Monday, 9 September 2013

(10.00 am)

(Delay in proceedings)

(11.08 am)

THE CHAIRMAN: Good morning, ladies and gentlemen, I'm sorry we are starting a little late. There was some business, which developed from Friday afternoon that we had to sort out before we heard from Mrs Doherty.

MRS ANNE DOHERTY (called)

Questions from MR ANDERSON

MR ANDERSON: You have been kind enough to provide the inquiry with a witness statement. That has been given the number 325/1 and it's dated 29 August 2013. Are you content that that should be entered as part of your evidence into the inquiry? Obviously subject to anything you wish to say today.

A. I'm happy.

Q. You have recently made an amendment to the witness statement, which we've taken account of, and that's the amendment to question 8(j). We won't call it up now, but we've accepted that correction and that is now entered in as part of your witness statement, so that correction has been taken into account.

You've also provided a CV to the inquiry and, if this can be brought up, it is at 317-043-001.

This obviously sets out your career history and qualifications and we can see from that -- and if we can go through them -- that you qualified in 1968 as a registered general nurse. Indeed, you did your training in Altnagelvin; is that right?

A. That's right.

Q. You then worked in the Roe Valley Hospital for a period of 23 years and then you transferred to Altnagelvin ward 6 in 1991, delivering care to the elderly.

A. That's right.

Q. In the course of doing that role, did any of that work inform your future work as a patient advocate?

A. Not really. It was a general nurse --

Q. Okay.

THE CHAIRMAN: But your experience in dealing with --

A. With people --

THE CHAIRMAN: -- parents and patients would have helped later on?

A. -- with people would have contributed. It would, Mr Chairman.

MR ANDERSON: So you might have been exposed to various complaints in the course of -- not necessarily with yourself, but you would have been familiar with how that whole process would have been working on the ground?

A. I would.

Q. You then completed an RGN professional development degree in 1992. That's obviously a nursing --

A. It was a nursing-based qualification.

Q. Could you explain what the professional development part of that is? Just what is involved in that?

A. It was a nursing-based qualification involving different aspects. We had the social aspect of things, the psychological aspect of it.

Q. Okay.

A. That would have been the ...

Q. Okay. It was then, from about 2001, that you began to provide support to the patient advocate, and I believe that was initially for two days a week.

A. That's right, two days a week.

Q. That then developed further and you became patient advocate in September 2000. First, as I understand it, was on a part-time basis and then, from 2001 you became full-time.

A. That's correct.

Q. And were you acting full-time at the time that Raychel was admitted?

A. From 1 September.

Q. 1 September?

A. 1 September.

Q. Okay. I wonder, considering the role, if I may,

Mrs Doherty -- and in your witness statement you've kindly provided us also with a job description. If I can maybe bring that up, that's at WS 325/1, page 8. I trust you would have seen and are familiar with this document.

A. I have.

Q. Indeed, we see at the top there it was provided by you. The document itself is dated August 2005. Obviously, the period we're concerned with here is 2001. Are you able to confirm that all the responsibilities and duties that are contained in this document would have applied to you in 2001?

A. They would.

Q. I might be going through some of them, so if you see any that I call up that didn't correspond, perhaps you'd let us know as we go. In any event, we can see your job description and your responsibilities and key tasks set out there. In your witness statement, however, you've indicated that your direct line manager was Mrs Diane Brennan; is that correct?

A. That's correct.

Q. Here, we see you're responsible and report to the chief executive. I wonder if you could explain how that worked in practice.

A. Mrs Brennan would have got the -- a copy -- would have

seen all the complaints and the responses before they would have gone over to the chief executive's office.

Q. So you would have had first initial contact with Mrs Brennan?

A. Uh-huh.

Q. And it would have been on a matter of grade of seriousness that it would have then gone to the chief executive or would it just have been that everything went to the chief executive through --

A. All the complaints would have gone to the chief executive and all the responses, she has signed them off to the -- the response letter to the complaint was signed off by the chief executive.

THE CHAIRMAN: Diane Brennan's job was what?

A. She was clinical services manager.

MR ANDERSON: It obviously begs a question then what directorate you operated under or that you fell under; do you know that?

A. At that time, I can't recall.

Q. Just back to your engagement with the chief executive at this level: would you have had a close working relationship with the chief executive in relation to your role?

A. I would have had.

Q. And could you describe how that working relationship was

at the time?

A. We would have had a meeting each week where I would have taken over the complaints and the response letters. We would have discussed anything that -- of any -- that needed to be discussed. And her door was always open, I could have contacted her at any time.

Q. Okay. Back to the document here, and we can see that your role is set out, and I will read this out to you. It states that your role was:

"... a focal point for patients, relatives, carers, visitors and staff to ensure a high quality service is provided for patients within AHSST. The purpose of this job is to ensure that, (i), patients and relatives are assisted in making known their concerns and dissatisfactions and, (ii), the administration of patient's and relatives' concerns and dissatisfactions [I think there's a bit of a phrasing problem there] so that the quality of the service can be optimised."

Did you see your role as a kind of focal point for patients, patients and their relatives, a point of contact?

A. Point of contact.

Q. And they would have then brought their concerns and dissatisfactions to you?

A. They would.

Q. What would you have done with them?

A. I would have listened to them, documented their concerns, got them investigated and drafted up a response letter for the chief executive.

Q. Okay. It's fair to say then that you would have engaged with them as a kind of representative of them. From the moment of them bringing the complaint or bringing a concern, you were a kind of representative?

A. On their part. I was there for the patient --

Q. Yes.

A. -- or the complainant.

THE CHAIRMAN: So the response that they would receive would be one which you had drafted, having heard what their concern was, having investigated it, and you having suggested to the chief executive, "This is my suggested response"?

A. That's correct.

THE CHAIRMAN: But any letter which they then received would come carrying the name of the chief executive?

A. That's correct.

THE CHAIRMAN: So the point of your weekly meetings with Mrs Burnside was that she might be saying to you --

A. Change the letter, correct.

THE CHAIRMAN: -- "I just don't quite understand why this bit's in it or that bit isn't in it", that sort of

thing.

A. That's correct, Mr Chairman.

THE CHAIRMAN: After you yourself began to have more experience in this role, that two of you were able to -- the number of occasions on which she might have to suggest something to you or she might make a point that maybe you'd missed from her perspective, those were reduced because you'd get into each other's way of working?

A. Correct.

MR ANDERSON: How would patients have known to come to you?

A. There were signs and notices throughout the hospital and on each ward, and staff were made aware that ... To refer patients that weren't happy or relatives to the patient's advocate office.

Q. If I can bring up your witness statement, 325/1, page 2, and this is just you describing your work commitments. Here we see reference to documenting complaints and coordinating statements for the chief executive. At point (d) you also indicate that one of the functions of your role was to support patients and relatives in voicing concerns and you have already said that. That obviously broadly corresponds with what was set out in your job description. If I can go back to page 8 of that job description, that is at

WS325/1, page 8.

I want to just take you through some of these responsibilities and key tasks and perhaps you can elaborate on them if you can. We see at "1" under "Responsibilities and key tasks", you see it's:

"To assist individual patients with their complaints and concerns."

And then further down at "2":

"To comply with the HPSS guidelines."

And we'll come to that. I presume you needed to monitor your compliance and the department's compliance with that guidance.

A. That's correct.

Q. How would you have done that?

A. There were guidelines set out. Confidentiality would have been one of them.

Q. Okay.

A. The response time. There was a -- I can't just recall them all. Confidentiality, there was a set response time that the complainant got a letter or some response within 20 working days. There probably were others that I just can't recall.

Q. Okay. You've mentioned briefly about signs and various other indications on the ward for patients indicating how they might engage with you. But could they have

engaged with you in any other way than making a complaint? Did it have to be via the complaints channel that you became engaged?

A. They could ring, they could come to the office. Is that what you're asking me?

Q. I'm just wondering: could they engage with you only through the complaints channel or could they come to you on a more informal basis?

A. They came -- just an enquiry or they came to say they were happy with the care they had received. It wasn't just complaints.

THE CHAIRMAN: Yes. But if there was a concern which they expressed, it wasn't -- I think what Mr Anderson was asking is to what extent did that have to become a formal issue or if they said, "We were treated a bit rudely by a doctor or a nurse", did they have to make a formal complaint about that or is that a concern they could express to you which you would follow up on?

A. If they weren't happy with their care, we would have taken that as a complaint.

THE CHAIRMAN: So you had a pretty broad interpretation of what a complaint was?

A. We had, we had. They might have said, "I really don't want to make a complaint, but ...", and that would have been documented as a concern.

THE CHAIRMAN: And you'd have followed up on that, would you?

A. We would, we would.

MR ANDERSON: At the time there was a -- we sought some information on guidelines in Altnagelvin in respect of the complaints procedure, and we were provided with a document entitled "Procedure for handling complaints and enquiries and commendations". If we can pull this up at 321-004fb-001, this might go towards what you're saying. This obviously sets out the procedure for handling complaints. Are you familiar with this document?

A. Sorry?

Q. Are you familiar with this document?

A. I am.

Q. And did you use this document as guidance in your role?

A. I did.

Q. I wonder if you can help us as well. We see at the front of the document, a number of iterations of the document. It was reviewed over a number of years. This document, it implies that this version of it was at least on or after 2005. So I just want to take you through one or two processes here and perhaps you could inform us whether that was how you understood the process to work in 2001.

If we go to page 2 -- for the avoidance of doubt there was also an earlier version of this that was dated 1995 that we received from, I think, Ms Duddy. But as we go through this, if you feel there were any differences, you can tell us.

We can see at page 2 that the written complaints can come in -- "Complaints received by officers other than a patient advocate", or at page 3, they may be directed to the chief executive's office. Or indeed they could have been, also at page 3, directed to your office. Is that how you saw the flow of complaints?

A. All the complaints came to the patient's advocate office. They might have originally gone to the chief executive's office or to the ward, but they were passed to us then.

Q. Okay. And then obviously at 3, and also page 5, we see that complaints -- and this is what you said already. Complaints should be made verbally to you or ward staff or department staff and they would then go about bringing these complaints to you.

A. That's correct.

Q. Essentially picking up a phone or knocking on your door and they'd bring that information to you. Did you ever receive a complaint in relation to Raychel's case?

A. We never had a complaint through the advocate's office.

Q. Did any of the medical staff or nursing staff or any of the management team ever inform you of the concerns that had been raised by Mr and Mrs Ferguson?
A. I wasn't informed of any concerns prior to the meeting.
Q. So it'd be your case then that prior to the meeting, or in advance of the meeting, there was no complaint raised and your first notification of your involvement or requirement for your involvement would have been on the morning of the meeting?
A. That's correct.
Q. If a complaint had been raised to you with respect to Raychel Ferguson, could you explain how you would have responded or in what way you would have gone about responding?
A. A copy -- we would have documented what the complaint was from Mrs Ferguson. That copy would have gone out to the ward manager and to the consultants and to the clinical director. We would have got a response back from those individuals to the office and, based on that, Mrs Ferguson would have received a letter.
Q. Thank you. So you would have taken it to the point of somebody who could deal with it and then continued to liaise until that matter was resolved?
A. That's correct.
Q. If I can touch briefly on this: did you appear in

various meetings and whatnot with respect to complaints that had been raised? Did you meet with the families yourself?
A. On occasions.
Q. And you're obviously employed by the trust. But did you see your role as independent of the trust at those meetings?
A. When I was appointed to that post, I was told that I was there for the patient. That's how I saw my role: as being there for the patient or the client or ...
Q. So you were able to -- were you able to balance that -- do you understand what I'm saying?
A. I am. There was no conflict --
Q. There was a conflict there. It seemingly --
A. No, there was no conflict. There was no conflict whatsoever. I was there for the patient or for the client. I think it was to the trust's benefit that if anything was raised, it was resolved or they were aware of people's concerns.
Q. Did they make it clear at these meetings, whoever was in attendance with you, that you were in fact employed by the trust?
A. I don't think it was ever specifically stated that I was employed by the trust.
Q. Okay.

THE CHAIRMAN: If a family or a patient came to see you they'd be seeing you somewhere in Altnagelvin; is that right?
A. We had an office on the ground floor of the hospital.
THE CHAIRMAN: So they mightn't be explicitly told you were employed by Altnagelvin, but in order to contact you or to ring you, they would ring Altnagelvin or see you in your office at Altnagelvin, and would you have said to them that your role was to represent the family and to be independent of the trust?
A. If they'd asked. It wasn't something that was specifically stated at each -- to each complainant.
THE CHAIRMAN: Okay.
MR ANDERSON: Did you receive any training in your role?
A. No training, no specific training.
Q. If I may take you to your witness statement at WS325/1, page 3, we're moving on now to the meeting itself. In response to question 3(vi), you have described how you see your role, your engagement, with the case of Raychel Ferguson. You state there:
"In my role as patient advocate I was not involved with Raychel's care. I had no contact with her family at any time apart from recording the minutes of the meeting and this issue did not come through the patient advocate office as a complaint or a concern."

Is that how you still see your engagement with respect to Raychel Ferguson?
A. It is.
Q. Who asked you to attend the meeting?
A. The chief executive.
Q. Do you remember what terms you were asked to engage --
A. I don't recall.
Q. It seems logical to say that she would have told you about Raychel in advance of the meeting; do you remember that?
A. I can't remember specifically, but I would imagine that that was -- I was told that.
Q. Do you know how you would have seen the purpose of your attendance at the meeting? What did you consider to be the purpose of your attendance?
A. To be there as a point of contact for the family if they wanted to come back again, and to take the minutes.
Q. Did you take any steps to engage with then at the meeting and to give them the indication that you were there as --
A. There was introductions made at the beginning, before the meeting started. Apart from that, I didn't.
Q. Mrs Burnside has been asked about this in her witness statement. If we can go to that, WS046/2, page 27. It goes on over the page as well.

She indicates there that:

"The September 2001 meeting happened following my invitation. I believe that Mrs Ferguson was given our honest understanding of the issues, informed of improvements which had already been instigated or were in process of change. I sensed that Mrs Ferguson was not sufficiently robust to be engaged with this process at the time. I gave Mrs Ferguson a clear invitation to make further contact and we assured her that the patient advocate would work on her behalf."

You can see how this seems to contradict what you were saying. Mrs Burnside obviously --

A. I couldn't just find that on this.

THE CHAIRMAN: Just go through it again, Mr Anderson. I think it's the bottom line on the left-hand page; is that right? Just take your time, Mrs Doherty. Take a few moments to catch up on that paragraph. (Pause).

