different parts of care given.

At page 45, can I draw this to your attention, this is the patients' physical needs and it deals, amongst other things, with patients on IV fluids.

We can go to the middle section where they conclude:

"To improve scoring, the following areas need to be addressed."

And the second bullet point is:

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

This is very relevant to what we're looking at. Do you remember this sort of information coming back to you?

A. Yes, I think I do, yes. Mm-hm.

Q. Whose responsibility would it have been to do something about this information?

A. Well, this information would have been fed back to me. I mean, I was obviously involved, or Mary McKenna would have fed back the information --

Q. Yes.

A. -- and it would have been then, you know, sessions of informing staff that they need to improve on their -- on their documentation. That would have been passed on to staff.

Q. Well, in this case we've heard of several deficiencies, as you know, and I think you have conceded in your earlier evidence, in relation to the fluid balance chart. So this seems to be eight months before, pointing out problems with the intake/outtake, something

has to be done about it, something ought to be done about it, it's your job to look into that. What was done? Was anything done?

A. Yes. Well, I do believe that we did ask staff to try and comply and be more fastidious in their documentation.

Q. Was anything put in writing?

A. No, not -- no, not that I can remember.

Q. So insofar as this inquiry is concerned, it could have been that nothing was done? Nothing was in writing, the fluid balance chart is deficient in several respects in this case. How do we know that these suggestions and recommendations were actioned at all?

A. Well, as I say, the staff were asked to improve on their documentation and I am not sure if there was a follow-up review done on that. I don't know.

Q. I certainly haven't seen it if there was one.

The same document deals with a number of other relevant matters, especially page 49, the bottom section. This is further evidence in relation to plans and so forth.

The bottom paragraph:

"It is also recommended that the core plans need to be revised to delete unnecessary material and add in new appropriate actions."

This is a care plan, and you'll see from the preceding bullet point that the problem identified is that nurses are not prescribing individualised care and individualising the care plans.

Were any steps taken to focus on this area that could be improved?

A. Yes. Well, I think that as far as I can remember, a member of staff was identified as being a coordinator for improving the care planning and checking up with the nurses, especially with new nurses that came on the ward.

Q. And who was that?

A. I can't remember.

Q. Was any one individual within Ward 6, any nurse, tasked to go and make a regular check of the notes and records to ensure that they were compliant with the UKCC records guidance?

A. Well, I know that Mary McKenna did check up on or do some audits on the fluid balance sheets at some stage, but it was after Raychel died. I know there were some audits done on that.

Q. These recommendations, which are relevant, are before she comes into hospital, and that's why we're interested in them. And there's nothing in writing to indicate that they were heeded at all, is there?

A. Well, there's nothing in writing.

Q. The junior monitor report was a different thing; is that correct? Was that a sort of a peer review type exercise?

A. That was to do with the placement of students on the ward, the training of students and the education of students and the facilities that were available to them.

Q. Did it also involve nurses from other hospitals coming in and seeing how you ran your ward and perhaps exchanging information?

A. No.

Q. Because Mrs Witherow did indicate that this happened.

Can we go to WS329/1, page 8? At paragraph 7 (f), at the very top of the page she says -- I think this leads on from the preceding page:

"I am aware that a system of peer review did take place in a number of wards where monitor was being used. Staff in the Sperrin Lakeland Trust and Altnagelvin, staff did cross over and review those facilities but I cannot say happened with the Ward 6 review."

Do you recall any sort of interchange with other nurses from other hospitals?

A. No, I can't remember.

Q. Would you ever, in the course of your professional networking and going to meetings outside of the

hospital, have met up with nurses from the Sperrin Lakeland?

A. Yes, very rarely, but at conferences or study days outside of Altnagelvin, say Belfast, or if they were held anywhere else, you would meet up with colleagues or other ward managers or specialist nurses and you would then get their views. But I didn't have an awful lot of contact with Sperrin Lakeland at that stage.

Q. The loss of a child in a children's ward is a very shocking and profoundly memorable event, isn't it? Would that be the sort of thing that you would have talked about when you met colleagues from other hospitals?

A. Um ... I don't remember discussing it with others outside of Altnagelvin. I personally can't remember. As I say, my contact with Sperrin Lakeland was very, very limited. I think there's much more contact now because they're all under the one -- Mary McKenna would be the nurse manager. But in those days, I rarely had any contact with Sperrin Lakeland.

Q. When did you first hear that Raychel had died?

A. When I returned on the Tuesday morning.

Q. Mrs Doherty had heard about it before you?

A. Yes. She must have had, because I left work about half 5/6, on the Friday, and I returned on Tuesday morning,

so I presume that Mrs Doherty was on on the Monday. But I don't know. But I think she knew about it before me.

Q. It seems that she did because she had got Sister Little to assist her in telephoning Staff Nurse Noble, noting down what she had to say, putting together a resume of what happened, looking at the notes, preparing, it seems, a little report.

Were you involved in that early gathering up of information stage?

A. No.

Q. Are you surprised that they didn't phone you?

A. Yes, I suppose I was, yes. I don't know if maybe I had been away for the weekend. I can't remember. But I certainly wasn't told. The first I knew was when I returned on the Tuesday morning.

