

Monday, 9 September 2013

1  
2 (10.00 am)  
3 (Delay in proceedings)  
4 (11.08 am)  
5 THE CHAIRMAN: Good morning, ladies and gentlemen, I'm sorry  
6 we are starting a little late. There was some business,  
7 which developed from Friday afternoon that we had to  
8 sort out before we heard from Mrs Doherty.  
9 MRS ANNE DOHERTY (called)  
10 Questions from MR ANDERSON  
11 MR ANDERSON: You have been kind enough to provide the  
12 inquiry with a witness statement. That has been given  
13 the number 325/1 and it's dated 29 August 2013. Are you  
14 content that that should be entered as part of your  
15 evidence into the inquiry? Obviously subject to  
16 anything you wish to say today.  
17 A. I'm happy.  
18 Q. You have recently made an amendment to the witness  
19 statement, which we've taken account of, and that's the  
20 amendment to question 8(j). We won't call it up now,  
21 but we've accepted that correction and that is now  
22 entered in as part of your witness statement, so that  
23 correction has been taken into account.  
24 You've also provided a CV to the inquiry and, if  
25 this can be brought up, it is at 317-043-001.

1

1 Q. You then completed an RGN professional development  
2 degree in 1992. That's obviously a nursing --  
3 A. It was a nursing-based qualification.  
4 Q. Could you explain what the professional development part  
5 of that is? Just what is involved in that?  
6 A. It was a nursing-based qualification involving different  
7 aspects. We had the social aspect of things, the  
8 psychological aspect of it.  
9 Q. Okay.  
10 A. That would have been the ...  
11 Q. Okay. It was then, from about 2001, that you began to  
12 provide support to the patient advocate, and I believe  
13 that was initially for two days a week.  
14 A. That's right, two days a week.  
15 Q. That then developed further and you became patient  
16 advocate in September 2000. First, as I understand it,  
17 was on a part-time basis and then, from 2001 you became  
18 full-time.  
19 A. That's correct.  
20 Q. And were you acting full-time at the time that Raychel  
21 was admitted?  
22 A. From 1 September.  
23 Q. 1 September?  
24 A. 1 September.  
25 Q. Okay. I wonder, considering the role, if I may,

3

1 This obviously sets out your career history and  
2 qualifications and we can see from that -- and if we can  
3 go through them -- that you qualified in 1968 as  
4 a registered general nurse. Indeed, you did your  
5 training in Altnagelvin; is that right?  
6 A. That's right.  
7 Q. You then worked in the Roe Valley Hospital for a period  
8 of 23 years and then you transferred to Altnagelvin ward  
9 6 in 1991, delivering care to the elderly.  
10 A. That's right.  
11 Q. In the course of doing that role, did any of that work  
12 inform your future work as a patient advocate?  
13 A. Not really. It was a general nurse --  
14 Q. Okay.  
15 THE CHAIRMAN: But your experience in dealing with --  
16 A. With people --  
17 THE CHAIRMAN: -- parents and patients would have helped  
18 later on?  
19 A. -- with people would have contributed. It would,  
20 Mr Chairman.  
21 MR ANDERSON: So you might have been exposed to various  
22 complaints in the course of -- not necessarily with  
23 yourself, but you would have been familiar with how that  
24 whole process would have been working on the ground?  
25 A. I would.

2

1 Mrs Doherty -- and in your witness statement you've  
2 kindly provided us also with a job description. If  
3 I can maybe bring that up, that's at WS 325/1, page 8.  
4 I trust you would have seen and are familiar with this  
5 document.  
6 A. I have.  
7 Q. Indeed, we see at the top there it was provided by you.  
8 The document itself is dated August 2005. Obviously,  
9 the period we're concerned with here is 2001. Are you  
10 able to confirm that all the responsibilities and duties  
11 that are contained in this document would have applied  
12 to you in 2001?  
13 A. They would.  
14 Q. I might be going through some of them, so if you see any  
15 that I call up that didn't correspond, perhaps you'd let  
16 us know as we go. In any event, we can see your job  
17 description and your responsibilities and key tasks set  
18 out there. In your witness statement, however, you've  
19 indicated that your direct line manager was  
20 Mrs Diane Brennan; is that correct?  
21 A. That's correct.  
22 Q. Here, we see you're responsible and report to the  
23 chief executive. I wonder if you could explain how that  
24 worked in practice.  
25 A. Mrs Brennan would have got the -- a copy -- would have