MR ANDERSON: Perhaps we'll go through it, break it down, if that's easier. You can see there how Mrs Burnside seems to be in no doubt that she reassured Mrs Ferguson that you'd be working on her behalf. That doesn't seem to tally with your recollection.

A. My memory isn't that good. I'm sure that that's what did happen.

Q. You say then that Mrs Burnside would have conveyed

a direction to you that you are appearing as patient advocate, not just to take minutes.

A. No, I was introduced as the patient's advocate.

Q. So you appeared essentially in the capacity of patient advocate?

A. There as a point of contact if the family want to come back, yes.

Q. But we've heard you talk about various other meetings that you maybe attended. In these other meetings, or generally in meetings that you attended as patient advocate, would your role have been more engaged than that, than just taking minutes, or would that have been the extent of it?

A. In other meetings I would have been more engaged if I'd had contact with the family or whoever's making the complaint. Because you're speaking to them you have a better understanding of what they're complaining about, of what their concerns are, and it's easier to address those from personal contact.

THE CHAIRMAN: So allowing for situations to be different, your normal -- do I gather that in a more normal setting you would already have met the family or known what their concerns were in advance of the meeting?

A. That's correct.

THE CHAIRMAN: And that you would have played some role in

investigating those concerns?

A. I would.

THE CHAIRMAN: So that a meeting with the family in that situation would come for you further down the line?

A. It would, it would be after. If they weren't happy with the response letter that they got and came back to us, quite often then we would set up a meeting with the staff that were concerned.

THE CHAIRMAN: So what was unusual in Raychel's case was that -- and correct me if I'm wrong -- you didn't know anything about Raychel before 3 September?

A. I didn't, no.

THE CHAIRMAN: On 3 September, Mrs Burnside asks you to join in a meeting which is going to take place later on, she wants you to take a minute at it. She has a recollection of what she told you in advance, but that was the first day that you knew anything about Raychel or that she died or that there were concerns within the hospital.

A. I probably had heard that Raychel had died previously, but --

THE CHAIRMAN: Because that would be such news in the hospital?

A. It was. It was. I knew.

THE CHAIRMAN: But did you know that, quite apart from

whatever concerns the Ferguson family had, there were serious concerns within the hospital about what had gone wrong in Raychel's case?

A. That would have been dealt with as a clinical incident and I wouldn't have been involved in it.

THE CHAIRMAN: Right. I'm just trying to get a clear picture of this. That means that you would not have been involved in any way in the clinical or critical incident review?

A. I wouldn't have been.

THE CHAIRMAN: So when this meeting is going to take place on 3 September, from your perspective, it's to address any concerns that the family have?

A. I felt that I was there to be known to them as a patient advocate, to know who to contact if they wanted to come back again.

THE CHAIRMAN: Did you know before you went into the meeting if the family had expressed any concerns about Raychel's care?

A. Well, I ... If there's a meeting set up like that, it is because the family has concerns.

THE CHAIRMAN: Right.

A. It is to answer questions.

THE CHAIRMAN: Did you know what those concerns were before you went into the meeting?

A. No, I didn't.
THE CHAIRMAN: And that would be unusual, wouldn't it, for you to go into a meeting with a family and not know what their concerns were?
A. Well, I knew there were ... I mean, to be quite honest with you, I knew that they would be concerned that the child died.
THE CHAIRMAN: Okay. But beyond --
A. Specific -- I didn't know specific concerns.
THE CHAIRMAN: Okay, thank you.
MR ANDERSON: If I can bring this up, it's at 022-084-223, and this is a minute of the meeting itself. We'll come to this in due course, but about halfway down the page:
"Mrs Burnside said to Mrs Ferguson ..."
And there we have -- Mrs Burnside indicated she was saying that:
"[She realises] this is a tragedy and devastating for you, but we don't want you to feel isolated if we can be of any help at all."
You've appeared at the meeting. Did you, at this point, sitting at the meeting -- if you didn't do so at any earlier point -- not realise that this was a very serious incident that you were dealing with and could you not have engaged yourself as a patient advocate at the meeting regardless of whether it had

been brought to you as a formal complaint or not?
A. In retrospect, I maybe should have done. I didn't.
Q. Did you feel or understand at the time that here was a situation that Mrs Ferguson and her family would have required your support as a patient advocate?
A. I felt at that time that the family wanted answers, and I, at that time, couldn't have provided any information. I felt they wanted to speak to the consultants and to the nursing staff.
Q. But by virtue of the title of your role, patient advocate, presumably that involves a degree in these meetings of speaking up for patients and their relatives.
A. It did, it did.
Q. Could you not have done that?
A. At the time, I didn't feel that I could contribute anything at that time.
Q. Mrs Burnside has indicated in her witness statement, and we've already gone over that, that there was a degree of -- and naturally so -- vulnerability on the part of Mrs Ferguson. Did you not feel that she would have required some input from you to assist her through the process?
A. Not at the time. I would have felt that I was there for her, or for any of her family, if they wanted to come

back to me again after the meeting.
Q. Well, that's my question then. Did you not, following the meeting, take any steps to try to engage with the family?
A. No, I didn't. Mrs Burnside had offered, had said to them, "The door is open, come back, contact us". So I felt the offer was left with the family. And in the circumstances, you don't want to intrude.
THE CHAIRMAN: Was your problem, Mrs Doherty, that the reason that you felt that you couldn't contribute anything was because you didn't know anything about the critical incident review, you didn't know what -- or did you know what changes had been made?
A. No, I wasn't aware.
THE CHAIRMAN: Okay.
A. That would have been more on a ward level or more ... More clinical than what I was doing at that time.
THE CHAIRMAN: And you must have known that any family is bound to want to ask questions about how their daughter, who comes in with an apparently minor problem, is dead 36 hours later or 48 hours later. But beyond knowing that, you really didn't know anything about Raychel's case?
A. I didn't really know anything.
THE CHAIRMAN: And if you didn't know anything about her

case, there are severe limits about what you can contribute at a meeting?
A. That's how I felt.
THE CHAIRMAN: Okay.
MR ANDERSON: In other cases that you may have encountered as a patient advocate, would you have always have taken a sort of reactive approach to it or would you have been proactive after meetings and so on to go and actually seek out the families, ask them if they need any assistance, ask them if they need you to support them in any way?
A. Are you asking me, did I go out looking for complaints?
Q. I'm asking you, in your role, would you always have waited for them to come back to you after you've engaged with them to some extent?
A. It would have depended on the circumstances. If ... If I had to go back to them, I would have done so.
Q. But you didn't feel that there was anything to go back on with respect to this case?
THE CHAIRMAN: I think you've -- correct me if this is wrong, but it seems to me almost, as patient advocate, you came in at the wrong end of Raychel's case. You came in after the hospital has had some level of investigation internally about what has gone wrong and it's decided to put various things right, but you don't

know about that at all when you go and meet the family.
A. No, I didn't.
THE CHAIRMAN: And beyond knowing that the family must be concerned about how their daughter died, you didn't know about the details of their concerns?
A. No, I didn't really.
THE CHAIRMAN: For instance, you didn't know that the family were concerned about the response which the nurses had made to Raychel's vomiting?
A. I didn't know any of that prior to the meeting.
THE CHAIRMAN: Right. In retrospect, you could have been more helpful to the family if you'd known before you went into the meeting far more about what had happened in June?
A. I feel -- that's correct. I feel I could have done. If I had spoken to the family and knew what their concerns were, what -- the aspects that bothered them the most, I would have done some investigation into that, I would have had some answers.
THE CHAIRMAN: And to that extent, the way in which you were involved in this meeting of 3 September was very unusual, because in effect -- and please correct me if this is wrong -- you were walking into it blind.
A. Well ...
THE CHAIRMAN: You didn't know any of the detail of the

family's concerns and you didn't know the detail of the hospital's critical incident review or the changes which had been made on foot of the critical incident review.
A. That's correct.
MR ANDERSON: Do you feel that anyone should have come to you earlier with this issue?
A. I really only took up this post on 1 September, so this was my first meeting as such.
THE CHAIRMAN: But had you not been doing it part time --
A. I had been on two days a week prior to that for the --
THE CHAIRMAN: -- for the previous year?
A. The patient's advocate would have attended the meetings and things like that. I would have --
THE CHAIRMAN: Sorry. There was a full-time patient's advocate before you?
A. There was, yes.
THE CHAIRMAN: And you were, in effect, a part-time back-up to that --
A. That's correct.
THE CHAIRMAN: So it was from 1 September 2001 that you became --
A. The patient's advocate.
THE CHAIRMAN: You became the full-time patient's advocate?
A. That's right.
THE CHAIRMAN: Okay.

MR ANDERSON: Continuing on the theme, if I can take you to the file that the inquiry received late on Friday. That, I believe, emerged following a consultation with you. This is the file that relates to the meeting. If we can bring that up at 321-076-001. This is the cover letter with the explanation as to what occurred.
Can you explain why these documents had never been provided to the inquiry earlier?
A. Sorry?
Q. Can you explain why these documents have not been provided to the inquiry earlier?
A. I can't answer that. I've been retired for four years.
Q. I understand that you've been retired, but you were in place, am I right in saying, until 2009?
A. That's correct.
Q. And in those intervening times -- and obviously the trust's engagement with the inquiry -- did you not think you had some documents that might have been of interest to the inquiry?
A. I would have ... I wasn't asked for them. I would have felt that if they were needed, that we'd have been -- they would have been requested.
Q. So no one ever, knowing that you've attended the meeting, came to you to ask if you have a file on this or --

A. No, they weren't requested from us.
Q. If we can go to page 3 of that document. I trust you're familiar with what's in this file.
A. I am.
Q. And that's the front of it, am I right in saying, and it's dated September 2001?
A. That's right.
Q. Then over at 004, we see here what is seemingly a list of enquiries for September 2001. Obviously the other cases have been redacted. But there's Mrs Ferguson's name re Raychel. What is this? Is this a list of enquiries that have reached your office?
A. That's correct.
Q. How was this file opened? Did the inquiry -- are you saying -- when did you receive this enquiry in respect of Raychel?
A. That was only a front cover put on to identify the documentation.
Q. Okay. What are those numbers, do you know?
A. We numbered all the complaints and numbered all the enquiries.
Q. Are you saying this is from the time or this has been added to the file after the fact?
A. No, that's there. "01" was 2001, and then the numbers of the ... The number of complaints that we had

received by that --
THE CHAIRMAN: So in September 2001 the issues about Raychel were the first ones dealt with under the heading "01/117"?
A. That's correct.
THE CHAIRMAN: And then there was a series of other patients --
A. After that.
THE CHAIRMAN: -- or relatives who ran from 118 to 131?
A. That's correct.
MR ANDERSON: If we can go to page 6 of that document. Here we find copies of a patient advocate form. Is this you completing this document? Is that your handwriting?
A. No, the secretary did that one out. My writing is the "description" and "action".
Q. Okay, I see it.
A. On the right-hand side.
Q. So this is a form that you would typically have filled in if something came to your office by way of concern or complaint or otherwise?
A. That's right.
Q. And we see down, there are some details, "Mr and Mrs Ferguson", and the details of the GP and the admitting consultant. Then we see a description there:
"Meeting offered following the death of Raychel.

Meeting held, 3/9/01."
And "Action":
"Minutes of meeting attached."
Was that filled out before or after the meeting?
A. After. Possibly the next day.
Q. So when we see there "Acknowledgment date, 3 September 2001" -- and at page 005, we see a similar page -- this indicates that the matter was resolved on 3 September 2001.
If you were --
THE CHAIRMAN: Sorry, has that come up on the screen or not?
MR ANDERSON: The "resolved"? It's down in the boxes at the bottom of the ...
THE CHAIRMAN: "Resolved, yes or no", and the answer is "Resolved 3 September". So that was entered on the file -- this is the point, Mrs Doherty. This was entered on the file that the complaint or issues with the Fergusons were resolved --
A. Well, it's just that the meeting was offered. That's the date that the meeting -- that really just ... The meeting was offered on that date.
THE CHAIRMAN: Right. So when it says "Resolved date", that simply refers to the date on which the meeting took place, it doesn't say that the concerns were resolved?
A. No, no, it doesn't.

THE CHAIRMAN: Right. Just one other point. If this was a typical investigation through your office of a concern or a complaint, it would have ended with a letter going from the chief executive --
A. That date would have been the date of the letter. If the patient wasn't happy and came back, we would have written in below that "re-opened on ..." whatever date they came back to us again.
THE CHAIRMAN: And that letter would have been drafted by you and sent by the chief executive and would, in effect, be a summary and the letter would have ended by saying what had been done or what had been agreed or not agreed?
A. Are you talking about a complaint or this in particular?
THE CHAIRMAN: Well, what I've just described doesn't apply to this in particular, sure it doesn't.
A. No, no.
THE CHAIRMAN: That's how a typical investigation would have ended?
A. That's correct.
MR ANDERSON: If we move on to the minutes of the meeting themselves, these are at 022-084-215, and they ran through ten pages, concluding at 224. Can you confirm that this is a minute that was taken by you?
A. That's correct.

Q. In your role, you have said you attended various other meetings and so on. Presumably, this has been a fairly familiar part of your role, taking minutes for these kinds of meetings.
A. That was the first meeting that I had documented in my role as patient's advocate.
Q. Okay. You were asked to take this minute then by Mrs Burnside and we've heard that. Could you describe how you went about taking the minute?
A. Longhand writing.
Q. That would have then formed the final typed up minute?
A. When I would have gone home that night, I wrote it out in better English so that it could be typed up.
Q. Did you retain that handwritten note?
A. I didn't, it was ...
THE CHAIRMAN: And if somebody had said, as often happens when meetings move on and then somebody says, "I have just one question about that point we were talking about before", when you come to type up that minute, you would put that later question back in the sequence, would you?
A. No, I'd probably just have documented it as it was spoken.
THE CHAIRMAN: All right. I'm not saying there's anything wrong with doing that; that's the way some people prepare a record and other people --

A. I had no previous experience of taking a minute. I just took it as it was spoken and to the best of my ability.
THE CHAIRMAN: Thank you.
MR ANDERSON: Attached to part of the new file that we've seen is a memorandum and that's you issuing the minutes out to a number of individuals for their approval. I think initially you indicated in your witness statement that the minute was circulated to the chief executive and a consultant that you couldn't remember.
A. I couldn't remember.
Q. But now we see here that it was indeed sent to Dr Nesbitt. If we can bring this up, this is at 321-076-008. This is a memorandum from yourself?
A. That's correct.
Q. And we can see it was sent out to Dr Nesbitt, Dr McCord and Sister Millar. Why did you not circulate this minute to the other attendees? Obviously there were nurses at the meeting and various others. Did you not circulate it any wider than the list that's listed there?
A. Sister Millar would have let Staff Nurse Noble see it. And would have let the staff who were involved see it. And ... Those were the ones responsible for the care that received it.