Q. Are the people you work with also your friends, like Margaret Doherty?

A. Were they my friends?

Q. Yes. Would you have phoned each other to exchange --

A. No, no. No, I -- Margaret Doherty was very much my senior, no. I wouldn't have -- we -- I was able to speak to her, of course, but no, I wouldn't say we were friends, no.

Q. Was Margaret Doherty in essence the director of paediatrics?

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

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

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

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

everybody was shocked, and I cannot remember if I spoke to any of the paediatricians or -- but I -- as I say, I had very scanty information.

Q. Because when you got to the meeting that afternoon, the nurses were very well represented, weren't they?

A. I can't remember what nurses were there. Nurse Noble was there.

Q. Yes.

A. I think Nurse Bryce.

Q. That's right.

A. But I'm not sure who else.

Q. It seems that apart from Mrs Doherty and Mrs Witherow, nurses Noble, yourself, Sister Millar, Gilchrist, Bryce and auxiliary nurse Lynch were all there.

Did the meeting focus upon the nursing aspect of the care Raychel received?

A. It focused -- the main focus was the documentation of the fluid balance sheet. The main focus -- the meeting -- I cannot remember very much about the meeting, I just -- I mean, there was a lot of discussion. It took off very slowly because everybody was -- you know, there was disbelief, shock, that this had happened.

There was some murmurings about Solution No. 18 initially and there was a rumour that -- maybe that it

was no longer being used in Belfast. Well, I found that very hard to believe, I remember at that time, because I thought, surely, you know -- I mean, I had used it for 35 years and had experience of it, and I just found it unbelievable that this could be a problem.

So there was a lot of discussion about a lot of different aspects. I just -- I do not remember the particular conversations about everything, but there was a lot of discussion took place. I know that there was focus on the documentation of the fluid balance sheet and, you know, the fact that it was felt that the urinary output and the vomits that Raychel had were -- could have been better documented.

Q. Yes.

A. But there was, as I say, a lot of discussion, but I just -- I just cannot remember what was said.

Q. You very helpfully told us the last time you gave evidence that the fluid balance chart was deemed to be unacceptable regarding intake of urine -- outtake of urine and vomit. You also, I think, accepted that electrolytes should have been taken, and you recognised that as a failure.

Can I ask you about the vomiting. That was discussed at the meeting? Do you remember that?

A. Yes. Well, I think the -- yes, I mean, there was

discussion around the vomiting, how much Raychel had vomited, and there was a difference of opinion between each nurse because each nurse would have been maybe had a different view on how much.

Q. Yes.

A. And it was felt that there may have been a problem with the documentation of the vomit.

Q. Can I ask you about the vomit --

THE CHAIRMAN: Just one point. When nurses have different views about vomiting, isn't that because the nurses aren't all there at the same time, so you might be there for a number of hours and another nurse might be there for a number of hours and you can only put the picture together --

A. Well, I was more thinking about the amount of vomiting. You know, what I may think was a small amount of vomit -- that's really what I was ...

THE CHAIRMAN: Thank you. On the plus or plus plus system, which wasn't unusual, your plus might be somebody else's plus plus.

A. Yes, that's right, and that system at that time was being used in other hospitals.

THE CHAIRMAN: Yes, yes, I understand that. I don't think the main issue about the vomiting is -- there's a bit of an issue about the plus or the plus plus, but there are

vomits which do not appear to have been recorded, and there certainly appears to have been a failure to appreciate the possible significance of coffee-ground vomiting later on on the Friday evening.

A. Yes.

MR STEWART: Can I ask, apart from the quantities of vomit, was there any discussion surrounding the protracted period over which the vomiting was suffered?

A. No, not -- I think there was discussion around the -- you know, there were three vomits documented during the day, at 10, 1 and 3, and there had been a small vomit or a vomit at 8 am. And there was some discussion around how that amount of vomiting would have caused the -- a problem. Because it didn't seem to be hugely significant, and so I think there was some discussion about that, but I -- and, you know, was all the vomiting documented? And it -- the staff that were present, as far as I remember, were sure that they had documented the vomits that they were aware of.

Q. On that point, Dr Fulton, who chaired that meeting, has given us a witness statement where he says that the nurses conceded they did not see all the vomiting, a witness statement in which he has said that the nurses told him that the Ferguson family had indeed informed them that she was continuing to vomit and they were

worried about it, and a statement in which he says that you pointed out the electrolytes should have been done in the afternoon of the 8th due to her continued vomiting. Do you remember any of that?

A. No.

Q. Can we go to WS043/3, page 15? This is all about the vomiting. Can we go to the preceding page as well? Page 14.

He's describing it towards the bottom of page 14:

"The extent, type and duration of vomiting suffered by Raychel on the 8th."

He says:

"This was described by the nurses who clearly believed it was due to prolonged post operative vomiting. They agreed that the vomiting was prolonged but not unusual after this type of surgery."

Was it agreed that the vomiting was prolonged?

A. I have no recollection of that being said.

Q. "They did not believe the vomiting was excessive though, they said they may not have witnessed all the vomit."

"They said they may not have witnessed all the vomit", is that right?

A. Well, I have no memory of that, but, you know, it may -- it may have happened that we did not witness, but anything that we did see, they were adamant that they

had documented it. But I cannot remember that conversation.