4

1 seen all the complaints and the responses before they  
2 would have gone over to the chief executive's office.  
3 Q. So you would have had first initial contact with  
4 Mrs Brennan?  
5 A. Uh-huh.  
6 Q. And it would have been on a matter of grade of  
7 seriousness that it would have then gone to the  
8 chief executive or would it just have been that  
9 everything went to the chief executive through --  
10 A. All the complaints would have gone to the  
11 chief executive and all the responses, she has signed  
12 them off to the -- the response letter to the complaint  
13 was signed off by the chief executive.  
14 THE CHAIRMAN: Diane Brennan's job was what?  
15 A. She was clinical services manager.  
16 MR ANDERSON: It obviously begs a question then what  
17 directorate you operated under or that you fell under;  
18 do you know that?  
19 A. At that time, I can't recall.  
20 Q. Just back to your engagement with the chief executive at  
21 this level: would you have had a close working  
22 relationship with the chief executive in relation to  
23 your role?  
24 A. I would have had.  
25 Q. And could you describe how that working relationship was

5

1 at the time?  
2 A. We would have had a meeting each week where I would have  
3 taken over the complaints and the response letters.  
4 We would have discussed anything that -- of any -- that  
5 needed to be discussed. And her door was always open,  
6 I could have contacted her at any time.  
7 Q. Okay. Back to the document here, and we can see that  
8 your role is set out, and I will read this out to you.  
9 It states that your role was:  
10 "... a focal point for patients, relatives, carers,  
11 visitors and staff to ensure a high quality service is  
12 provided for patients within AHSST. The purpose of this  
13 job is to ensure that, (i), patients and relatives are  
14 assisted in making known their concerns and  
15 dissatisfactions and, (ii), the administration of  
16 patient's and relatives' concerns and dissatisfactions  
17 [I think there's a bit of a phrasing problem there] so  
18 that the quality of the service can be optimised."  
19 Did you see your role as a kind of focal point for  
20 patients, patients and their relatives, a point of  
21 contact?  
22 A. Point of contact.  
23 Q. And they would have then brought their concerns and  
24 dissatisfactions to you?  
25 A. They would.

6

1 Q. What would you have done with them?  
2 A. I would have listened to them, documented their  
3 concerns, got them investigated and drafted up  
4 a response letter for the chief executive.  
5 Q. Okay. It's fair to say then that you would have engaged  
6 with them as a kind of representative of them. From the  
7 moment of them bringing the complaint or bringing  
8 a concern, you were a kind of representative?  
9 A. On their part. I was there for the patient --  
10 Q. Yes.  
11 A. -- or the complainant.  
12 THE CHAIRMAN: So the response that they would receive would  
13 be one which you had drafted, having heard what their  
14 concern was, having investigated it, and you having  
15 suggested to the chief executive, "This is my suggested  
16 response"?  
17 A. That's correct.  
18 THE CHAIRMAN: But any letter which they then received would  
19 come carrying the name of the chief executive?  
20 A. That's correct.  
21 THE CHAIRMAN: So the point of your weekly meetings with  
22 Mrs Burnside was that she might be saying to you --  
23 A. Change the letter, correct.  
24 THE CHAIRMAN: -- "I just don't quite understand why this  
25 bit's in it or that bit isn't in it", that sort of

7

1 thing.  
2 A. That's correct, Mr Chairman.  
3 THE CHAIRMAN: After you yourself began to have more  
4 experience in this role, that two of you were able to --  
5 the number of occasions on which she might have to  
6 suggest something to you or she might make a point that  
7 maybe you'd missed from her perspective, those were  
8 reduced because you'd get into each other's way of  
9 working?  
10 A. Correct.  
11 MR ANDERSON: How would patients have known to come to you?  
12 A. There were signs and notices throughout the hospital and  
13 on each ward, and staff were made aware that ... To  
14 refer patients that weren't happy or relatives to the  
15 patient's advocate office.  
16 Q. If I can bring up your witness statement, 325/1, page 2,  
17 and this is just you describing your work commitments.  
18 Here we see reference to documenting complaints and  
19 coordinating statements for the chief executive. At  
20 point (d) you also indicate that one of the functions of  
21 your role was to support patients and relatives in  
22 voicing concerns and you have already said that. That  
23 obviously broadly corresponds with what was set out in  
24 your job description. If I can  
25 go back to page 8 of that job description, that is at