Q. Okay. Does that explain why Mrs Burnside's not on the list?
A. Well, I would have met with Mrs Burnside. I can't say for sure, but I would imagine I took it over and let her read it -- took a copy over, let her read it and then brought it back again.
Q. You obviously state in that memorandum that you would appreciate it if they would check the document and amend accordingly. Did anyone come back with any suggestions?
A. If there had been any amendments, it would have been attached and the new minutes attached in front of it.
THE CHAIRMAN: So if you had received any amendments, they would be in the file which turned up last week?
A. They would be in the file. The typed thing with their amendments would have been filed as well if there had been any amendments.
MR ANDERSON: So we would have seen the responses in your file presumably?
A. If there had been.
Q. Did you provide a copy of the minute to Mr and Mrs Ferguson?
A. I didn't, no.
Q. Did you see or know if anyone else who was attending the meeting took notes or minutes of the meeting?
A. Not that I am aware of.

THE CHAIRMAN: Can I ask you: why would you not send a copy to Mrs Ferguson?
A. It wouldn't have been our practice to send it out unless it was specifically requested.
THE CHAIRMAN: Thank you.
MR ANDERSON: And did anyone then contribute to your finalisation of the minute? Did anyone help you to finalise the minute apart from you sending it off to these individuals?
A. No, that's just the minutes as were taken, typed up.
THE CHAIRMAN: So if nobody comes back to, you assume that they're content?
A. That they're happy enough.
THE CHAIRMAN: You wouldn't expect people to come back nitpicking, but if something significant is missed --
A. They have on occasions come back with amendments where somebody ...
MR ANDERSON: Sir, I have nothing further.
THE CHAIRMAN: Can I just ask you, do you have any recollection beyond your minute of the meeting itself?
A. Not a big lot.
THE CHAIRMAN: Of the people who were in the room, I think you would have known least about Raychel; would that be right? The family would have known more.
A. And I would have known least.

THE CHAIRMAN: And the others there, led by the chief executive, would have known substantially more than you did because many of them were involved, in some way, with her treatment or in the aftermath of her treatment.
A. Within the aftermath, yes.
THE CHAIRMAN: So did you form any impression about how that meeting had gone, how well or how badly it had gone?
A. Not that I can now recall. I can't say. I was taking notes longhand. I would have been concentrating on that. I really can't comment on how I felt at the time.
THE CHAIRMAN: You were just too busy taking the record?
A. That's correct.
THE CHAIRMAN: Okay. Mr Coyle?
MR COYLE: We have nothing, sir.
THE CHAIRMAN: Any questions from the floor? Mr Lavery, Mr Stitt?
MR STITT: No.
THE CHAIRMAN: Actually, just let me ask you one other thing. It's moving away from Raychel's case. You've described your limited role, which seems to have been unusual or atypical of what you did as a patient advocate; is that right?
A. It is, that's correct.
THE CHAIRMAN: But did you remain as a full-time patient

advocate until 2009?
A. I did.
THE CHAIRMAN: Over those years, the role of the patient advocate, did it seem to develop and maybe improve because you got more experience and you were better placed with that experience to handle concerns and complaints?
A. It did change more in that wards and departments were made more aware of the complaints. There was more documentation of the changes that were made because of complaints.
THE CHAIRMAN: So if we were looking at something that you'd done in 2007, we might see that as the system improves there's better records? That's just the way it is. It doesn't mean that other records weren't good enough; it means you are learning as you go through the job.
A. That's correct.
THE CHAIRMAN: Do you think it then became a more valuable service as the years went on?
A. I think it did.
THE CHAIRMAN: Do you think you were able to achieve more for people than you were in the very early days in 2000 and 2001?
A. I would say that it's possible. You would have seen -- basically I would have seen more changes being made as

a result of complaints in the latter days.
THE CHAIRMAN: Is that because the hospital's system was responding better to concerns --
A. Yes, I think so.
THE CHAIRMAN: -- or complaints that were raised? I'm trying to get a feel generally, Mrs Doherty, as you might have guessed from this, whether you have then detected a greater willingness or a greater openness on the part of hospital as time has gone on.
A. I think there was.
THE CHAIRMAN: And that then leads to -- inevitably patients and families have some ideas which might be of use to the hospital --
A. Certainly.
THE CHAIRMAN: -- and they've been picked up.
Can you think off the top of your head of some example? I don't want you to name a patient, but can you think of something that would illustrate the general point you're making?
A. On a very minor incident, somebody from outpatients came round and complained that the telephone behind them was in too public a place. If someone was using it, she was sitting and she could overhear the conversation. The telephone was moved to a different position.
THE CHAIRMAN: Right. So that was a phone that a member of

staff would be using?
A. No, a member of the public in outpatients.
THE CHAIRMAN: So they couldn't talk privately enough so other people would be hearing their business?
A. This lady said, "I was sitting and I could hear what that woman was saying and that's in too public a place". So that was moved.
THE CHAIRMAN: Okay. Was there some point?
MR LAVERY: Yes, Mr Chairman.
MR STITT: Sir, in the interim, Mr Lavery and I have had an opportunity to discuss and there are a couple of points.
THE CHAIRMAN: Okay, let's hear what they are.
MR LAVERY: First of all, just to follow on what you were asking her there, Mr Chairman, about her role as a part-time advocate. She was asked earlier by Mr Anderson whether or not she received any specific training. I wonder, could she be asked whether she considered any part of her training to have been involved with sitting with the patient advocate, the full-time patient advocate when she was a part-time patient advocate?
THE CHAIRMAN: Did you do that from time to time?
A. I spent two days a week with the patient's advocate in the year prior to taking up the post full-time.
THE CHAIRMAN: Right. When the former patient advocate was

meeting a family or a patient and going through concerns, would you have sat in on that?
A. I would have taken some of the complaints myself. I wouldn't have sat in because that would have been too ...
THE CHAIRMAN: Too difficult? Too intrusive?
A. No, no, for the patient. A one-to-one, I think, is better if they are wanting to make a complaint rather than two members of staff sitting listening.
THE CHAIRMAN: But if you didn't sit in these meetings -- is this your point? Maybe I've picked up your point wrong, that it wasn't necessarily sitting in the meeting with patient, but she would have seen how the patient advocate did the work?
MR LAVERY: Precisely, Mr Chairman.
THE CHAIRMAN: So you got a feel for the work?
A. I did. I would have taken complaints and I would have chased up responses that were delayed. I never sat in on any meetings with the patient's advocate.
THE CHAIRMAN: Okay, but when you met your first patient in September 2001, you had a pretty good idea from the previous year how that would go?
A. I had. That's correct.
MR LAVERY: A form of apprenticeship, perhaps.
I wonder, could the witness be asked if there was

anything said at that meeting that she wouldn't have recorded? Perhaps, first of all -- and I think, in fairness, the family accept, Mr Chairman, at the outset of the meeting that there were expressions of sympathy. That's one example.

THE CHAIRMAN: Yes. For whatever reason, that isn't in your note, but it's accepted by the family and the other people who were there on the trust side that that is how the meeting started.

A. I recall the apology and it's my omission that it's not written down.

THE CHAIRMAN: Right.

MR LAVERY: Also whether there were perhaps other matters spoken about at the meeting, Mr Chairman.

THE CHAIRMAN: Well, I think -- I guess your answer to that, Mrs Doherty, must be that you can't, because you didn't have a tape recorder and you don't have shorthand, that that's the best record --

A. That's the best that I could do at the time.

THE CHAIRMAN: So it's not impossible that something was missed?

A. It's very possible that I didn't get it all down.

THE CHAIRMAN: You'd like to think you didn't miss anything significant.

A. I would like to think I didn't.

MR LAVERY: Thank you.

THE CHAIRMAN: Mrs Doherty, thank you very much for coming and helping us out this morning. Unless there's anything else that you want to say, that brings to an end your evidence.

A. No. Thank you, Mr Chairman.

THE CHAIRMAN: I'll rise for a few moments to let Mrs Doherty leave.

(The witness withdrew)

THE CHAIRMAN: Is Mr Campbell around?

MR STITT: He's in the building.

THE CHAIRMAN: What I'll do is I'll rise for ten minutes and, when we come back, I will take your discrete point and hopefully then we'll start the evidence of Margaret Doherty.

(12.03 pm)

(A short break)

(12.17 pm)

THE CHAIRMAN: Mr Stitt?

MR STITT: Mr Chairman, I'd like, if I may, to ask you to -- what happened was, last Thursday I took the opportunity to review the various transcripts, including Monday, 2 September. And having read an interchange or exchange between you, sir and myself, there's one thing I would like to go back to, if I may.

THE CHAIRMAN: Right.

MR STITT: It's the transcript from Monday, 2 September, it's two pages, page 173 and 174. If both pages could be brought up together on the screen.

You, sir, at 173, line 23 -- this is the background. You'll remember it was who would have made the decision to call off Dr Warde or not to call Dr Warde as a trust witness for the inquest.

You say at line 23:

"Who else apart from you would have made the decision?"

And this is fairly well into the day, it's page 173, so it's in the afternoon. The witness has been asked fairly, I think it's fair to say, quite a number of times over the preceding pages by my learned friend and yourself, sir, about this particular point, and she's tried her best to answer it. And I interject and I say at line 24:

"Well, we all know, and Mr Stewart knows, that one of the persons who could make -- one of the bodies of people that could have made the decision [those are the important words] were legal advisers --"

You say "yes" and I say:

"-- or it could have been the trust or it could have been a combination of the two."

THE CHAIRMAN: Mm-hm.

MR STITT: And we move on further down the page. The questioning goes back to the witness, Mrs Brown. I really want to deal with what I said, sir, when I said:

"One of the persons who could make [this is line 25 at the bottom of 173] -- one of the bodies of people that could have made the decision were legal advisers."

When I read that in the cold light of day, I felt I really should clarify and correct myself. It's my practice and understanding that legal advisers provide legal advice --

THE CHAIRMAN: Yes.

MR STITT: -- and that's their duty, whether they be solicitors or whether they be counsel. And then it is the responsibility of the client to either accept that advice, reject that advice, have further debate about that advice, but the decision ultimately, in my experience, would be that of the client, depending on what they thought of the legal advice. And I can say that in my fairly lengthy experience of being involved in clinical negligence cases that that has been my universal experience, and of course that is appropriate. I can speak for members of the Bar, but I can say from my own experience it's also the practice, in my

experience, of any solicitors with whom I have been instructed and working with.

So when I say that a decision could have been made by the legal advisers, what I meant was that they would have had an input in giving legal advice as to any number of issues to do with an inquest or to do with an action, and ultimately the decision would be that of the client. I'm sorry I'm taking up the inquiry's time at this point by going back over the point, but I was mistaken when I said what I said and I'm grateful for the opportunity to correct myself.

THE CHAIRMAN: I think we could have a rather long debate about whose decision it ultimately is, but what I'm accepting that you're correcting Mr Stitt is that certainly you're not suggesting that in this particular case it was the decision of the legal advisers to the trust and your general experience in doing this area of work is that counsel advise, solicitors advise, and the client decides.

MR STITT: The client may accept that advice or may reject that advice. Ultimately, the decision would be that of the client, based upon, hopefully, good legal advice.

THE CHAIRMAN: Okay, thank you very much.

MR STITT: I'm not going to comment in relation to specifically the advice that was given for the reasons

which are clear to the inquiry, or to the response from the trust to that advice --

THE CHAIRMAN: Okay.

MR STITT: -- but I hope I have made that as clear as I can.

THE CHAIRMAN: Thank you very much.

Mr Stewart?

MR STEWART: I call Mrs Margaret Doherty, please.

MRS MARGARET DOHERTY (called)

Questions from MR STEWART

MR STEWART: Mrs Doherty, you have supplied the inquiry with a witness statement, which is WS336/1, dated by you 13 August 2013. Are you content that the inquiry should adopt that statement as part of your formal evidence?

A. Yes.

Q. Thank you. You were, at the time of Raychel's admission to Altnagelvin Hospital, the clinical services manager in the women and children's care directorate?

A. Yes, I was.

Q. And you have a background in nursing?

A. I do.

Q. You have supplied us with your career history and your job description. Could we see, please, WS336/1, page 26? That is your career history going back to your student nursing days.

A. Mm-hm.

Q. And moving upwards through the page to 1991 in Altnagelvin when you were senior nurse manager.

A. Yes.

Q. And that post --

A. That's in February.

Q. Yes. That seems then to have translated into your post as clinical services manager.

A. That's right. That's correct.

Q. Did you see them as much the same post or were they different?

A. The clinical services manager's post was different to the senior nurse manager's post because she had more responsibility over budgets and training and a wider remit.

Q. You have given us your job description, which appears at WS336/1, page 45. Your title is given, and then in the third line down, you were to report to the clinical director. Who was the clinical director of the women and children's care directorate?

A. It was in the first instance, Dr Quinn, and then it was Dr Martin.

Q. Because Dr Quinn has not yet been mentioned as a clinical director within the women and children's care directorate. The annual report for 2001/2002, which is at 321-004gk-022. That shows us the page from the

annual report dealing with this directorate and it names the clinical director as Dr Denis Martin and yourself as clinical services manager, which was, up until now, our understanding of the structure. Are you saying that there was another clinical director within --

A. No, he was previous. I can't remember the year that Dr Quinn became the -- when we had clinical directors and clinical services managers. But in the first instance, Dr Quinn took over the clinical director's position and he did -- he carried that position for three years, maybe four, but it was for three years. Then Dr Martin took over, and at the end it was Dr Parker when I was retiring.

THE CHAIRMAN: In fact, that was quite a big change, isn't it, because Dr Quinn was a paediatrician?

A. That's right.

THE CHAIRMAN: So he was the clinical director for women and children's care?

A. Yes.

THE CHAIRMAN: So at that point if there's a --

A. It was for children's as well, women and children's.

THE CHAIRMAN: Yes, but one of the points that we've heard about Dr Martin is that his input into the children's side was quite limited because he had no knowledge or expertise in children's care.