Q. Okay:

"The nursing method of recording vomit volume on a plus scale was questioned. It was decided this was too subjective and other methods of recording should be used. This was to include attempting to record and measure all vomiting, as well as urine. Sister Millar actioned the recording of all vomit and urine immediately. The nurses said that the Ferguson family told them during 8 June that they, the family, believed that Raychel's vomiting was repeated and severe."

First of all, do you remember that being said to the review, to Dr Fulton?

A. No, I don't.

THE CHAIRMAN: If you just pause there. What that means is that the nurses were telling Dr Fulton on 12 June what the Ferguson family had been saying before Raychel died. Right? So this isn't the Fergusons coming along after Raychel has died and saying for the first time that the vomiting was repeated and severe, this is the nurses acknowledging that on the Friday, the family at that time was already making the point that her vomiting was repeated and severe. In other words, they were worried and concerned about her condition.

A. Yes.

THE CHAIRMAN: Isn't that right?

A. Yes.

THE CHAIRMAN: Assuming that Dr Nesbitt's (sic) note is correct or his recollection is correct, that confirms that the Ferguson family were saying this about the vomiting before Raychel died.

A. Mm. Yes. I mean, I can't remember that being said, but if it's in the minutes ...

MR STEWART: Move down the page to paragraph (j), and that's asking about shortcomings in the frequency of assessment of the assay of Raychel's electrolytes.

Dr Fulton says:

"Sister Millar clearly stated that the blood electrolytes should have been checked in the afternoon because of the continued vomiting. She stated this was the responsibility of the doctors. There was total agreement on the need for regular electrolyte measurement while receiving IV fluids."

Did you clearly state at the review meeting that electrolytes should have been checked in the afternoon because of the continued vomiting?

A. I don't remember clearly stating that the electrolytes should have been done. Obviously, with hindsight, they should have been done, but I don't -- and I believe that

they should have been done, but I don't remember saying that.

Q. Because this clearly implies that the vomiting was so bad that it necessitated electrolyte assessment.

A. Mm-hm.

Q. It's the acknowledgment of the severity of the vomiting.

A. Yes. I don't remember saying that.

THE CHAIRMAN: But it's consistent, isn't it --

A. Yes.

THE CHAIRMAN: I know it's a bit difficult for you to put yourself back into this meeting, but let's assume for the moment that Dr Fulton's recollection is correct. Then, if he correctly recalls you saying that the blood electrolytes should have been checked because of the continued vomiting, that would give an indication of the frequency and severity of the vomiting, wouldn't it?

A. Yes.

THE CHAIRMAN: Because you wouldn't have been saying that if it was just an occasional, small vomit.

A. If I said it, which it's written there -- I don't remember saying it, but I presume his record is correct, I don't know -- yes, it would.

THE CHAIRMAN: Thank you.

MR STEWART: So at the critical incident review, you can recall that there were problems identified of

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

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

A. No, I didn't.

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. I have no explanation for that.

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

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

A. Yes, I do.

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

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

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

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

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

Now, whatever you recall now, 10 years later, I understand everybody's memory has faded in some respects, but I don't understand how this issue has -- I was going to say it was resurrected, but I'm not sure it was ever an issue at all. I just don't understand how it became an issue before the coroner in light of what we're told about the critical incident review. I'm making that point to you because if you can help me with it, I'd like you to.

A. Yes. I'm sorry, but I can't.

THE CHAIRMAN: Okay.

MR STEWART: Can I ask you in a similar vein to look, please, at WS056/1, page 9. This was the first witness statement you provided to this inquiry, and the third paragraph, you write and told this inquiry:

"I am confident that Raychel received the highest standard of care from the nursing staff in Ward 6. Raychel's treatment and care was no different from any other child who required a surgical procedure."

You've accepted to the inquiry that the fluid balance chart was deficient, that there were problems in this area and that area and so forth. How could you have brought yourself to tell the inquiry that you are confident that she received the highest standard of care?

A. Well, I mean, we did care for Raychel the same as we would care for any post-operative child. She did vomit, she was vomiting, but as I say, I've seen other children vomit more than that and not have a catastrophic event as Raychel had. I have been questioned on this before in my previous appearance --

Q. I'm sorry.

A. -- and I suppose, with hindsight now, and looking back, we could have done better.

THE CHAIRMAN: Sorry. You're quite right to say that some of this was touched on when you were here last, but could I take you to the last paragraph:

"All members of nursing staff were devastated ..."

And I'm sure that's right, but would you look at the next sentence:

"It was totally unexpected as she had been recovering very well on Friday the 8th."

Now, if you told the critical incident review that she should have had her electrolytes taken on the afternoon because of her continued vomiting, that must be inconsistent with her recovering very well, mustn't it --

A. Yes.

THE CHAIRMAN: -- because you can't be recovering very well if you need your electrolytes taken because you're

vomiting so much?

A. Mm-hm. No, I would agree that that sentence is not right.

THE CHAIRMAN: I'm afraid what I have to then ask you, Mrs Millar, is this. How does it come to be written? How does it come to be written that you say in your statement that she's recovering very well when that simply wasn't the case? I mean, if she'd been recovering very well on the Friday, by some point on Friday afternoon -- as Friday went on, she would have been sipping more and more. The intravenous fluid would have been diminished and then stopped, and she would have started to eat; isn't that right? That was the expected recovery path, and that is a child who does that is recovering very well.