8

1 WS325/1, page 8.  
2 I want to just take you through some of these  
3 responsibilities and key tasks and perhaps you can  
4 elaborate on them if you can. We see at "1" under  
5 "Responsibilities and key tasks", you see it's:  
6 "To assist individual patients with their complaints  
7 and concerns."  
8 And then further down at "2":  
9 "To comply with the HPSS guidelines."  
10 And we'll come to that. I presume you needed to  
11 monitor your compliance and the department's compliance  
12 with that guidance.  
13 A. That's correct.  
14 Q. How would you have done that?  
15 A. There were guidelines set out. Confidentiality would  
16 have been one of them.  
17 Q. Okay.  
18 A. The response time. There was a -- I can't just recall  
19 them all. Confidentiality, there was a set response  
20 time that the complainant got a letter or some response  
21 within 20 working days. There probably were others that  
22 I just can't recall.  
23 Q. Okay. You've mentioned briefly about signs and various  
24 other indications on the ward for patients indicating  
25 how they might engage with you. But could they have

9

1 engaged with you in any other way than making  
2 a complaint? Did it have to be via the complaints  
3 channel that you became engaged?  
4 A. They could ring, they could come to the office. Is that  
5 what you're asking me?  
6 Q. I'm just wondering: could they engage with you only  
7 through the complaints channel or could they come to you  
8 on a more informal basis?  
9 A. They came -- just an enquiry or they came to say they  
10 were happy with the care they had received. It wasn't  
11 just complaints.  
12 THE CHAIRMAN: Yes. But if there was a concern which they  
13 expressed, it wasn't -- I think what Mr Anderson was  
14 asking is to what extent did that have to become  
15 a formal issue or if they said, "We were treated a bit  
16 rudely by a doctor or a nurse", did they have to make  
17 a formal complaint about that or is that a concern they  
18 could express to you which you would follow up on?  
19 A. If they weren't happy with their care, we would have  
20 taken that as a complaint.  
21 THE CHAIRMAN: So you had a pretty broad interpretation of  
22 what a complaint was?  
23 A. We had, we had. They might have said, "I really don't  
24 want to make a complaint, but ...", and that would have  
25 been documented as a concern.

10

1 THE CHAIRMAN: And you'd have followed up on that, would  
2 you?  
3 A. We would, we would.  
4 MR ANDERSON: At the time there was a -- we sought some  
5 information on guidelines in Altnagelvin in respect of  
6 the complaints procedure, and we were provided with  
7 a document entitled "Procedure for handling complaints  
8 and enquiries and commendations". If we can pull this  
9 up at 321-004fb-001, this might go towards what you're  
10 saying. This obviously sets out the procedure for  
11 handling complaints. Are you familiar with this  
12 document?  
13 A. Sorry?  
14 Q. Are you familiar with this document?  
15 A. I am.  
16 Q. And did you use this document as guidance in your role?  
17 A. I did.  
18 Q. I wonder if you can help us as well. We see at the  
19 front of the document, a number of iterations of the  
20 document. It was reviewed over a number of years. This  
21 document, it implies that this version of it was at  
22 least on or after 2005. So I just want to take you  
23 through one or two processes here and perhaps you could  
24 inform us whether that was how you understood the  
25 process to work in 2001.

11

1 If we go to page 2 -- for the avoidance of doubt  
2 there was also an earlier version of this that was dated  
3 1995 that we received from, I think, Ms Duddy. But as  
4 we go through this, if you feel there were any  
5 differences, you can tell us.  
6 We can see at page 2 that the written complaints can  
7 come in -- "Complaints received by officers other than  
8 a patient advocate", or at page 3, they may be directed  
9 to the chief executive's office. Or indeed they could  
10 have been, also at page 3, directed to your office.  
11 Is that how you saw the flow of complaints?  
12 A. All the complaints came to the patient's advocate  
13 office. They might have originally gone to the  
14 chief executive's office or to the ward, but they were  
15 passed to us then.  
16 Q. Okay. And then obviously at 3, and also page 5, we see  
17 that complaints -- and this is what you said already.  
18 Complaints should be made verbally to you or ward staff  
19 or department staff and they would then go about  
20 bringing these complaints to you.  
21 A. That's correct.  
22 Q. Essentially picking up a phone or knocking on your door  
23 and they'd bring that information to you. Did you ever  
24 receive a complaint in relation to Raychel's case?  
25 A. We never had a complaint through the advocate's office.