A. Mm.
THE CHAIRMAN: Does that mean then when Dr Quinn was director, his emphasis from his personal perspective would have been much more in children's care rather than women's?
A. It would, but they would discuss with each other. I'm sure they would have discussed with each other at the directorate meetings.
THE CHAIRMAN: Thank you.
MR STEWART: If we can go back to your job description, please, WS336/1, page 45. Perhaps you'll see how this confusion arises, because third line down, your description indicates that you were to report to the clinical director, which would have been Dr Martin.
A. Yes.
Q. But when you were asked this question when you made your witness statement, you said at WS336/1, page 2, down at 1(e):
"My professional line manager was the director of nursing, Ms Duddy."
A. Yes.
Q. So you can see where the confusion arises?
A. There's a conflict there.
Q. Did you liaise much with Dr Martin?
A. Yes, I met him more or less every Monday morning in the

labour ward, in his office, and discussed things.
Q. Was this meeting just the two of you?
A. Yes.
Q. Was this meeting minuted?
A. No. It was just to raise any concerns I had or any concerns he had for us both to address.
Q. So this was the mechanism whereby, if you had an issue, you would go into his office on a Monday morning and tell him?
A. Mm-hm.
Q. But you had formalised meetings with the consultant paediatricians? You had consultant paediatrician meetings which were minuted formally?
A. Mm-hm.
Q. Did Dr Martin ever attend those meetings?
A. Not that I can remember.
Q. Were those meetings attended by consultant surgeons or consultant anaesthetists who worked with the children patients?
A. No. It was the consultants and sometimes a senior reg would attend the meeting. Sister Millar would be there, the neonatal unit would be there, and the infant unit. It was all to do with paediatrics and neonates.
Q. Yes. I'm interested in pursuing how you would have formally brought a medical matter that you were aware of

to the attention of the medical director, say. One would imagine that you would go through Dr Martin.
A. We also had directorate meetings and, at those directorate meetings, the paediatric consultants were always invited and the obstetrics and gynaecology consultants were always invited and sometimes senior regs would come and sometimes we would have also a visitor. You know, and at those directorate meetings I would there with Mrs Gillen and Mrs Beattie, the clinical midwifery specialists.
Q. Were those meetings minuted?
A. Yes.
Q. Would a case such as Raychel's have been mentioned at that type of meeting with midwives and --
A. No, that would have been with the paediatric meeting.
Q. Paediatric meetings?
A. Mm, but it wasn't raised.
Q. So I come back to my question again: was there a formalised route for you to raise medical matters with Dr Martin and thus with the medical director?
A. Yes, that would be through the directorate, our directorate meeting. And then issues like that -- then I would take it, if it had nursing implications, to Ms Duddy and Dr Martin would take it to the medical director.

Q. You said, yes, it would be through the directorate meetings.
A. Yes.
Q. But I though you indicated a moment ago that in those meetings, cases such as Raychel's, were not mentioned.
A. That was never discussed at any of the meetings.
Q. At those directorate meetings, would you have had representation from surgical staff, doctors?
A. No, not unless it was requested.
Q. So the directorate meeting was really just you and some nurses meeting with the other side of the house, the midwives and so forth?
A. No, the directorate meetings were the consultants in the paediatric department and senior regs, consultants and maybe senior regs in the obstetrics and gynaecology department, the clinical director and myself, and the two senior midwives would be in, one from the community and one from the hospital.
Q. Why was a consultant paediatrician not named as a director for the paediatric department?
A. I honestly don't know. Because the clinical -- the children's unit was very large. By the time I retired the children's unit was a complete unit, an outpatient's department, transitional rooms were being built, children's education, children's playroom, the infant

unit, and the children's ward. So it was a large area.
Q. Because other large units had a number of clinical directors. The surgery and critical care directorate, we heard the other day, whilst it was led by Mr Bateson -- he was the lead clinical director -- other clinical directors served with him: Dr Nesbitt, we know for one, and another in specialist surgery.
A. Mm. If I recollect correctly, Dr Quinn would have been the person that you would relate to, if there was anything that was to be passed, you know, to all the other consultants by Dr Martin. And I think Dr Brown took that over later on. I think Dr Brown took that role over later on, but you know, this is 13 years ago. It's very hard for me to remember everything.
Q. Of course it is. Do you remember, for example, an issue coming to you from Sister Millar about a difficulty experienced by nurses on Ward 6 in getting surgical doctors to come across to attend to their patients?
A. Yes.
Q. Do you remember that being raised even before Raychel's admission?
A. No, I can't say I remember it -- I remember her making a comment about it and I said, "I will take this to Dr Martin", and I do remember her saying she would deal with it, and I said, "If you have a problem, come back

to me". She did raise that with me and it must have been before Raychel because we had -- I raised it at the paediatric meeting. You know, the consultant paediatric meeting. I raised it there. And it was discussed and it was decided that one of the paediatricians would contact the consultant. They still had this little bit about, you know, nurses did not contact consultants.
Q. I see. I think Dr McCord recollects that this was raised, but he says that it wasn't left to paediatricians to contact the surgeons, but that rather Sister Millar was to herself contact the surgeons.
A. No, no. I don't ... My recollection was that it was the -- in fact, I think it's minuted.
Q. Certainly you have given that response in your witness statement request. I'm sure we can find it.
A. The surgeons would have taken more notice of another consultant.
THE CHAIRMAN: Yes. Rightly or wrongly, they might be perceived as having more rank to pull.
A. Yes. Rightly so.
MR STEWART: Did you have very much control, on a day-to-day basis, of the paediatric department?
A. Well, Sister Millar was an H grade, so that gave her management of that unit. But I was on -- I used to visit the children's ward very frequently and for

about -- was it two and a half, three years? -- my office was on that floor. So I was frequently on Ward 6 until my office was moved to opposite the theatres, which was down on the first floor.
Q. I asked that question only because of the Altnagelvin Hospital policy document "Control and administration of medicines", which you contributed to as one of the three members of the working party that produced it.
A. Mm-hm.
Q. At page 321-004-009 of this document, we can see -- sorry, 009. The page before that, 009. This is really -- it's termed "definitions", but it's really just a description of what the individual persons named in the document do. And you can see "clinical services manager", third from the end there, that's you, and:
"Practitioner responsible for day-to-day management of [a directorate]."
A. Mm-hm.
Q. So you'd agree that that's really how you would have described your role?
A. Yes.
Q. So when an issue like Sister Millar's difficulty getting surgeons to come across to Ward 6 was raised, would you not have fixed upon that, noted it, and seen the issue

through to some form of resolution?
A. Well, to be quite honest with you, after it was decided that a consultant was going to speak to the other consultants, I would have then liaised with the consultant that was going to see. However, I was never informed that he'd seen the consultant. So I had asked Sister Millar to let me know if the problem had progressed, you know, carried on, or if it had improved. And it had improved for a couple of weeks and then, I think it was after the meeting, after Raychel's meeting, that's when Sister Millar started to say how bad it had been.
Q. Was this ever reduced to writing?
A. No, not to me.
Q. Put as an issue arising on any agenda, ever tracked in a documented way?
A. Well, only on the minutes of the meeting of the consultants -- the paediatric consultants' meeting. I'm sure it was documented. My secretary took the notes, took the minutes.
Q. That's not before Raychel's --
A. That was before Raychel's.
Q. If that reference could be brought to our attention, we'd be very grateful.
A. I've been to the hospital on numerous occasions and I've

asked for my sisters' minutes meetings and my meetings with the consultant paediatricians, and because I have left, apparently everything has been put into boxes, even my diaries, everything, and cannot be sourced.

Q. When did this happen?

A. Well, I left -- well, I didn't leave, I went off on sick leave in 2003, the end of March 2003, because I contracted a second cancer. I decided then I was leaving because of stress and stuff like that. So it would be -- and they moved offices over to the prefabs while I was off sick. I remember there was a lot of my stuff in that prefab office when I went to see my secretaries and my colleagues. But where it's gone --

Q. So it was --

A. -- all that work ...

Q. It was there then. When was that? When did you go back to see your secretaries and so on?

A. I remember going in to see them a few times because I just wanted to keep in contact with them all. The last time -- I know my hair was grown back. So that would have been in the December. I went and they were in the prefab and I noticed some of my files there.

Q. What year was that?

A. Oh, that was the end of 2003.

Q. End of 2003?

A. Mm-hm.

Q. At that time, of course, in terms of Raychel's case, the medical negligence action had started.

A. Yes, but to be quite honest with you, I wasn't following that at the time.

Q. No, I can appreciate that. Tell me this: may I ask you about the documents that came to light and you found when you were sitting down to draft your responses to the witness statement request?

A. Well, actually it was before I was drafting my responses. I went to see one of my staff nurses, Mary McKenna, we were chatting, and I said, "Do you know, I know I made a folder, following the risk management". Because I had to get into my head exactly what had happened. I said, "I know I made a folder. Everything of my stuff's gone". And I had it in my paediatric drawer, you know, file, with all about Beverley Allitt and everything there and the recommendations. But I couldn't -- she said, "It wasn't found", and it must have been a week later, and I told the -- Therese who was helping me to get all the records about it --

Q. Is that Mrs Brown?

A. No, no, no, this was Teresa McGuinness who was helping

me to get everything that I thought I needed. I remember saying that to her. And then I got a call to say that Mary had found it in the back of one of her cupboards.

Q. Mary McKenna?

A. Yes. She said -- how it got there, we don't know, haven't got a clue, because my office had been moved out to the prefabs, in what used to be the car park near the mortuary.

Q. That was before you sat down to do your statement, was it?

A. Yes. Well, I'd taken the statement -- I was trying to get all the information collated.

Q. When was that?

A. Oh gosh, now then ... that would have been April, May, when I got all the -- was it April?

Q. It was June, in fact, that we were informed that you had requested a senior member of the trust to look for documentation to assist you with your witness statement. And the documentation was found in an old cabinet --

A. Mm.

Q. -- which had been used while Mrs Doherty worked for the trust.

A. That wasn't in my filing cabinet.

Q. It was in a file marked "complaint". How did that come

about?

A. I have no idea.

Q. Had you been asked by Mrs Brown to look for your records, files and documentation at any earlier stage?

A. Yes. After the critical incident review or meeting, I had then thought, "I've got to get my head around this", because that morning was the first I'd heard.

Q. I'm not really referring to the documents you were creating at that time. But subsequently have you been asked to get your files and documents you retained after that time?

A. You mean that I'd kept in my office? Well, yes, everyone asked, "Did you have anything, do you know where it would have been?", and yes, when I met with Teresa McGuinness she said --

Q. And that was June of this year?

A. Yes.

Q. I see.

A. I hadn't been contacted.

Q. Did you have any records kept on a computer?

A. Well, any records that would have been kept on the computer would have been on my secretary's computer because she would have been taking notes of all the minutes of everything and they would have been on that computer.

Q. And that computer record would still be available, would it?
A. It should be.
Q. What sort of files did you open and create in relation to Raychel Ferguson's case?
A. Are you talking about the one that I created straight after?
Q. Yes, at that time, yes.
A. I ... I left the meeting, I spoke with Sister Millar, and said that I would need to speak with her, you know, on a one-to-one basis or, you know, I wanted to know more of what was happening at the ward level then.
THE CHAIRMAN: Just to get it right, this is after the critical incident review meeting?
A. Yes.
THE CHAIRMAN: Okay.
A. I also spoke with -- I remember when I was sitting in there, in that room, I remember seeing one of the nurses, she was very young and she had blonde hair. I have since been told that that was Staff Nurse Rice.
MR STEWART: Yes.
A. I remember speaking to her outside because she was very distressed, extremely distressed -- they all were distressed, they were very upset, but specifically her. I took her aside and asked her if she needed any

counselling because she was really sobbing. She said, no, she would be fine, but I do remember speaking to her. I can't remember the full conversation, but I do know I offered her counselling.
Q. I'll ask you, if I may, in a moment about your involvement at that time. It was really about documentation and the files you actually physically opened.
A. Sorry, yes. Well then I came back to the office and I rang up the ward and I asked for Raychel's notes. I also asked Ms Gillen if she would go across to the ward and see if Sister Millar, who -- not Sister Millar, Sister Little -- to see if Sister Little could ring the girls that had been on duty that night and just get a brief overview of what had happened. And then, I had the notes and I was going through the notes and I was making notes about it of what I was reading, you know, about what the doctors had written and what they'd said. I then received the verbal statements over the phone and one-to-one that Sister Little had made for me.
I then collated it into my -- you know, into a kind of report for myself. But during that time when I was looking at Raychel's notes, I received a phone call, saying that any information I had, could I send it down to risk management, they needed the notes, and they rang

the ward and were told that I had them.
Q. Send it to who? I missed that.
A. To the risk management. To send it to risk management's office. And I said I was going through the notes at the time. They said they needed them and everything was being taken over by the risk management team. I said, "I'll drop them down when I've finished", but they came for them, and later on I was asked if I would send all my information down and could I send my information that I'd collated. And you'll see in my evidence that I've given you that I had made it in report format and at the bottom, I have it typed out -- I mean, this was all in my rough handwriting. And I had then sent it to Hazel, that was my secretary, she would type it up, and I would sign it and send it off. So I know I was sending that to somebody else.
Q. All right. Let's deal with this. Can we go to a report that you drafted at 316-085-011? This is the first page. Can we look at, side by side with that, another copy of essentially the same report, which is at 316-085-009?
As I understand it, from the witness statement of Sister Little, she was asked by you to contact, first of all, Staff Nurse Noble, which she did by telephone, and she took notes of the interview. She gave those notes

to you, you needed them to make a report, which you needed for the critical incident review meeting. So on Sister Little's recollection, you create this report before you go to the meeting.
A. No, this was after.
Q. That's what she says.
A. Oh, sorry.
Q. You say, no, you created this after the meeting.
A. Mm.
Q. Well, first of all, can I ask you what "MD copy" means at the top right-hand corner of the right-hand --
A. That's my copy.
Q. Sorry?
A. This is my copy, "MD" being me.
Q. So that you have kept for yourself?
A. Mm-hm.
Q. And you'd have circulated other copies to other people?
A. No, just to the -- no, that was just to the risk management.
Q. So you just kept one for yourself and sent one to risk management, to Mrs Brown?
A. Mm-hm.
Q. Why did you have to mark yours "MD copy" then?
A. I do it on everything that I have copied.
Q. If you have your file and you have your copy in your

file, you don't need to mark it "MD copy", do you?
A. But I did that as practice so I knew that this was the copy and the other had been sent.
Q. These two reports are different in a number of small respects.
A. Yes.
Q. For example, if we look at the one on the left-hand side, you'll see in the second paragraph it ends:
"(Fluid balance chart not available.)"
A. Yes.
Q. And in the second one, you can see that that has been omitted and instead:
"She was seen by the anaesthetist and prepared for theatre. Intravenous fluid of Solution No. 18 was prescribed and erected and set at 80 ml per hour."
So it looks as though one report was drafted before you got the information from the fluid balance chart and the other after it.
A. There were two --
Q. As I understand it, the critical incident review meeting had access to the notes and to the fluid balance chart. So it would look as though you drafted this first report before you were at the meeting.
A. This one here (indicating)?
Q. The one on the left, yes.