A. Mm-hm.

THE CHAIRMAN: A child who isn't sipping beyond one or two sips, a child who isn't eating, a child who's still on IV fluid and a child who gets two anti-emetics is not a child who's recovering very well.

A. Mm-hm. No, I would agree with you.

MR STEWART: Can I ask you, have you at all times, since 2001, been aware of the UKCC code of professional conduct?

A. Yes.

Q. And aware of the guidance in relation to it given by the UKCC Guidelines for Professional Practice of 1996?

And paragraph 24 of that is about truthfulness:

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

Do you think that Mr and Mrs Ferguson have had honest answers?

A. Um ... (Pause). Well, I -- I mean, it's very difficult. I agree that -- I mean, that sentence that I wrote, that it was totally unexpected, she had been recovering well, is wrong. But it's not -- I mean, why I wrote that, I -- you know, I have no answer for that. It wasn't trying to tell untruth. I don't know why I wrote that.

THE CHAIRMAN: Let's put it another way. Let's suppose it's not telling untruths, it's not telling the truth.

A. Mm-hm.

THE CHAIRMAN: Let's move away for a moment about whether somebody's lying. That statement does not tell the truth about what happened to Raychel; is that right?

A. Yes. But at the time, you know, it was -- I mean, it wasn't written in trying to, you know, tell an untruth.

But I would have to agree that she was not recovering well.

THE CHAIRMAN: Okay.

MR STEWART: After the critical incident review, there was an update prepared for the chief executive by Mrs Brown. Can I take you to that, it's 022-097-307.

This you will see is dated 9 July 2001, and you will see in the middle section at paragraph 4 Mrs Brown writes:

"A meeting has been held with Mrs Witherow [that's the clinical effectiveness coordinator] Mrs Doherty [who was the clinical services manager] Sister Millar, Sister Little, nursing staff and nursing auxiliary Ward 6 to discuss in detail the fluid balance management. The following has been agreed ..."

That looks as though there was a meeting of the complement of nurses from Ward 6, doesn't it, or a large part of them anyway?

A. Yes.

Q. And it looks as though there was discussion about the fluid balance and a number of matters were agreed.

A. Yes.

Q. Is there any documentation relating to that? Was any documentation created as a result of that meeting of the nurses of Ward 6?

A. Do you mean minutes of the --

Q. Minutes, notes, memoranda, records, agenda, attendance notes. Anything like that?

A. No. As far as I know, that -- I cannot remember who was at that meeting, I just don't remember. I would presume that Mrs Witherow or Mrs Doherty would have taken notes. I cannot say.

Q. And were you there? Do you remember?

A. Was I there?

Q. Yes.

A. Well, my name is there, so I must have been there.

Q. But you've got no recall of it otherwise; is that right?

A. No.

Q. Okay.

THE CHAIRMAN: Can I just ask you, just to clarify, what does paragraph 4 (e) mean?:

"Nursing staff to be proactive in advising medical staff regarding discontinuation of fluids."

What were nurses going to tell the surgeons about?

A. Well, I think it was about signing for the discontinuation of the fluid. On the back of the fluid balance sheet at that time there was no box as such that a doctor could sign that the IV fluid was to be discontinued. So we amended the fluid balance sheet that we were using at the time. There was a number of

amendments, minor amendments, and one of them was an area where the doctor could sign to say that he had discontinued the IV fluid.

THE CHAIRMAN: So in effect what the nurses were going to do was make sure the doctor signed that?

A. Yes.

THE CHAIRMAN: You couldn't sign it but you wanted to do was to improve the record keeping by making sure that the doctors did what they were supposed to do.

A. Yes.

THE CHAIRMAN: And under (g), you were then to be involved in training the nursing staff --

A. Well, it was informing them of the above decisions that had been made.

THE CHAIRMAN: Well, you were to train them about (e) and (f), weren't you? So you were to train the nurses effectively to make sure they got the doctors to complete the forms properly.

A. Yes.

THE CHAIRMAN: In other words, there's limited value in the nurses completing the forms better if the doctors don't also complete the forms better.

A. Yes.

THE CHAIRMAN: And then at paragraph (f):

"Nursing staff to be proactive in management of

fluids required after 4 pm. Refill bag not just automatically put up."

A. Yes.

THE CHAIRMAN: Do you remember Dr Butler in her evidence that she was passing through and she signed off a new bag which was given to Raychel around about midday or not long before? Is that what this paragraph (f) is referring to?

A. No. Well, I think what that was -- that, you know, the doctors went off at 5 o'clock, the day doctors went off, and it was to make sure that before they went off that the fluids had been written up rather than calling somebody, you know, during the ...

THE CHAIRMAN: Out of hours?

A. Out of hours, yes. And also sometimes the same fluid would have been put up if we had difficulty getting a doctor. So we were to ensure that the fluids were written up before the changeover time for the medical staff.

THE CHAIRMAN: Right. But for that to happen, would that mean that there would be a doctor coming back in before the end of the day shift just to check off what was happening on Ward 6?