12

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

13

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

14

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

15

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

16

1 She indicates there that:  
2 "The September 2001 meeting happened following my  
3 invitation. I believe that Mrs Ferguson was given our  
4 honest understanding of the issues, informed of  
5 improvements which had already been instigated or were  
6 in process of change. I sensed that Mrs Ferguson was  
7 not sufficiently robust to be engaged with this process  
8 at the time. I gave Mrs Ferguson a clear invitation to  
9 make further contact and we assured her that the patient  
10 advocate would work on her behalf."  
11 You can see how this seems to contradict what you  
12 were saying. Mrs Burnside obviously --  
13 A. I couldn't just find that on this.  
14 THE CHAIRMAN: Just go through it again, Mr Anderson.  
15 I think it's the bottom line on the left-hand page;  
16 is that right? Just take your time, Mrs Doherty. Take  
17 a few moments to catch up on that paragraph. (Pause).  
18 MR ANDERSON: Perhaps we'll go through it, break it down, if  
19 that's easier. You can see there how Mrs Burnside seems  
20 to be in no doubt that she reassured Mrs Ferguson that  
21 you'd be working on her behalf. That doesn't seem to  
22 tally with your recollection.  
23 A. My memory isn't that good. I'm sure that that's what  
24 did happen.  
25 Q. You say then that Mrs Burnside would have conveyed

17

1 a direction to you that you are appearing as patient  
2 advocate, not just to take minutes.  
3 A. No, I was introduced as the patient's advocate.  
4 Q. So you appeared essentially in the capacity of patient  
5 advocate?  
6 A. There as a point of contact if the family want to come  
7 back, yes.  
8 Q. But we've heard you talk about various other meetings  
9 that you maybe attended. In these other meetings, or  
10 generally in meetings that you attended as patient  
11 advocate, would your role have been more engaged than  
12 that, than just taking minutes, or would that have been  
13 the extent of it?  
14 A. In other meetings I would have been more engaged if I'd  
15 had contact with the family or whoever's making the  
16 complaint. Because you're speaking to them you have  
17 a better understanding of what they're complaining  
18 about, of what their concerns are, and it's easier to  
19 address those from personal contact.  
20 THE CHAIRMAN: So allowing for situations to be different,  
21 your normal -- do I gather that in a more normal setting  
22 you would already have met the family or known what  
23 their concerns were in advance of the meeting?  
24 A. That's correct.  
25 THE CHAIRMAN: And that you would have played some role in

18

1 investigating those concerns?  
2 A. I would.  
3 THE CHAIRMAN: So that a meeting with the family in that  
4 situation would come for you further down the line?  
5 A. It would, it would be after. If they weren't happy with  
6 the response letter that they got and came back to us,  
7 quite often then we would set up a meeting with the  
8 staff that were concerned.  
9 THE CHAIRMAN: So what was unusual in Raychel's case was  
10 that -- and correct me if I'm wrong -- you didn't know  
11 anything about Raychel before 3 September?  
12 A. I didn't, no.  
13 THE CHAIRMAN: On 3 September, Mrs Burnside asks you to join  
14 in a meeting which is going to take place later on, she  
15 wants you to take a minute at it. She has  
16 a recollection of what she told you in advance, but that  
17 was the first day that you knew anything about Raychel  
18 or that she died or that there were concerns within the  
19 hospital.  
20 A. I probably had heard that Raychel had died previously,  
21 but --  
22 THE CHAIRMAN: Because that would be such news in the  
23 hospital?  
24 A. It was. It was. I knew.  
25 THE CHAIRMAN: But did you know that, quite apart from

19

1 whatever concerns the Ferguson family had, there were  
2 serious concerns within the hospital about what had gone  
3 wrong in Raychel's case?  
4 A. That would have been dealt with as a clinical incident  
5 and I wouldn't have been involved in it.  
6 THE CHAIRMAN: Right. I'm just trying to get a clear  
7 picture of this. That means that you would not have  
8 been involved in any way in the clinical or critical  
9 incident review?  
10 A. I wouldn't have been.  
11 THE CHAIRMAN: So when this meeting is going to take place  
12 on 3 September, from your perspective, it's to address  
13 any concerns that the family have?  
14 A. I felt that I was there to be known to them as a patient  
15 advocate, to know who to contact if they wanted to come  
16 back again.  
17 THE CHAIRMAN: Did you know before you went into the meeting  
18 if the family had expressed any concerns about Raychel's  
19 care?  
20 A. Well, I ... If there's a meeting set up like that,  
21 it is because the family has concerns.  
22 THE CHAIRMAN: Right.  
23 A. It is to answer questions.  
24 THE CHAIRMAN: Did you know what those concerns were before  
25 you went into the meeting?