A. I did them both together. I did this one and then I got the fluid balance chart and everything. I was writing that and taking it from the notes. I didn't see the notes before the meeting. I didn't see -- I didn't have --
Q. Yes, which is exactly why this has been drafted without the notes on the left. But once you have been to the meeting or have had sight of the notes, you then draft the updated copy, which is on the right. And you've introduced into these reports information that you got from Sister Little, information that came to you via Sister Little from Staff Nurse Noble. It's on the second page.
A. Mm.
Q. Is there anything on those reports that you could only have learnt about from the review meeting or was this more likely a review report by you, prepared for the assistance of the meeting?
A. No. I didn't have a report going into that meeting. I wrote this report after the meeting, and obviously I must have got more information and then I updated the report. I did not write that report before the meeting.
Q. Well, at the meeting do you remember any debate about what may have gone wrong, about what was done right or what was done wrong?

A. No, I don't remember a debate.
Q. You don't?
A. No.
Q. Do you remember Dr Nesbitt calculating the amount of fluid that Raychel received and concluding that she'd had more than she should have?
A. I remember that being said at the meeting, but not before.
Q. Does that find any reference in these reports?
A. But this wasn't a report of the meeting.
Q. No, but it's a report of the treatment that Raychel received whilst on Ward 6.
A. Yes, from the notes.
Q. And I would imagine that that would be informed by all that you heard at the meeting as well as what you read from the notes.
A. No, I was listening in the meeting. I didn't take any notes whatsoever in the meeting.
Q. What was the point of you writing a report which wasn't informed by all of the individuals at the meeting might have said?
A. Because I wasn't taking minutes at the meeting, I was listening.
Q. What's the point of you making a report if it doesn't actually reflect what you heard?

A. But this report was for me in the first instance.
Q. I see. Even more apposite is the question: if it's for you, why doesn't it note for your benefit what you heard because there are nursing issues there which were relevant to your job?
A. Yes, but you see I wrote this so that I could then scrutinise and see what went wrong and go and see the sister of the ward, speak to the consultants and have some knowledge of it all before I, just, you know, walked in. This was not written before that meeting and it was written for my knowledge. And I put it in like that for -- when they asked me for anything I had.
Q. It seems that there's general agreement that the meeting identified the fluid balance chart record as being not as good as it could have been.
A. Yes.
Q. That's a nursing issue which you, as clinical services manager, would want --
A. To know about.
Q. And to put right.
A. Yes.
Q. So if you're at that meeting and that issue arose, you'd have put it in here, into your report, if this report was for you and your benefit, wouldn't you?
A. Yes, after I'd scrutinised it, I would make a list of

what I had to do. I would like to mention here that I used to be a staff nurse on a renal ward and I know how important fluid balance charts are. I was a stickler for fluid balance charts being correct, being well documented, and that is why straight after I spoke with Staff Nurse McKenna and said, "We have to address this fluid balance chart".

Q. I'm still grappling with why on earth you would take time to draft, redraft and type a report which doesn't reflect the issues that you'd have heard about, which were very relevant to you and what you had to do.

A. This was just the scene, setting the scene for me, knowing what was going on, what Raychel had experienced, what the doctors had done, what the nurses had done, any information I could collate for my information. Anything from there I would have made myself a written list of what had to be addressed.

Q. Where is reference in this report to, for example, the deficiencies identified in the nursing notes? Presumably you were a stickler for the nurses keeping their nursing notes --

A. I was a stickler. Documentation is so important.

Q. Absolutely. Why didn't you make a note in your report here of that?

A. Because I was just taking down what was written by

others, what I could see and then what needed to be done.

Q. So where is the reference to what needed to be done?

A. I didn't have it done there. That was sent down that evening. That was sent down about 5, 6 o'clock that evening. I'd just put it together and got Hazel to type it. And when we saw there were things missing, I went and sought them out and then copied it again, typed it again. So there's nothing sinister about that report.

Q. I'm not suggesting it is sinister, I'm merely suggesting it was not, in all probability, written by you after the meeting when it would have had no purpose in its present form, but was written for the meeting.

A. No. It was written for me after so I could get a clear view of what had happened.

Q. Did you feel, after the meeting, that you had to report back to the director of nursing?

A. The director of nursing wasn't there at that time. She had two members of her team at that meeting -- that would be Therese Brown and Anne Witherow -- who would report back to her. I would have reported back to her straightaway if she had been there, but she wasn't, and she was -- and her own staff reported to her.

Q. Okay. We'll just go to your job description, WS336/1, page 45. We find here that not only are you the

individual responsible for the day-to-day management of Ward 6, but if you look at your job summary, we find in the second paragraph that you:

"... support the clinical director and on occasions the postholder will be required to deputise for the director of nursing in her absence."

A. Mm-hm.

Q. Can I ask you, first of all, why was the director of nursing not at the review meeting?

A. I don't know. She didn't discuss her diary with me, nor did she ask me to stand in for her or deputise.

THE CHAIRMAN: Sorry, I don't quite understand. I don't want to make too big a fuss of this, but if you thought that Mrs Brown and Ms Witherow would be reporting to Ms Duddy, why then would you have gone straight to her if she'd been available if you have just identified the two other people who, in your words, Ms Duddy had there?

A. She did have them there, yes, but I would have gone just out of respect.

THE CHAIRMAN: Right. Just to make sure that the ground that you wanted to be covered had been covered and to ensure it was covered?

A. Yes.

THE CHAIRMAN: Okay.

MR STEWART: One of your responsibilities was to ensure that

policies were followed.

A. Mm-hm.

Q. And I assume that you knew the policy and the protocol for critical incident reviews in the paediatric directorate, department?

A. Yes, they were called "untoward incidents" at that time. "Critical review" was later.

Q. Well, you know that the policy said that you, first of all, had to fill out a report form.

A. Yes, that would be on the -- that's in a book and it happens at ward level.

Q. And presumably, that was your job?

A. No, that was the sister's job or the person reporting the incident.

Q. Well, if the sister didn't do it, then it's your responsibility to find out why it hadn't been done?

A. Yes. I was told an incident report had been sent down to the risk management office.

Q. You were told a report had been sent?

A. Mm-hm.

Q. Who told you that?

A. The ward sister.

Q. Did you take that to be a written report?

A. I took that to be the untoward incident form that is completed when there's an untoward incident.

Q. Did you ever see that?
A. No, I didn't.
Q. So you didn't see that. You went to the meeting, the director of nursing wasn't there, you weren't deputising for her. Did you submit to the director of nursing or the risk management coordinator the notes you received from Sister Little of her interview with Staff Nurse Noble before the meeting?
A. No, because I didn't get them until after.
Q. You didn't get those until after?
A. No.
Q. So Sister Little is quite wrong in that regard as well?
A. My recollection is that I got those after the meeting.
Q. Let's have a look at what Sister Little said. It's at WS345/1, page 4. She's being asked about those five pages of handwritten notes. At 2(b) she says:
"I recall being asked and I strongly believe that the request came from my line manager, Mrs Margaret Doherty, in the absence of Sister Millar, to provide her with a resume of events which she required urgently for a meeting. I cannot recall the exact date when Mrs Margaret Doherty asked me to take these notes, however I believe it may have been 10 or 11 June 2001 as Sister Millar was off duty and I was in charge in her absence. This was the only time I was

involved in the case."
And she goes on:
"I believe that Mrs Margaret Doherty asked me to take these notes as she needed them for a meeting, which I believe was to take place on Monday 11 June 2001 at 2 pm."
A. The meeting was on the 12th.
Q. Quite right. And she goes on --
THE CHAIRMAN: But that apart, you see the point that's being made?
A. Oh, I can see the point there, yes. But I didn't get that information until after the meeting. I did not have anything except a wee notebook with me at the meeting.
MR STEWART: And when you got that information after the meeting from Sister Little, her handwritten notes, what did you do with them?
A. I put them in -- with my written information and sent that down to the risk management.
Q. You see, the information didn't come to us from risk management; it came to us from a file that was left in the back of an old cabinet.
A. I can't -- it wasn't in the back of my cabinet; it was right at the front of my cabinet. And that was 13 years ago in my office in the trust area --

Q. It came to us from an old cabinet.
A. Yes. But I mean I can't explain where it went after I'd left. But it was in the drawer and I did send everything down to risk management.
Q. What else did you send to risk management?
A. I sent down the whole little package, and in that package there was the -- no, I sent the report down. Didn't sent everything else down. I have to -- I correct myself. Because I wrote all that and I sent that down because that's the piece of paper I'd signed. The statements -- I think I must have kept them in that folder because I remember getting a note from Therese, saying that the inquest -- something, thank you for such-and-such a thing, and then about the nurses may not to go to the inquest. But I'd already told her I would like to go to the inquest.
Q. No --
A. I'm just saying there was a note in that package too from Therese Brown saying she would let me know when the inquest was.
Q. Let's just go back to the question: what did you send to Mrs Brown after the meeting?
A. The report.
Q. Did you send --
THE CHAIRMAN: Just for my clarification, when you say "the

report", is it the report that you were drawing up for yourself on the back of what Sister Little had sent you --
A. Yes. And the notes.
THE CHAIRMAN: -- or Sister Little's report?
A. No, no. Sister Little didn't make a report out for me.
THE CHAIRMAN: So just what you had put together?
A. Yes, from the notes and from the information that I --
MR STEWART: Why did you not send Sister Little's account of Staff Nurse Noble's engagement with this case?
A. I don't know. I just put the file on the side and sent that report down.
Q. What's the point of you asking Sister Little to get this for you if you're not going to do anything with it?
A. But I put that into the report.
Q. Well, you put one small bit in. It's at the top of page 2, and that's at 316-085-010:
"Staff Nurse Noble verbally reported to Sister Little that she had checked pupil reaction between 3 and 3.30 am, both pupils were equal and reacting to light."
But there was a great deal that Staff Nurse Noble was reported to have told Sister Little, which you might have put in. For example, shortly after midnight Raychel was thought perhaps to have been confused and

behaving funnily; would you not think that had been useful?

A. I didn't have that written down.

Q. Well, it came to us from you, and it appears --

A. It says here --

Q. -- at 316-085-013.

A. Appendix 23.

Q. You see at the bottom:

"Approximately 12.30 am, Fiona Bryce reported to Anne that Raychel was behaving funny, query confused."

A. I see it there, yes.

Q. Quite a number of things in this report which are relevant, which you didn't put in your report, and which you obviously should have passed on to the people conducting the investigation.

A. I should have, yes. I stand corrected.

Q. So why didn't you?

A. I don't know. I have no reason.

Q. You must have had a reason because you've asked this individual, a senior sister, to go and do this for you. Then you have no reason not to go something with it; why?

A. But I did do something with it. I kept that so that I could know what was happening, this is what that was all about. I had then be told that they were then all

giving their statements and that -- and I forgot about it. I must have forgotten about it in the drawer because I was then told that it was being taken over by risk management and I had no more involvement.

Q. You see, that would be all very well if these documents were your only means of finding out and knowing what was happening, but you were at the meeting.

A. Yes.

Q. You knew what was going on.

A. Some of it, yes. It was very confusing at that meeting.

Q. Did you go to the director of nursing and tell her what had happened at the meeting in her absence?

A. No.

Q. Why didn't you?

A. I have already said, because she had two people there, she wasn't there. If she'd been there I would have gone down out of respect and explained what had happened.

Q. Did you ask her if she wanted a briefing note?

A. No. I don't recall.

Q. So you just assumed that somebody else would do it and that --

A. No, I didn't assume somebody else would do it. I knew they were reporting back.

THE CHAIRMAN: Okay, just one final point on this. The risk management said that they wanted your report, the report

that you were doing; is that right?

A. It wasn't really a report, it was just for my own ...

THE CHAIRMAN: Your own note?

A. So that I could go and find out just what had taken place and look at everything else and investigate.

THE CHAIRMAN: Were you helped in doing that report by what had been sent up to you by Sister Little?

A. Well, I took it really from the charts and the notes. And then I got those sent to me, and I mean, that's -- and I copied them for this inquest as soon as I found them. Well, I didn't find them. As soon as they were found.

THE CHAIRMAN: Okay.

A. To be quite honest with you, I'd forgotten all about that, that I'd taken all that.

THE CHAIRMAN: Let me make it clear, I'm not surprised that, in 2013, you'd forgotten. I think what Mr Stewart was questioning you more about was what you had and forwarded to risk management in 2001.

A. Mm.

THE CHAIRMAN: And you had --

A. That report.

THE CHAIRMAN: You had more information than you provided to risk management, was really his question.

A. That was ... That wasn't done on purpose.

THE CHAIRMAN: Okay.

MR STEWART: Can we go back to your report again to look at the second page again at 316-085-010? Do you see that you've entered the information at the end, the information taken from notes and verbal statements from staff?

A. Mm.

Q. Which notes are you referring to?

A. Raychel's notes and anything that was in Raychel's notes that I could see was relevant to it.

Q. And which statements were you referring to?

A. That must have been these.

Q. That's just the verbal statement of Staff Nurse Noble as relayed via Sister Little?

A. Mm.

Q. Any others?

A. I don't think I -- I can't remember. I honestly can -- it's not there, but I can't ... That must have been from ... It's obviously that's from there.

Q. Did you ask anybody else to give you their recollection of what had happened?

A. I asked for any information from the staff that was on on the night that this occurred.

Q. When did you ask them?

A. I asked Sister Little for that information, and she had

rang up -- she rang up Ann Noble.
Q. So when she came back with information from one nurse only --
A. No, there's something about Sandra spoke to Bernie, but that's not in. I cannot -- I honestly can't remember.
Q. If you were mounting a little investigation of your own so that you are to be informed, presumably you'd want information from more than one nurse.
A. Yes.
Q. So did you get information from more than one nurse?
A. Well, if I had, it would be here. And I should have done, I should have had it.
Q. You're a very experienced nurse.
A. Mm-hm.
Q. You're in charge more or less of Ward 6. Here we have a case of a patient who, before the very eyes of the nurses on duty on the ward, deteriorates to the point where, to all intents and purposes, she dies. Surely your first question must be: what happened?
A. I did.
Q. "Bring me those nurses. Now tell me."
A. I did. I spoke to Sister Millar and I said, "What on earth happened?", and then I had to go to this and I said, "I'll be back", and that's why after the meeting I said to sister, "I want to speak to you".