A. Well, we would -- we would call him back. We would -- if they weren't coming back to write up a patient or,

you know, back to discharge a patient, we would actually bleep them to come back and write up the fluid before they went off at 5 or 5.30, 6, whatever time they went off. It was to ensure that we weren't calling doctors out of hours.

THE CHAIRMAN: I'm sorry to interrupt, Mr Stewart, but can I take this on one step further? One of the actions that was taken on foot of the critical incident review was that you would no longer call on very junior doctors, like doctors Curran or Devlin, or people of their level of experience, that from then on it would be more senior doctors who were available to you?

A. It would be an SHO or -- yes.

THE CHAIRMAN: Did that work in practice?

A. It mostly did work, but not always. But it mostly did.

THE CHAIRMAN: I'm asking you because I can understand why that would be a lesson that was learnt from Raychel's death, but SHOs and registrars might be even busier than pre-registration doctors; is that right?

A. Yes.

THE CHAIRMAN: So although it's fine in principle and in theory to say for the children's purpose they need somebody more senior, that might not ease the problem of getting someone more senior along. So how was that largely achieved that you were able to get somebody

along?

A. Well, I think the -- the doctors were aware after Raychel died as well that it was to be an SHO and registrars that wrote up fluid. And, I mean, I do remember that things did improve.

THE CHAIRMAN: Was that maintained?

A. It was mostly maintained, but there were times it wasn't always -- it wasn't 100 per cent but it was certainly a lot better than what it was.

THE CHAIRMAN: Okay. Thank you.

MR STEWART: So in short -- and thank you, sir -- that was a valuable meeting in terms of what was agreed, quite an important meeting in making sure that everybody was now agreed as to what their responsibilities were and what was to happen in the future?

A. Yes.

Q. Perhaps this might be a convenient moment to break for 10 minutes?

THE CHAIRMAN: Yes. We'll be back in 10 minutes.

(3.27 pm)

(A short break)

(3.40 pm)

THE CHAIRMAN: We won't be much longer, okay?

A. Thank you.

MR STEWART: Sister Millar, can I bring you to the meeting

with Mrs Ferguson on 3 September 2001 at the clinical education centre at Altnagelvin. You were there along with Staff Nurse Noble and Dr Nesbitt, Dr McCord, Mrs Burnside and the patient's advocate for and with the Altnagelvin Hospital.

You explained part of what you remembered about that meeting the last time you gave evidence here on 1 March, and you explained that, insofar as you could remember, Dr Nesbitt was very open and he explained that there was a fault on the care of Raychel. And that was explained as meaning, by fault, that she should have had her electrolytes done.

Is that correct, you remember giving that evidence?

A. Yes, I do. I cannot remember in detail, you know, the explanation that Dr Nesbitt gave to Mrs Ferguson, but I do remember that it did evolve around the Solution No. 18 and I cannot be sure that the electrolytes were mentioned but I think they were. But I cannot -- I mean, I'm not -- I cannot remember what he said. But I do remember that I felt at the time that the explanation was ... Was ... I was satisfied that it was a good explanation.

Q. Were you satisfied that it was an acceptance, an acknowledgment of fault?

A. I was, yes.

Q. Can we go back then, please, again to the statement, your statement to this inquiry, WS056/1, page 9. This is the paragraph beginning:

"I am confident ..."

To ask you how it was you allowed yourself to make this statement, given that you'd been at a meeting with Mrs Ferguson where fault had been admitted by the hospital, you wrote:

"I am confident that Raychel received the highest standard of care from the nursing staff. Her treatment and care was no different to any other child who required a surgical procedure."

How could you write that having been at a meeting where fault was admitted?

A. Well, at the meeting the fault was very much around the Solution No. 18 and -- I mean, it was recognised that there were deficiencies in the documentation. I can't remember if that was mentioned. I don't think it was. But it was very much around Solution No. 18. It wasn't -- it didn't highlight on the nursing care of the child --

Q. Well --

A. -- of Raychel.

Q. Excepting only the fluid balance chart which you've just referred to is clearly --

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

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

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

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

I don't remember Nurse Noble there, which I think she was. I remember Dr McCord, Dr Nesbitt, the patient's advocate person -- I can't remember her name -- Mrs Burnside. And I remember a Dr Ashenhurst, the GP, because I know her.

THE CHAIRMAN: Okay. Thank you.

MR STEWART: Did the patient advocate do anything?

A. I know she was in the background. I cannot remember if she said anything, but I think she was taking the minutes.

Q. In relation to your observation that you weren't really sure about what you could contribute and what you were meant to contribute to the meeting, you had been part of the critical incident review, you were tasked with doing things in the agreed action plan. There in the update with the chief executive on 9 July, which we looked at just before our tea break. You'd been part of that meeting with the nurses. You were going to involve yourself in training the nurses in relation to some of those agreed objectives. You had a lot you could have told Mrs Ferguson about lessons learned, things put in place to stop a recurrence.

Why didn't you tell her about those things?