20

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

21

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

22

1 back to me again after the meeting.  
2 Q. Well, that's my question then. Did you not, following  
3 the meeting, take any steps to try to engage with the  
4 family?  
5 A. No, I didn't. Mrs Burnside had offered, had said to  
6 them, "The door is open, come back, contact us". So  
7 I felt the offer was left with the family. And in the  
8 circumstances, you don't want to intrude.  
9 THE CHAIRMAN: Was your problem, Mrs Doherty, that the  
10 reason that you felt that you couldn't contribute  
11 anything was because you didn't know anything about the  
12 critical incident review, you didn't know what -- or did  
13 you know what changes had been made?  
14 A. No, I wasn't aware.  
15 THE CHAIRMAN: Okay.  
16 A. That would have been more on a ward level or more ...  
17 More clinical than what I was doing at that time.  
18 THE CHAIRMAN: And you must have known that any family is  
19 bound to want to ask questions about how their daughter,  
20 who comes in with an apparently minor problem, is dead  
21 36 hours later or 48 hours later. But beyond knowing  
22 that, you really didn't know anything about Raychel's  
23 case?  
24 A. I didn't really know anything.  
25 THE CHAIRMAN: And if you didn't know anything about her

23

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

24

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

25

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

26

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

27

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

28

1 received by that --  
2 THE CHAIRMAN: So in September 2001 the issues about Raychel  
3 were the first ones dealt with under the heading  
4 "01/117"?  
5 A. That's correct.  
6 THE CHAIRMAN: And then there was a series of other  
7 patients --  
8 A. After that.  
9 THE CHAIRMAN: -- or relatives who ran from 118 to 131?  
10 A. That's correct.  
11 MR ANDERSON: If we can go to page 6 of that document. Here  
12 we find copies of a patient advocate form. Is this you  
13 completing this document? Is that your handwriting?  
14 A. No, the secretary did that one out. My writing is the  
15 "description" and "action".  
16 Q. Okay, I see it.  
17 A. On the right-hand side.  
18 Q. So this is a form that you would typically have filled  
19 in if something came to your office by way of concern or  
20 complaint or otherwise?  
21 A. That's right.  
22 Q. And we see down, there are some details, "Mr and  
23 Mrs Ferguson", and the details of the GP and the  
24 admitting consultant. Then we see a description there:  
25 "Meeting offered following the death of Raychel.

29

1 Meeting held, 3/9/01."  
2 And "Action":  
3 "Minutes of meeting attached."  
4 Was that filled out before or after the meeting?  
5 A. After. Possibly the next day.  
6 Q. So when we see there "Acknowledgment date,  
7 3 September 2001" -- and at page 005, we see a similar  
8 page -- this indicates that the matter was resolved on  
9 3 September 2001.  
10 If you were --  
11 THE CHAIRMAN: Sorry, has that come up on the screen or not?  
12 MR ANDERSON: The "resolved"? It's down in the boxes at the  
13 bottom of the ...  
14 THE CHAIRMAN: "Resolved, yes or no", and the answer is  
15 "Resolved 3 September". So that was entered on the  
16 file -- this is the point, Mrs Doherty. This was  
17 entered on the file that the complaint or issues with  
18 the Fergusons were resolved --  
19 A. Well, it's just that the meeting was offered. That's  
20 the date that the meeting -- that really just ... The  
21 meeting was offered on that date.  
22 THE CHAIRMAN: Right. So when it says "Resolved date", that  
23 simply refers to the date on which the meeting took  
24 place, it doesn't say that the concerns were resolved?  
25 A. No, no, it doesn't.

30

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

31

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

32

1 A. I had no previous experience of taking a minute. I just  
2 took it as it was spoken and to the best of my ability.  
3 THE CHAIRMAN: Thank you.  
4 MR ANDERSON: Attached to part of the new file that we've  
5 seen is a memorandum and that's you issuing the minutes  
6 out to a number of individuals for their approval.  
7 I think initially you indicated in your witness  
8 statement that the minute was circulated to the  
9 chief executive and a consultant that you couldn't  
10 remember.  
11 A. I couldn't remember.  
12 Q. But now we see here that it was indeed sent to  
13 Dr Nesbitt. If we can bring this up, this is at  
14 321-076-008. This is a memorandum from yourself?  
15 A. That's correct.  
16 Q. And we can see it was sent out to Dr Nesbitt, Dr McCord  
17 and Sister Millar. Why did you not circulate this  
18 minute to the other attendees? Obviously there were  
19 nurses at the meeting and various others. Did you not  
20 circulate it any wider than the list that's listed  
21 there?  
22 A. Sister Millar would have let Staff Nurse Noble see it.  
23 And would have let the staff who were involved see it.  
24 And ... Those were the ones responsible for the care  
25 that received it.