Q. Did you get the nurses and speak to them?
A. It was taken out of my hands. It was all taken -- I have to be honest, it was all taken out of my hands. I wasn't even -- I didn't even go to the inquest. I mentioned that to you previous.
Q. I'm interested in what investigation you put in train of these nurses and what had happened because you have to go to the director of nursing and tell her what had happened so she can assure the board that nursing is satisfactory and appropriate in the trust.
A. Yes, and I totally agree with you.
Q. So what investigation did you put in train?
A. Well, I started to put in an investigation, I was told then that the report had to go down, I was then told it was the risk management that were taking it over, the management of this case.
Q. Well, why didn't you then send to risk management all the papers you had, including Sister Little's contribution?
A. I don't know. I honestly don't know.
THE CHAIRMAN: Can I ask it in another way? When you say it was all taken out of your hands, just to get this clear, are you regretting that it was all taken out of your hands?
A. Yes, yes, I am.

THE CHAIRMAN: Do you say that you should have had a more active role to investigate what went wrong?
A. Yes, I do.
THE CHAIRMAN: And what advantage do you think that would have given if you yourself had investigated more directly? Why do you think that might have been better?
A. Well, I don't know how to put this ...
THE CHAIRMAN: Take your time.
A. I've always, always through my whole nursing career, have been a patient's advocate. Patients always come first, the family. That's where your loyalties lie as a true nurse. And I wanted to -- I did want to be in on the investigation. Although when ... Then, later on, I took ill and had to have an operation and then came back to work, and I missed the second review because I was in hospital, and then, of course, I took really ill.
THE CHAIRMAN: Okay. I understand that and your own illness later affects the extent to which you can contribute or make suggestions. But let's go back to the start. When you say that you've always been a patient advocate and it's patients and family who come first, I want to be careful that I'm not reading too much into it and I want to be careful that I'm understanding clearly what you're saying.

Was it your concern that if something went to risk management that there might not be the same focus on the interests of the patient and the interests of the family as it would be if the investigation stayed with you?
A. Sorry, no. Could you ...
THE CHAIRMAN: When I asked you earlier, you said you had regretted that it had been taken out of your hands and had gone to risk management.
A. No, no, I would have liked to have been involved with risk management. I didn't want it all in my hands, but I did want to be involved.
THE CHAIRMAN: Okay. And why were you not involved with risk management?
A. I don't know. I honestly -- I mean, I ... Therese Brown said she would let me know when the inquest was. I mentioned to Ms Duddy and she said, no, she was going to the inquest and Therese was going and that was sufficient. I was needed.
MR STEWART: That's 2003. Let's just go back again to 2001 because a lot happens.
A. Yes, it did.
Q. One of the things that happened was that you went to your regular meeting with the director of nursing --
A. Mm-hm.
Q. -- which is a minuted, formal meeting.

A. Mm-hm.
Q. And then one happens on 5 July 2001.
A. Mm.
Q. There we are. You've found out what happened, you've written a report for yourself, you have given information to the risk management coordinator, you've been to the meeting, and now you're meeting with your director of nursing.
A. Mm-hm.
Q. And she had told the inquiry that there was no reference made at that meeting to Raychel Ferguson's case.
A. Mm.
Q. Why would that be?
A. Well, I have to agree with her, there wasn't. I mean, I'll be quite honest with you, I don't recall Raychel being brought up at any of our meetings.
Q. Do you agree that serious nursing issues were identified at the critical incident review which required attention?
A. Yes.
Q. These were essentially shortcomings that needed to be addressed?
A. Yes.
Q. Needed to be addressed in the interests of patients --
A. Yes.

Q. -- and their safety? So what are you doing about that with the director of nursing?
A. Oh, well, the director of nursing asked Anne Witherow, who was the clinical co-ordinator, to meet with myself and Sister Millar and I think Sister McKenna was there too, and we then -- but we'd already said that we were going to do a review of the fluid balance chart and everything. We had a big meeting there and we reviewed the fluid balance chart. We made another one, you know, we designed another one that we felt would be easier to complete and record on. We put it on a month's trial as an audit in Ward 6. After the month's trial I remember that we said we would now extend it to a year because it seemed to be working, so that was that.
Letters about documentation were sent out, there was a review of IV fluids, a new policy went out, and I adopted Ms Duddy's way of distributing policies, by putting a sheet on the front for all the sisters to sign that they had received their copy and have read this.
Q. What date was this?
A. I couldn't tell you the dates on them. I can't remember.
Q. I'm not sure the inquiry's seen that document either.
A. I sent the documents of the IV infusions in.
Q. Okay.

THE CHAIRMAN: We can check that over lunch.
MR STEWART: Can we just go back to 022-097-307? It is an update written by Mrs Brown for the benefit of the chief executive. You'll see at paragraph 4 she makes reference to a nursing meeting with yourself, Mrs Witherow, sisters Millar and Little, nursing staff and the nurse auxiliaries in Ward 6. Is that the meeting you were referring to?
A. No, no, that was to talk about the fluid balance management and how fluid balance charts should be correctly completed.
Q. I'm --
A. But we then -- following that meeting, we carried on.
Q. Okay. I'm interested in the meetings that the nurses had in the aftermath of Raychel's death and I'm interested in the documentation of these meetings. Do you remember this meeting? Where did it take place?
A. This took place on the ward, as far as I can remember.
Q. And did you take a note of it?
A. I'm sure I did. I took -- I'm sure I took notes of it, yes.
Q. Would you then have yourself given an update for the director of nursing in much the same way as Mrs Brown has done for the chief executive?
A. No. That would have been -- Anne would have related

back to the director of nursing.
Q. Okay. You say would have, but you don't know whether she did --
A. Oh, she did.
Q. I'm not sure whether I've seen that document either.
A. I didn't receive this myself.
Q. No, well, this is for the chief executive. What I'm interested in is what documentation you and Mrs Witherow created in relation to this meeting where these particular heads of agreement are reached.
A. You mean about the -- that there (indicating)? Well, we sat together and we just devised a fluid balance chart, sent that round for comments to everybody, to the doctors and to everybody else, and then when we received it back, then Anne would have made the corrections if it was agreed.
Q. Are you saying that you circulated this to the consultant paediatricians?
A. It would have been circulated to the nursing staff and to the paediatric consultants at the meeting, I'm sure.
Q. When you say "it would have been", are you saying that it was?
A. Well, I can't say for sure because this is 13 years ago.
Q. Because certainly there is nothing of that nature revealed to the inquiry.

A. But that was the process that we did. I mean, it would be circulated and comments would come back and then the form would be reviewed and updated.

THE CHAIRMAN: Okay. If we look at this, I'm looking at the relationship between 4 and 6. 4(a) says:

"The following has been agreed: fluid balance sheet must be correctly completed ..."

And so on.

A. Mm-hm.

THE CHAIRMAN: And 6 says:

"The fluid balance documentation currently in use will continue to be used. The documentation will be kept under review by Mrs Witherow."

A. Mm. That was the one that we were -- the trial.

THE CHAIRMAN: Okay, that's the trial. So paragraph 6 is referring to --

A. The trial documentation.

THE CHAIRMAN: -- the trial improved documentation and you were going to see how well that worked --

A. Mm-hm.

THE CHAIRMAN: -- and Mrs Witherow would keep that under review and if it needed to be tweaked again or improved again --

A. We'd have got together again, mm-hm.

MR STEWART: I wonder if we can have a look at another

document, which is 316-085-004, and it might be placed alongside this one.

Is this your handwriting, can I ask you first of all?

A. Yes.

Q. Could this document have been created by you in preparation for the meeting described at paragraph 4?

A. It could have been.

Q. Because certainly you're dealing with the fluid balance charts and exactly what they should contain and how they should be filled out, and you have made a note, in handwriting, as to the timeliness of a second U&E test and at the bottom you have written:

"SHO, JHO and [presumably] reg in surgery under pressure. No lead clinician in surgery."

A. Yes, now, that must have been reported to me. That must have been said to me by somebody because I've taken a note of that and that must have been for me to speak to somebody.

Q. Okay.

A. To speak to probably Dr ...

Q. Do you now remember when this note was made by you?

A. Do you know, I ... I think I may have done that from ... I think I may have done that from the clinical -- the critical incident.

Q. The critical incident review?

A. Yes, I might have ... You see ...

Q. Do you see the questions there posed at number 2:

"Same bag of Solution No. 18 --

A. That's what's making me think:

"-- recommenced post-operatively."

And:

"What solution was commenced at 200 --

Q. Because those look like questions you'd want to address at the review itself.

A. Yes. I can't make out the second -- on the last line, "if" ... Is that "if"?

Q. "If 3 litres erected, who prescribed third litre?"

That's about the actual fluids themselves.

A. I'll tell you what that is: that's probably what I've done after reading the notes.

Q. After you read the notes?

A. Mm.

Q. Would that be what you'd done after the meeting? Because that seems to be informed by the review meeting --

A. Yes.

Q. -- unlike your report, which doesn't seem to be informed by it.

A. No, the report was taken from the notes. That seems to

me to be from the meeting.

THE CHAIRMAN: What pressure were the doctors under in surgery?

A. Apparently there was a few emergency admissions that needed to go to theatre.

MR STEWART: This was at the time of Raychel's collapse, was it?

A. Mm. Yes, but I must have got that information there at that meeting.

THE CHAIRMAN: Sorry, just clarify it because Mr Stewart and I are not sure which time you're referring to. When it says about the doctors who are under pressure in surgery, is that at the time of Raychel's appendix being removed or is that after she's collapsed on Ward 6 in the early hours of Saturday morning?

A. I think that was when she collapsed. I'm not sure. I can't be certain because it's just a jot that I've made in my writing and I've had that written out.

THE CHAIRMAN: Then when it says, "No lead clinician in surgery", is that -- when Raychel collapsed, it wasn't surgery that was really being discussed, sure it wasn't.

A. No.

THE CHAIRMAN: So surely the reference to surgery --

A. But then again, you see, they couldn't be removed from surgery. I'm only surmising here. It says:

"The senior house officer and junior house officer and reg were in surgery under pressure, no lead clinician in surgery."

So they couldn't leave.

THE CHAIRMAN: And the effect of them not leaving was what?

A. They didn't get to the ward. I don't know. I don't really want to be quoted on saying anything like that because I don't know and I don't want it to be misread.

THE CHAIRMAN: I agree. I don't want you to start guessing what your note means.

A. Yes.

THE CHAIRMAN: I'm trying to get you to remember as best you can what your note means.

A. I wish I could. I really wish I could and I know I've jotted that down and I know someone must have just said that and I've written it down on there because that is my writing, that is my paper.

THE CHAIRMAN: Okay.

MR STEWART: Can we just see that right-hand page in its full size, please? You see the bottom left-hand corner, that page has come to us from the DLS. That page wasn't in your file that was recovered from the old cabinet.

A. Sorry?

Q. Can you explain how this page was not in your old file?

A. I don't know. I don't know because I don't even know

why my file would have gone missing. I don't know why it was missing for 13 years, for all those years.

THE CHAIRMAN: Mr Stewart, it's 1.30. We'll break.

We are going to break for lunch. I'm sorry this morning has been a bit up and down for everybody, that we haven't quite kept to the timetable as we have been doing for the last few weeks. We'll finish your evidence this afternoon. I know you've come some distance and I want you to have a chance to get a bite to eat. Can we start again at 2.20? Is that okay, 50 minutes?

A. Yes.

THE CHAIRMAN: Thank you very much.

(1.30 pm)

(The Short Adjournment)

(2.20 pm)

MR STEWART: Mrs Doherty, looking back now after the review, were you able to identify nursing issues that you thought required attention?

A. Yes.

Q. What were those?

A. Well, the completion of the fluid balance charts, to start with, and the kardex -- well, I call it the kardex -- but the patients' charts, you know, the patients' information sheets, and also the continuation

sheets where the nurses write information so that the next nurse that comes on knows exactly what's happening.

Q. Were you able to incorporate any of that information into the education of nurses in Ward 6?

A. We had quite a few meetings with the staff to see how they felt, but these weren't minuted; this was just me going on to the ward and suggesting to the senior staff that we should discuss with the nurses where they needed training. And I mean, apart from that also, the IPRs would have also told us where they needed training too, that was the individual performance reviews. But at that specific time I just felt they really needed an awful lot of information on how documentation should be presented.

Q. Because one of your responsibilities was the induction courses given to nurses when they took up their posts.

A. Mm.

Q. And in fact it was a teaching hospital?

A. It is.

Q. And it was used for teaching, not only medical students, undergraduate students, but nursing students. I wonder can I ask you about this, this was something you exhibited to your witness statement. It's a copy of the benchmarking exercise undertaken by the Altnagelvin Hospital in November 2000.

A. Yes.

Q. And at page WS336/1, page 67, this compared and contrasted Altnagelvin against other hospitals in the north of Ireland -- there's Craigavon, Antrim, Ulster. What it concluded was that Altnagelvin had a significantly lower percentage of qualified staff within the children's unit compared to the other hospitals benchmarked.

A. Yes.

Q. And you can see there it is 76 per cent and the others are well over 80 per cent.

A. Mm-hm.

Q. Did this highlight to you the necessity to incorporate ongoing education?

A. Yes, of course, but the 76 per cent of qualified staff that's represented there, it -- we had an ongoing problem of recruitment at that time, and we -- if you look at the other part of the benchmarking -- had also stated that we had the higher number of staff per bed than the other hospitals. So we couldn't recruit qualified paediatric nurses, children's nurses, because they seemed to stay in the Belfast area or go across to the mainland.

Q. Does that not emphasise the point I was trying to make, that you should then be educating those nurses you have

who are not qualified?
A. Those nurses were being educated. When I took over the children's ward, you'd know that the Beverley Allitt inquiry had been ongoing, and it stated there quite clearly that at all times there should be two whole time equivalent paediatric nurses, trained nurses, and that was our aim. And we reached that aim before 2000, well before 2000. However, to maintain that number of qualified nurses we sent our children's nurses that weren't qualified as children's nurses -- the staff nurses within the children's ward that were state registered, we sent them on courses, on training, to become registered children's nurses.

We also advertised very, very frequently -- nearly every other month we had advertisements in the papers for qualified paediatric nurses. We then advertised for staff -- registered nurses who had an interest in children's nursing so that we could then retrain those as paediatric nurses. Failing that, we then decided we would get nursery nurses in and we advertised for nursery nurses, and we did get, I think, three or four.