A. Dr Nesbitt and Dr McCord had spoken at length. They had been asked questions by the -- there were two ladies

with Mrs Ferguson, I can't remember who they were. I think one may have been her sister. A lot of what the recommendations about the electrolytes -- electrolytes was mentioned and the fact that they would review the -- you know, that this management of the children was being reviewed, or was reviewed, and that there was going to be a change in management, that lessons had been learned. I mean, these are words that I remember but I cannot remember the exact conversation.

It went on quite a lengthy time, and Mrs Ferguson was very, very upset, and I didn't feel that -- I felt that Dr Nesbitt had covered a large area and, I mean, I -- as I say, it was an extremely difficult meeting.

When I went into that meeting I thought I would be able to speak to Mrs Ferguson face to face on her own or almost on her own. I did not expect that there were so many people in the room and that the atmosphere was so difficult. And when I -- I wrote, I remember that I felt that I was unable to give Mrs Ferguson the reassurance and the explanation. What I meant by reassurance was actually that I could have gone and comforted her. That's what I meant by that.

Q. What explanation would you have given her, had you the opportunity at the time?

A. And the explanation was that, you know, during the day,

that day that I had been on -- and yes, Raychel had vomited but she was up walking to the toilet with her father. You know, that, yes, I had -- whilst I had concern, I had no doubt that she would recover. I did not expect -- I mean, I did say that in a shortened sentence that I never expected, when I went off duty, to come back on the Tuesday and to hear of the catastrophic event that had occurred. But I just -- I mean, I wanted to talk to Mrs Ferguson, but mostly to comfort her and to say how sorry I was. But I just -- I just couldn't, it was very, very difficult.

And I mean, I'd had many years of experience of nursing, but I had never experienced anything like this. I had never been involved in a child who had died in such circumstances. I just found it very difficult.

THE CHAIRMAN: Can I ask you just on one separate issue on this. You have described now from coming back into work after Raychel had died right through to 3 September, and at no point has there been any reference to the director of nursing being involved in the reviews or exchanges or meetings. Do you remember Ms Duddy being involved in this period at all from June to September in anything to do with Raychel?

A. No. No, just -- I think she was at the critical review meeting, but I don't remember anything after that.

THE CHAIRMAN: I'm subject to correction, but I don't think she was actually at the critical --

A. I could be wrong.

MR STEWART: The summer.

THE CHAIRMAN: At the end of the summer or the start?

MR STEWART: End of the summer, I think.

THE CHAIRMAN: But in the various discussions -- I mean, because you said that you remember her coming round once or twice in separate winters when there were pressing issues about staffing, and here you have a pressing issue about a child's unexpected death. What I'm just exploring with you is, do you have any recollection of Mrs Duddy being involved in any of the discussions or proposals or reviews?

A. No, I don't, no.

THE CHAIRMAN: Thank you.

MR STEWART: Do you have any recollection of anyone senior to you, after the critical incident review, gathering you and the other nurses together for further interviews?

A. No.

Q. Do you have any recollection of being interviewed yourself on any subsequent occasion?

A. No.

Q. Can I ask for document 160-163-003 to be shown? This is

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

The second paragraph down there:

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

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

A. No.

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

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

Q. Yes.

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

Q. Yes.

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

interviewed individually, no.

THE CHAIRMAN: Or together?

A. No. I have no recollection of that.

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

A. No, I don't.

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

A. Mm-hm.

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

A. Yes. As I have said before, Mr Chairman, I was not of the opinion that the vomiting was severe and prolonged. We talked earlier about Dr Fulton's note or his minutes, where he said that the nurses were of the opinion that the vomiting was severe and prolonged. I have no recollection of that.

THE CHAIRMAN: Sorry, he says it was prolonged.

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

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

A. Yes, but --

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

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

A. Mm.

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

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

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

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

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

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

A. Yes, I agree with that.

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

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

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

A. Well --

THE CHAIRMAN: -- that it has become severe?

A. Yes. Mm-hm.

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

agree that there's an element of severity and an element of prolongation.

But might I respectfully remind the inquiry, if it's necessary, that her evidence on page 159 of the transcript was, before the questioning started, was that she was not of the opinion that the vomit was severe or prolonged.

THE CHAIRMAN: Yes.
MR STITT: That's a statement. It may be wrong for a number of reasons in terms of its technical assessment, but nonetheless she is stating what her opinion was.
THE CHAIRMAN: The reason I went back over that over the last few minutes, Mr Stitt, was because it seemed to me to rather contradict the evidence that she gave before the break. And it also seems to me to ignore the evidence that we heard in February and March, and that's why I was anxious to go over with it and that is why I'm trying with the witness to put together the vomits from about 8 o'clock in the morning until late at night.
MR STITT: Yes. I was on a slightly different point, and that was that it was being suggested to the witness that she could not recall being interviewed on any further occasions or on her own or with a group, which would tend to indicate that the statement in the letter was inaccurate that the nurses felt that the vomiting was

neither prolonged nor severe, and I'm simply saying that in terms of her answer, it is consistent, notwithstanding the answers which she's given to you.
THE CHAIRMAN: But I'm not clear where the information on that letter comes from if she wasn't interviewed.
MR STITT: Well, she can't remember being interviewed. I can't comment any further. It's not my place to do so, and you'll form your own view, sir, but this is 2013.
THE CHAIRMAN: Yes, but I'm sorry, I need a bit more than that, Mr Stitt. This was an issue which the trust was contesting. The basis for the contest is set out in this letter written by your instructing solicitor, I assume that the letter's written on instructions from the trust, and in light of what we have heard about what was agreed at the critical incident review we're trying to get to the root of the information contained in this letter.

Now, if this witness wasn't -- effectively her two major contributions are her presence at the critical incident review and the statement she then wrote, which became her coroner's statement. If that's her contribution and she was not part of any subsequent interview on her own or with other nurses, at least so far as Sister Millar is concerned, where does this

information come from. That's what I'm trying to get at.
MR STITT: I understand where you're trying to get to, and I for one certainly wouldn't want to stand in your way, Mr Chairman, but I am saying that her answer is not inconsistent with the letter, but your point is a different one.
THE CHAIRMAN: Thank you.
MR STEWART: Perhaps we can move to the evidence that you did give at the inquest. First of all, by way of background can we go, I wonder, to the transcript of your evidence for 1 March 2013, page 57.

It's at line 11:

"But there was always a difficulty in getting doctors. If I had two or three surgical children, I could spend more time with them than I would with maybe 15 or 20 medical children. So the amount of time wasted on trying to get doctors -- and it wasn't that they weren't answering their bleeps, it was they are in theatre, they were in clinics, they were in A&E, they were in outlying wards, there was an emergency going on in A&E, you know, it was very difficult to get them."

The chairman:

"So they seemed to be everywhere other than where you needed them?

"Answer: Yes, I'm saying this, I said it at this meeting as far as I remember. I can't remember exactly what I said..."

And you describe fully your frustration at getting the doctors.

The evidence you gave at the inquest can be found at 012-041-204. This is in the handwritten portion and you can see your signature at the foot of the page.

The sentence beginning about five lines down:

"The surgical team do a round in the morning and are available if required. It would not be unusual for them to return without being asked for."

Can I suggest to you there seems to be a great difference between assuring the coroner on the one hand that the surgical team are indeed available if required and there was always difficulty getting them, the amount of time wasted on trying to get doctors, you know, it was very difficult to get them, seems to be two separate stories?

A. No. There were problems with getting the medical staff, right? But they were to be available if they were needed. And --

Q. I'm sorry, your evidence here was "are available if required", not "were to be". We're not in the hypotheticals, we're in the concrete, "are available if

required".

A. If we required them, we would bleep them.

THE CHAIRMAN: Yes, but the problem that you were expressing at the critical incident review was that you had great difficulty getting them.

A. We did at times, yes, we did.

THE CHAIRMAN: And we've already heard in Raychel's case that there was a specific problem in the afternoon getting a doctor, the first doctor along, Dr Devlin.

A. Mm-hm.

THE CHAIRMAN: So the delay -- and in fact, Dr Devlin wasn't actually responding to a bleep, he happened to be on Ward 6 doing something else and was grabbed and administered the anti-emetic; right? So he didn't respond to the bleep.

There's nothing unusual about that because what you told the critical incident review, and the point was being emphasised, and you were being quite blunt about, was: the surgeons need to get their act together and provide us with a proper service for the children. Right?

A. Yes.

THE CHAIRMAN: But that's not what you told the coroner. You didn't tell the coroner anything like that. Why didn't you say to the coroner, without even having to go

into all the detail, "The surgical team do a round in the morning and if we need them otherwise, we sometimes have difficulty getting them but ultimately somebody always arrives"?

The answer as noted -- and then you sign that at the end, the answer that you gave doesn't go down that route at all:

"The surgical team do a round in the morning and are available if required."

A. Yes. Well, I suppose that what I meant was that -- you know, that you would bleep them if you required them back. I suppose I wasn't thinking at that time of the difficulties that we had, but there were difficulties.

THE CHAIRMAN: I'm sorry. In light of everything around Raychel's case, including the specific difficulty on the Friday afternoon in getting a doctor, and in light of the discussions afterwards in the critical incident review, and in light of the changed practices that you told me about when I asked you before the break, how could you not have been thinking about that when you were giving evidence to the coroner about Raychel?

Let me spell this out to you, Sister Millar. It rather looks as though you didn't pull your punches in the hospital, in the critical incident review, but then you didn't speak quite so openly and frankly when

you were before the coroner. That's how it looks to me. Now, if that's not fair, please tell me why it's not fair.

A. Well, I expect I should have expanded on that for the coroner, but I didn't.

THE CHAIRMAN: Thank you.

MR STEWART: If we go to the foot of this page where it says Mr McAlinden -- a question coming from counsel:

"On sheet 37, the degree of vomiting shown is not that unusual based on my experience."

So you're saying -- you're giving evidence about the degree of vomiting based upon the records. Did you tell the coroner that in fact the clinical incident review had recognised that there was poor documentation of the fluid balance in this case?

A. Did I tell the coroner?

Q. Yes.

A. No. By that I didn't.

Q. Can I ask in relation to the vomiting itself that we have a look at your evidence on the transcript from 28 February, page 82?

Line 10, you were asked by Mr Wolfe:

"Could I ask you, Mrs Millar, did you actually physically see any of the vomit, any of the vomiting?

"Answer: Yes, I saw the vomit at 10 o'clock ...