Following that then, the trust recruited Filipino nurses because we were getting so short staffed, but if you look at the benchmarking you will see that the staffing on Ward 6 and the unit, you know, related to

it, was very well staffed.
Q. Yes, I'm not talking about the quantity of staff, but really the extent to which the staff that were deployed were informed. Can we go to WS336/1, page 14? There you're asked about the guidance given to nursing staff back in June 2001 in respect of:

"(a) monitoring and recording of post-operative fluid balance."

And you indicate there that:

"Whilst there was not a policy, nonetheless the induction on to the ward covered the maintenance of fluid balance charts and student nurses were also taught the importance of these charts throughout their training and how to complete them correctly."

A. Yes.
Q. We have seen, Mrs Doherty, that the fluid balance charts were not completed correctly --
A. No.
Q. -- in this instance.
A. No, they weren't.
Q. So the obvious question is: what went wrong with the teaching if it didn't actually find effect in practice?
A. Well, nurses are taught from the minute they start nursing about fluid balance charts and how to document and everything, and you are taught that all the way

through your training. Even when you're on placement in wards they're taught it, and they were inducted into how to complete a fluid balance chart. I can't explain why they didn't fill that in correctly. However I did speak very sharply, as you mentioned earlier -- and now I'll say how sharply. I spoke very sharply to those nurses, I told them that they would be retrained in fluid balance charts. I also spoke very sharply to the sister of the ward. But following that then, I had to step back because I was not reviewing the situation. But they knew exactly what they had to do.
Q. You say you spoke sharply to them after the event. Did you have any prior warning, prior warning before June 2001, that the fluid balance charts were not being completed properly?
A. If I had had warning before, I would have spoken before to them. I would have brought it up at the sisters' meeting, and I am sure I did bring it up on many occasions at the sisters' meetings, if I could find the records -- I did bring up about the importance of completing charts correctly and timely.
Q. I wonder can we see, please, WS323/1, page 45? This comes also from that benchmarking exercise, November 2000. You can see this is about fluid balance charts, amongst other things, the second section:

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

Second bullet point:

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

A. That's terrible.
Q. Yes. This is seven months before Raychel. I assume this benchmarking report came to you.
A. Yes.
Q. There was an area that needed to be addressed, that area was the fluid balance chart, what did you do about it?
A. I had brought that up at the sisters' meeting to all of the sisters when I got that benchmarking because it was about all of the wards, but it was particularly about this ward here, and I brought it up to all of them and I spoke very, very straight.
Q. You speak to these people sharply after the event, but seven months before the event this is flagged up to you as something that needs addressed?
A. No, what I said just then was I brought this up then at the sisters' meeting about the benchmarking and we went through this thoroughly and I told them quite clearly at the sisters' meeting to ensure that the charts had been filled in correctly.
Q. And what steps did you take --

A. Speak to the staff and see what training they need.
Q. What steps did you take to make sure that the sisters had put into effect your instruction?
A. Obviously I'd have been going round the wards too and looking, but I can't remember exactly. But I do remember the strictness that I had about fluid balance charts because I know how important they are.
THE CHAIRMAN: Let me just clarify something with you because I want to contrast two answers. You said a few minutes ago that you had spoken sharply to the nurses after Raychel's death about completing charts correctly, but that you had to step back because you weren't reviewing the situation.
A. When I say "reviewing", I wasn't investigating the situation.
THE CHAIRMAN: Okay. So you weren't investigating, but you knew --
A. But that was a nursing issue.
THE CHAIRMAN: But there was a nursing issue which you were aware of, but you said you had to step back. Seven months before Raychel's death, when you get a benchmark report which -- in some respects, not in every respect, but in some respects -- is a wee bit disappointing, at that time you didn't have to step back.
A. No.

THE CHAIRMAN: At that time you could be as strong and interventionist as you wanted because you had specific responsibility.
A. Yes.
THE CHAIRMAN: So beyond speaking to the sisters at the sisters' meeting about the poor result, how did you follow up on that?
A. Well, I would have expected the sisters to go back and address the staff. I would have expected the sisters to have monitored it for me and come back and reported to me. I can't exactly remember who came back and who didn't, but I do know that if it had been ongoing, I would have certainly stepped in again, but I had a big remit.
THE CHAIRMAN: I understand.
A. And I had --
THE CHAIRMAN: I think unfortunately, what appears is that looking at it from a different angle -- and I want you to comment on whether this is unfair -- there's a report some seven months before Raychel's treatment, which says that the standard of recording of information on charts is disappointing.
A. Mm-hm.
THE CHAIRMAN: You take steps that you have just summarised to try to make sure that's improved, and in June 2001 it

remains a problem.
A. Mm.
THE CHAIRMAN: And if you were Mr and Mrs Ferguson, you might think "That suggests that actually nothing much changed in between".
A. Oh, but there was a big change in some of the places. I can't say about the children's ward, but there was. On this occasion --
THE CHAIRMAN: In this area do you understand the suspicion that in fact not sufficient was done?
A. No, not sufficient was done and I should have stepped in. I have to agree with you.
THE CHAIRMAN: Thank you.
MR STEWART: I wonder can we go back, please, to WS336/1, page 14? This is again the question which was posed to you in respect of the guidance provided to the nursing staff prior to June 2001. Towards the bottom of the page in relation to monitoring, (h):
"What guidance was given to nursing staff in relation to updating, amending and compiling nursing care plans and episodic care plans?"
You have indicated:
"With reference to (b) above, sections 11(h) were all addressed through the ward induction programme."
So you seem to be telling us that updating,

amending, compiling episodic care plans was dealt with at induction.
A. I also said that they had mentors and that the mentors would teach them and guide them as they were -- you know, as they came across things.
Q. Several deficiencies in the episodic care plan have been found. And it wasn't updated properly, it made no reference to post-operative nausea or vomiting. There was no reference to one of the anti-emetic medications that was given. It doesn't completely record the vomiting. So the episodic care plan was not updated and it wasn't accurate.
A. I didn't see that care plan, but I'm very disappointed to hear that.
Q. If you've got a system in place whereby nurses are trained in relation to this and there's mentoring, what went wrong with the mentoring and the training?
A. I can't say. I can't say.
Q. You see --
A. They should have been disciplined.
Q. If you can't say, who can say?
A. This is 13 years ago. I can't remember everything that happened.
THE CHAIRMAN: There's an impression about the care planning, the care planning documentation, that

a problem might have been that this system which you were operating at the time about having then on computer rather than at the end of the bed, might not have worked terribly well. Is that --

A. It may not have done. I'll be quite honest with you, I'd have preferred the written documentation rather than the computer because the written documentation -- you could write everything.

THE CHAIRMAN: Did you go back to the written documentation or did you stay on computer after 2001?

A. It remained on computerised.

THE CHAIRMAN: It remained on computer so that you couldn't go to the end of a child's bed and see the care plan?

A. No, I don't think -- no, we didn't have them at the end of the bed, the care plans. Charts, you know, were at the end of the bed, but not the care plan.

THE CHAIRMAN: So potentially, on a worst-case scenario, the gaps in this that are that a doctor who's called to the bedside of a child won't have a care plan immediately before him or her, they have to go back to the station because it's on the computer there and not at the end of the bed.

A. Probably, yes.

THE CHAIRMAN: And it means that if a nurse who's on the ward wants to see the care plan, they too have to go to

the station to the computer; is that right?

A. Mm-hm, but there were three stations on the ward.

THE CHAIRMAN: Yes, okay. This is an issue which goes beyond Raychel.

A. Yes.

THE CHAIRMAN: Would you have still have been in the old-fashioned camp that you would like a written care plan at the end of the bed?

A. Yes, I would to be quite honest with you, because you write everything when the doctor attended, what he prescribed. Everything would be there.

THE CHAIRMAN: And why was that system moved away from?

A. Because of the DM Nurse.

THE CHAIRMAN: Because of the --

A. The computer system being introduced.

THE CHAIRMAN: And the view was taken this should be better?

A. This is moving forward.

THE CHAIRMAN: But in your view, on this occasion, moving forward didn't actually mean moving forward?

A. No, not to me.

THE CHAIRMAN: Okay.

MR STEWART: Did you have any prior warning, warning prior to June 2001, that there was a need to update and to change the episodic care plans in line with the patient and the treatment?

A. Sorry, can you repeat?

Q. Did you have any prior warning, warning prior to June 2001, that there were areas of deficiency in the episodic care plan which required change?

A. No, not really.

Q. I'm just going to go back, if we may, to the same benchmarking exercise that was brought to your attention in November of the preceding year, to page WS323/1, page 50.

This is all about Ward 6 and we go down to the third paragraph:

"It will be necessary to make nurses aware of the need to update and change care plans when there is a change in treatment and not just evaluate."

A. Mm-hm.

Q. So what did you do about that?

A. I would have brought that to their attention, I'm sure of it.

Q. It's all very well just bringing things to people's attention. But in order to effect a change you have to actually attend upon it --

A. Yes.

Q. -- and make sure there is a change.

A. Yes.

Q. What did you do?

A. I had H grades, who were in management situations at that time. I had F grades and G grades on that ward. And when I went to meet with them and said, "This has to change", and, "I want this, this, and this done", and then went back to check that it was done, that they've spoken to the staff and that they have educated them in how they should be doing it, then I take their word unless I see something myself or somebody from the ward face tells me this isn't working and then I go back and readdress it.

Q. But if you have a system of delegation where in effect you wash your hands of something once you have told someone about it --

A. No, I'm not washing my hands.

Q. -- you must have a system whereby you can check, otherwise you might be deluding yourself and others.

A. No. I was not washing my hands of anything. I was very into the wards, I was doing ward rounds, I was speaking to patients, I was speaking to members of staff, I had an open-door policy. I worked extra hours and I did not wash my hands of anything.

THE CHAIRMAN: Just in fairness so that you understand this questioning, because the conclusion at the bottom of this page, just for the record, it confirms that:

"This study demonstrated that the standard of care

was high --
A. But there were also areas of weakness.
THE CHAIRMAN: -- but there were also areas of weakness."
And that is what you would expect in any benchmarking exercise because you won't test any system without finding some areas of weakness. It's those areas of weakness which then need to be addressed. The disappointing thing is the hospital, having then gone to the trouble of organising this benchmarking exercise and putting some time and effort into it, we then find some months later that the care plan hasn't been kept to quite the standard that would have been expected and that the fluid balance charts haven't been kept to the --
A. I'm very, very annoyed about that myself. I really am, because I did go back and back, and I would have expected that to have been raised. Short of just going round and checking every care plan and every chart ...
THE CHAIRMAN: Thank you.
MR STEWART: Do you remember in 1999/2000, a major documentation audit throughout Altnagelvin Hospital?
A. I'm trying to ... 1999/2000. Which one was that one?
Q. It looked at, amongst other things, nursing records, medical records and --
A. Yes, yes, I remember that.

Q. And it in fact was reported in the clinical audit report, which covered the years 1999 to 2001. And just to refresh your memory, that appears at 321-068-002. That's the cover page. If we go to page 006, this is part of the nursing audit, and these are the key issues arising from that audit. Question 5 is all about individualised care planning:
"Has the care plan been individualised?"
You run down this and see "compliance", 44 per cent compliance and as low as 27 per cent. That looks as though the care planning is not being individualised properly.
A. No.
Q. And nothing is being done to correct any deficiencies in this. Would this audit have come to your attention?
A. I can't remember seeing that one. This is Ward 6, is it?
Q. Yes, indeed. This is nursing throughout the hospital.
A. Throughout the hospital?
Q. Yes.
A. Well, I'm sure it did come -- I'm sure I must have seen it.
Q. If you saw that and you saw --
A. Because it --
Q. -- reference to such a low compliance percentage, you'd

have wanted to know --
A. Why.
Q. -- what was being done on Ward 6?
A. Mm-hm, mm-hm.
Q. And if it had previously or simultaneously come to your attention during the benchmarking exercise, would that not have flagged it up to you as an issue that required immediate attention?
A. I'm sure I did give it immediate attention.
Q. Can we just go back a page in this document to 005, which is another question, 2 and 2(b), the named nurse:
"Is there a named nurse for the patient, how much input into the patient's care does the named nurse have? The Patients' Charter states that the patient should be allocated a named nurse who will have a major input into their care.
"Compliance. 83 per cent of patients appeared to be allocated a named nurse on admission with 84 per cent of those patients having almost no contact with their named nurse."
In this case, I think Staff Nurse Patterson was named, but then she went off duty, so as you say, in your own witness statement, there was low compliance --
A. That's right.
Q. -- with this notion. But there was a protocol, wasn't

there?
A. There was, but it was very difficult to implement because you had them on 12-hour shifts at that time and that meant they were working only three and a half days a week. And how could you -- I mean, the patient would come in, they'd be allocated a named nurse of somebody on duty that day, and as I said in my statement, the next day she could be off duty. It was impossible to implement that.
THE CHAIRMAN: So in fact, you would say this isn't an example of poor compliance with a protocol, this is an example of a protocol which actually doesn't make much sense.
A. No. It was -- I mean, if the patient came in and the staff were working for, say, three days, and the patient was discharged then, that patient had a named nurse. But if that patient came in and the nurse was going off duty that night, she wasn't the named nurse the next day, but what you were supposed to have had was somebody who was on the opposite of your shift to take over as that named nurse. But to be quite honest, it didn't really work.
THE CHAIRMAN: And did it remain the system?
A. We had to -- well, we changed staff duties as well then because I started to bring in part-time staff and

I started to change our system so that the nurses would be on duty long -- you know, maybe more days, but not for as long periods.

THE CHAIRMAN: Right.

MR STEWART: Can we just look at the protocol to see the wording of it? 317-042-001. It's dated February 1994 and it starts:

"The named nurse/midwife represents the minimum standard acceptable within the directorate of patient services, Altnagelvin Group of Hospitals."

Second paragraph:

"Patients attending Altnagelvin Hospital either as an inpatient or outpatient should be allocated a named nurse to plan and coordinate their care from admission to discharge."

A. Mm.

Q. Can I ask: if a protocol is decided upon and issued by a director, under what circumstances do you then decide to just ignore it because it's --

A. It wasn't ignored.

Q. Well, do you then go back and say, "Let's amend this protocol, let's repeal it"? Do you just simply let it go by the wayside and have a paltry compliance with it? How do you approach protocols if they are not possible?

A. I remember that report coming out and I remember the

meeting that we sat with Ms Ryan and discussed it and said it was impossible, but this was in a report and named nurses should be there and named midwives, and it was the protocol. And we did our best to implement it. But as I say, 12-hour shifts and three-and-a-half days, and granted they didn't even work three-and-a-half days sometimes. It was quite a long time to work 36, 37 hours on the go. They would have split days off, they might have only worked two days and had two days off and come back for one-and-a-half days. It was impossible, impossible -- well, virtually impossible to be a named nurse. You would have a named nurse, that's why I brought in part-time staff so that there was a link and that you would have the full-time nurse would be the named nurse and the part-time nurse would be the link between the two.

Q. I'm interested in what you did with the protocol and the performance --

A. That's how I made that work.

Q. I can understand it was very difficult in practice to achieve this, but this is important --

A. Oh, it is.

Q. -- because this is something that was given to all patients as a right by the government.

A. Mm, under the Patients' Charter.

Q. Indeed. And let's have a look at that. It's 306-085-010:

"New rights. As part of the charter programme the government has introduced four important new rights for hospital patients."

Second one:

"A named nurse."

And that was 1992.

A. Yes.

Q. So I assume that your protocol in 1994 followed that in order to give effect to it.

A. Mm-hm. And we did our utmost to bring that in.

THE CHAIRMAN: Since you're now retired from the Health Service, do you feel free to say that this is the government promising something which couldn't be delivered?

A. Yes, I would.

THE CHAIRMAN: Okay. Well, what was the problem or the weakness which the government was trying to address?

A. They wanted to have somebody, to relate back to a named nurse would be -- if anything had gone wrong that named nurse would be the person that you'd go to or that the relatives could go and speak to about the care that their child or their mother and father were receiving.

THE CHAIRMAN: So the intention is fine?

A. Mm-hm, oh, the intention was very good. It's just we didn't have enough staff.

THE CHAIRMAN: Well, you couldn't possibly have enough staff because by the time nurses have --

A. Days off, annual leave, sick leave.

THE CHAIRMAN: From what you're saying to me, from your perspective, that system couldn't work.

A. No.

THE CHAIRMAN: So --

A. But it was brought --

THE CHAIRMAN: When you retired was that system still in force?

A. Named nurse? Yes, and there was a named consultant as well at the time.

THE CHAIRMAN: Okay. How might it be changed or improved?

A. If they could have ... I'd have to really think this one out now -- I've been out of it for so long -- and see how it would work. But if they had an identified contact nurse, that that nurse -- maybe one of the senior nurses -- was in charge of so many patients and the nurses in that area reported to that nurse so that should relatives or anybody need to speak to somebody and the nurse that was caring for their relative at the time wasn't there, you know, could identify with this lead nurse. Do you know what I mean? If you've got

a ward and you divide it into sections and say there's six patients there, six patients there, you had one nurse that should somebody want to have any information, she would have all the information. It used to be the ward sister knew everybody, everything about every patient. I know that's what it was like when I was a ward sister.

THE CHAIRMAN: Yes.

A. And the relatives would be directed to the ward sister and she would be able to say what was happening with the patient, what tests were about to be done, everything. But then it got, I suppose, so wide, the area of responsibility, that it took more people. And that's where you lose --

THE CHAIRMAN: You mean the ward sister's responsibility got so wide, so she knew a bit less about the patients who were on the ward?

A. I would say a bit less, yes. She wouldn't be so involved with each patient. She would know all about each patient, but she wouldn't be that involved. She wouldn't be like, you know, I would be, when I was a ward sister, I would be nursing the patients as well. So I would know them all very well.

THE CHAIRMAN: I'm not sure if we can go much further than this, but one of the frustrations that I understand the

Fergusons have is that they felt they weren't being listened to and they felt there wasn't enough recognition of what was going on on the ward. If there had been a named nurse, or some other person with a similar title who they could have gone to to say, "Look, you're Raychel's named nurse, these are the problems that we see and nobody seems to be doing anything about them, nobody seems to have recognised them", that might make it easier for a family in the position of Mr and Mrs Ferguson to be able to speak to somebody who could expect to be able to help them.

A. I understand what you're saying.

THE CHAIRMAN: I'm afraid that's not what happened.

A. I know they spoke with the sister, did they? Why did they not ask to speak to me?

THE CHAIRMAN: I'm not sure if the Fergusons knew who to ask to speak to because they were -- part of their concern -- and Mr Coyle will correct me if this is a wrong summary -- was they felt the nurses were not responding to the concerns which they had about Raychel and to her deterioration. Is that a fair --

MR COYLE: That's one of the concerns the family had, sir, about vomiting and the child's general condition.

THE CHAIRMAN: I think that's where the government's idea comes from about having a named nurse.

A. To have them to talk to, yes. But when you're working 12-hour shifts, it's impossible.

THE CHAIRMAN: I can understand what the government is aiming at. I also understand entirely why there are severe limitations on that system working properly.

A. On the entrance to the children's ward, I had a big board put up with everybody's photograph on, all the members of staff that were on that ward, so that nobody came near a child that wasn't a member of staff and that you didn't recognise. My photograph was up there and my title. You know, I would have had an open-door policy for -- I would speak to anybody.

THE CHAIRMAN: Okay.

MR STEWART: Indeed, Professor Swainson makes the point. He says that had there been a named nurse, it might have allowed better communication with Mr and Mrs Ferguson.

A. Mm. Well, they had a named nurse, but it was in name only.

Q. In name only?

A. Yes.

Q. Had there been one, perhaps they would have known who to speak to.

A. Well, there were other staff that they could have asked to speak to me, to contact me, because I would have even come to the ward.

Q. I wonder can we look again at the protocol itself, which is at 317-042-001? This is the final paragraph. So you find yourself unable to comply with the right granted to patients and the government diktat. The last paragraph here says:

"Each ward or department has a responsibility to produce its own guidelines and establish their own standard on the implementation of the named nurse and ensure audit on a yearly basis."

So if you found yourselves unable to comply with the Altnagelvin protocol, all you had to do was to amend it, apply your own standards by way of guidelines and see that they were audited. Was that considered?

A. I did. I brought in part-time staff that would be the links --

Q. No, sorry, did you produce your own guidelines and establish your own standards that you could comply with?

A. I didn't make guidelines, no. I discussed it with the staff and that's how we did it on every ward.

Q. Because one of your specific job responsibilities -- if we go back to your job description and responsibilities again to WS336/1, page 46 and page 47, side by side. You'll see there at paragraph 2.12 on the left-hand side it is your responsibility:

"To ensure compliance with trust policies and

maintenance of statutory requirements as laid down by ..."

And the next page at the top, paragraph 3.3, it is your responsibility:

"To ensure that directorate and trust policies are implemented in the process of establishing and monitoring standards of service provision."

So I suggest to you that your job responsibility makes it fairly clear that you should have been adhering to this protocol and actually getting your own guidelines and standards if you couldn't comply with these.

A. I should have put it into guidelines, but I did have linked nurses on every ward and in the midwifery department and the children's ward, but I should have made it into guidelines and I failed there, but it was in practice.

Q. It was in practice?

A. Yes.

Q. Did you commit to writing any of your communication or information in relation to Raychel after that meeting of the 7th, or rather after the nurses' meeting which was noted in the 9 July update? After 9 July were you engaged in anything --

A. I wasn't engaged in that at 9 July. I wasn't invited to

that.

Q. Sorry, I beg your pardon, the update I'm talking about is that document we looked at earlier at 022-097-307. That's the 9 July update which refers back to a nursing meeting. Just to refresh your memory, there's the nursing meeting that you're at with Mrs Witherow and all the others.

A. Oh, you mean the meeting with Anne Witherow? Did I put it into writing?

Q. No, after that, did you put anything into writing relating to Raychel's case?

A. No.

Q. You received -- I think you mentioned it earlier -- a note from Mrs Brown to indicate to you that the inquest was going to happen but that no nurses were required.

A. Mm.

Q. I think that's at 316-085-003.

A. That's the one.

Q. Mrs Brown's note to you:

"Margaret, just to let you know that Raychel Ferguson's inquest is on 10 and 11 April."

That's 2002:

"None of the nursing staff have been asked to attend. I will keep you advised."

Were you surprised that none of the nursing staff were going to be asked to give evidence at the inquest?

A. Yes.

Q. Why did it surprise you?

A. Because of the fluid balance charts and things like that. I thought that would be raised.

Q. When did you first become aware that nurses were going to have to give evidence?

A. It was quite a while after that. Ms Duddy informed me that they were to go. I think it was the time --

Q. Sorry?

A. Ms Duddy, the director of nursing, informed me. It wasn't Therese that informed me then, it was Ms Duddy that informed me and I think that was the time I met her on the corridor and I said I want to go to that, asked Therese to mention to you that I want to go to that and that's when Ms Duddy told me that she was going and Therese was going.

Q. Did Ms Duddy go to the inquest?

A. Yes, as far as I know.

Q. You didn't?

A. No. I wasn't --

Q. Do you know why the nurses were asked to go to the inquest? Why it was then decided they should attend the inquest?

A. I think it was because of documentation. I can't remember fully the conversation Ms Duddy and I had, but I asked why were they going suddenly, and I think she mentioned -- I think it was the documentation.

MR STEWART: I see. Thank you, Mrs Doherty. I have no further questions.

THE CHAIRMAN: There's one issue I'm not very clear about. You said that you wanted to be involved with risk management, but you weren't.

A. No, I would have liked to have been involved.

THE CHAIRMAN: Yes, but you weren't actually involved. You then went on to tell me that apart from not going to the inquest, you had been involved in working with a new fluid balance chart, which was tried out, and then drawing up a new IV fluids policy.

A. I wasn't involved in the IV fluid, no. That was Ms Duddy, I think. She had a group.

THE CHAIRMAN: If the answer to your concern was, look, everybody can't be involved in everything, we've got a team of managers at different levels here; is there any particular contribution that you think you could have made or are you satisfied that even though you weren't directly involved in this, there was action taken afterwards which was positive and helpful?

A. Oh yes, oh yes. I know there was positive action.

I don't mean to say I would have made a great difference, but it was my directorate and I did feel that I should know more about what had happened, what lessons could be learned, what I could do personally. Just, you know, for that reason, and ...

THE CHAIRMAN: Right. The reason that some nurses did go to the inquest was because they were challenging the view which had been given to the coroner that Raychel's vomiting had been severe and prolonged. Did --

A. They were challenging about the vomiting?

THE CHAIRMAN: Yes.

A. I didn't know that.

THE CHAIRMAN: There was a report to the coroner that said that Raychel had suffered from prolonged and severe vomiting, and the Directorate of Legal Services wrote to the coroner to say that that view was challenged and that it would be appropriate for the coroner to hear from nurses. And it was that step which led to the nurses giving evidence.

A. Mm.

THE CHAIRMAN: You didn't hear about that?

A. No, I didn't.

THE CHAIRMAN: Were you unaware of it until I just told you?

A. Mm. I thought it was the documentation of the charts. But having said that, the inquest ... No, that

didn't -- that was before. I'm just thinking -- no, I wasn't there from 2003. So it could have been after that and it could have been when I was off with surgical procedures.

THE CHAIRMAN: But again, we'll hear more about this perhaps over the next few days, but if it was your directorate and the nurses were giving evidence about a specific issue, unless you were off sick at that time when the decision was taken, it's something you might have been expected to know about?

A. Mm.

THE CHAIRMAN: Okay. Mr Coyle?

MR STEWART: Sir, I have one question arising.

THE CHAIRMAN: Of course.

MR STEWART: Can you recall now when you were off work --

A. Yes.

Q. -- with your illness?

A. I know when I was off, yes. Do you want to know the dates?

THE CHAIRMAN: Yes.

A. Oh yes, definitely. I went off -- the first time I had acute cholecystitis and had to have a cholecystectomy.

THE CHAIRMAN: I --

A. You don't want to know why? Fair enough.

THE CHAIRMAN: Frankly, it's not our business. If you were

off work, you were off work for a good reason, so don't feel obliged to tell us the details. What Mr Stewart was asking for was the periods when you were off.

A. I was off from ... I was -- 4 April.

THE CHAIRMAN: In 2002?

A. 2002 until the end of June 2002. And the following time I was off from ... I had my operation again on 4 April 2003 and I retired then in 2004. I didn't come back because I had ...

THE CHAIRMAN: Thank you very much.

MR STEWART: And after the Department of Health published its guidelines on the prevention of hyponatraemia in children, an IV fluid therapy policy consensus statement was put out in your directorate.

A. Mm.

Q. And can we go to 077-004-005? This is it. I'm not entirely certain of the date, it does look like May 2002, which of course was --

A. Could have been before --

Q. -- you were on sick leave?

A. I went on sick leave on the 4th, the day I was admitted to hospital.

Q. We can see you're signing there.

A. Mm-hm.

Q. There appears to be no attempt for Dr Martin to sign

that as clinical director of the directorate.

A. No.

Q. So it would look as though you --

A. Almost all the paediatricians and the surgeons and the --

Q. Surgeons, anaesthetists, paediatricians --

A. Yes.

Q. -- and a pharmacist and you.

A. Mm. I may have signed that when I came back, you know.

Q. It isn't dated.

A. Mm.

MR STEWART: Thank you.

THE CHAIRMAN: Mr Coyle, is there anything?

MR COYLE: No, sir.

THE CHAIRMAN: No questions from the floor?

Questions from MS GOLLOP

MS GOLLOP: Can I just get clear in my mind to whom you sent the document that you compiled after the critical incident meeting on 12 June? You sent it to Therese Brown; is that right?

A. I think so, yes.

Q. Did you send it to anybody else?

A. No, I couldn't recall whether it was to the director of nursing or to the risk management team. But then when I got my memory back, so to speak, Irene was off, so

it would have been to the risk management. But I knew I sent it to somebody because there was a signature place and a copy for me.

Q. Did you go to the meeting on 3 September 2001 between the doctors and the nurses and Mrs Ferguson?

A. No, I wasn't invited.

Q. Last question. At the end of 2002, while you were at work, the trust obtained an expert report, and one of the things the expert wanted to know was further details about relevant nursing and medical procedures and management in relation to fluid administration and post-operative monitoring of fluid intake, urine output and other losses such as vomiting. Did anybody come and ask you about that?

A. No.

MS GOLLOP: Thank you.

THE CHAIRMAN: Unless there's anything else, Mr Lavery, Mr Stitt? Mr Campbell?

Thank you very much for coming, and unless there's anything more that we haven't asked you, you're now free to leave.

A. Thank you very much.

(The witness withdrew)

THE CHAIRMAN: Ladies and gentlemen, that brings an end to today's evidence. We've got doctors Jenkins and McCord

tomorrow. I think that the intention is to take Dr Jenkins first, if that can be arranged, from 10 o'clock. Thank you very much.

(3.13 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X