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

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

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

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

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

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

A. No, I didn't.

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

THE CHAIRMAN: Mr Quinn?

MR QUINN: Just one question.

THE CHAIRMAN: You don't have to.

Questions from MR QUINN

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

A. No.

MR QUINN: Thank you.

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

A. No.

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

Sister, thank you very much for coming again. Unless there's anything more you want to say, that brings your evidence to a conclusion.

A. No.

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

A. Thank you.

(The witness withdrew)

Housekeeping

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

MR QUINN: Yes.

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

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

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

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

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

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

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

week of the inquiry.

What we're looking at to see is how tight we run those last weeks together, if it's two weeks of departmental witnesses and then a week of presentations at which the department and the Belfast Trust say what happens now, and we can then probe them by putting examples: well, if Raychel happened or Conor happened now or Adam happened now, how would things be different and the sort of episodes we've seen and queried over the last year, how would the new procedures allow that to be treated differently? That will be the way we conclude.

The historical abuse inquiry needs to move in here. We are not going to be rushed out, but I think we are coming towards the end in any event, so it's a question of how quickly we can draw the last few pieces together.

MR QUINN: Can I just clarify then? That means we're sitting next week for four days.

THE CHAIRMAN: Three days, Monday, Tuesday, Wednesday.

MR QUINN: Monday, Tuesday, Wednesday. Week commencing the 9th, three days?

THE CHAIRMAN: Yes, Monday, Tuesday, Wednesday.

MR QUINN: And the week commencing the 16th?

THE CHAIRMAN: It looks like it's definitely two days. We may need a third.

MR QUINN: Does that mean, then, that the week commencing

the 23rd is free at the moment?

THE CHAIRMAN: As is the week of the 30th. As is the week of the 7th.

MR QUINN: So it's three weeks free?

THE CHAIRMAN: Yes.

MR QUINN: Then we're into the 14th. We sit the 21st and we're also sitting --

THE CHAIRMAN: Well, that's the aim, but we're still waiting. In light of the evidence that was heard, which has been heard to date, apart from the presentations from the Belfast Trust and the department, we've asked for additional witness statements, and we're hoping to have those back in time for us to be able to sit through from 14 October. But that's the target, Mr Quinn. I can't yet confirm that. We have to look at how extensive those statements are, but as inevitably as all of these things happen, we're narrowing down the focus on more and more precise issues now.

MR QUINN: But does it look as though we're going to sit some of the week of 20 October?

THE CHAIRMAN: Probably.

MR QUINN: Just for clarity on that point.

THE CHAIRMAN: I'm sorry this is a little vague at the moment, but it depends on information coming back to us and how quickly we can get through that information in

a way that we can turn it round to present it publicly.

MR QUINN: With respect, Mr Chairman, for some clarification, does that mean that we hope to finish on 1 November at the latest, which is Friday, 1 November?

THE CHAIRMAN: No, it wouldn't be because if we did the week of the 14th for Conor, the weeks of 21st and 28th for the historic issues involving the department, what the department knew or didn't know about what was going on at all of these different times, that would probably mean that the week of the 4 November would be the presentation week.

I'm saying it's presentation, but it's on the basis that there's effectively agreement that people like the Permanent Secretary will lead a small team, who will come here. They will present papers or set out position papers and there will be two or three of them here who can be probed about how this works and how that works.

MR QUINN: And the last issue I want to ask you about, Mr Chairman, is it likely that the coroner is to be recalled?

THE CHAIRMAN: No, but I have written to the coroner and asked him if it's possible for him to give us an indication in light of what he has heard and his own evidence on how things might possibly change in the future.

MR QUINN: Yes, because that is a relevant issue that vexes the parents.

THE CHAIRMAN: You will, of course, remember that while Mr Leckey is the senior coroner, he's not the head of the coronial service, it's Mr Justice Weir. Do you want me to ask Mr Justice Weir for a paper?

MR QUINN: I might get there first!

THE CHAIRMAN: If you want me to ask him for a written paper I'll do that. We've got a holding response from the coroner's office to say that our enquiry of him about how things might change in light of what he's heard is being taken forward, and we've got a holding answer on that. But I'm assuming something that you know this, Mr Quinn, but just so the families and everybody else knows it. Mr Leckey, the senior coroner who gave evidence here, is not the only coroner for Northern Ireland, and the head of the coronial service is a High Court judge called Mr Justice Weir, so Mr Leckey can't just write back to us and say, "I'm going to do five things differently in future", he needs to confer with the head of the service and the two other full-time coroners, and that's not just an overnight decision to be made.

MR QUINN: Yes.

THE CHAIRMAN: I'm hoping we get an answer. I just don't

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

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

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

scheduling. We will definitely be sitting for three days next week, three days the week after, and what we'll tweak over the next few days is how we finish off in the fourth week.
Okay. First we've got Ms McKenna and Ms Duddy.
MR STEWART: The witness McKenna will be the shorter of the two.
THE CHAIRMAN: And that leaves Dr Carson on Friday?
MR STEWART: Yes.
THE CHAIRMAN: 10 o'clock tomorrow. Thank you very much.
(4.40 pm)
(The hearing adjourned until 10.00 am the following day)

I N D E X