33

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

34

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

35

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

36

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

37

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

38

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

39

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

40

1 anything said at that meeting that she wouldn't have  
2 recorded? Perhaps, first of all -- and I think, in  
3 fairness, the family accept, Mr Chairman, at the outset  
4 of the meeting that there were expressions of sympathy.  
5 That's one example.  
6 THE CHAIRMAN: Yes. For whatever reason, that isn't in your  
7 note, but it's accepted by the family and the other  
8 people who were there on the trust side that that is how  
9 the meeting started.  
10 A. I recall the apology and it's my omission that it's not  
11 written down.  
12 THE CHAIRMAN: Right.  
13 MR LAVERY: Also whether there were perhaps other matters  
14 spoken about at the meeting, Mr Chairman.  
15 THE CHAIRMAN: Well, I think -- I guess your answer to that,  
16 Mrs Doherty, must be that you can't, because you didn't  
17 have a tape recorder and you don't have shorthand, that  
18 that's the best record --  
19 A. That's the best that I could do at the time.  
20 THE CHAIRMAN: So it's not impossible that something was  
21 missed?  
22 A. It's very possible that I didn't get it all down.  
23 THE CHAIRMAN: You'd like to think you didn't miss anything  
24 significant.  
25 A. I would like to think I didn't.

41

1 MR LAVERY: Thank you.  
2 THE CHAIRMAN: Mrs Doherty, thank you very much for coming  
3 and helping us out this morning. Unless there's  
4 anything else that you want to say, that brings to an  
5 end your evidence.  
6 A. No. Thank you, Mr Chairman.  
7 THE CHAIRMAN: I'll rise for a few moments to let  
8 Mrs Doherty leave.  
9 (The witness withdrew)  
10 THE CHAIRMAN: Is Mr Campbell around?  
11 MR STITT: He's in the building.  
12 THE CHAIRMAN: What I'll do is I'll rise for ten minutes  
13 and, when we come back, I will take your discrete point  
14 and hopefully then we'll start the evidence of  
15 Margaret Doherty.  
16 (12.03 pm)  
17 (A short break)  
18 (12.17 pm)  
19 THE CHAIRMAN: Mr Stitt?  
20 MR STITT: Mr Chairman, I'd like, if I may, to ask you to --  
21 what happened was, last Thursday I took the opportunity  
22 to review the various transcripts, including Monday,  
23 2 September. And having read an interchange or exchange  
24 between you, sir and myself, there's one thing I would  
25 like to go back to, if I may.

42

1 THE CHAIRMAN: Right.  
2 MR STITT: It's the transcript from Monday, 2 September,  
3 it's two pages, page 173 and 174. If both pages could  
4 be brought up together on the screen.  
5 You, sir, at 173, line 23 -- this is the background.  
6 You'll remember it was who would have made the decision  
7 to call off Dr Warde or not to call Dr Warde as a trust  
8 witness for the inquest.  
9 You say at line 23:  
10 "Who else apart from you would have made the  
11 decision?"  
12 And this is fairly well into the day, it's page 173,  
13 so it's in the afternoon. The witness has been asked  
14 fairly, I think it's fair to say, quite a number of  
15 times over the preceding pages by my learned friend and  
16 yourself, sir, about this particular point, and she's  
17 tried her best to answer it. And I interject and I say  
18 at line 24:  
19 "Well, we all know, and Mr Stewart knows, that one  
20 of the persons who could make -- one of the bodies of  
21 people that could have made the decision [those are the  
22 important words] were legal advisers --"  
23 You say "yes" and I say:  
24 "-- or it could have been the trust or it could have  
25 been a combination of the two."

43

1 THE CHAIRMAN: Mm-hm.  
2 MR STITT: And we move on further down the page. The  
3 questioning goes back to the witness, Mrs Brown.  
4 I really want to deal with what I said, sir, when  
5 I said:  
6 "One of the persons who could make [this is line 25  
7 at the bottom of 173] -- one of the bodies of people  
8 that could have made the decision were legal advisers."  
9 When I read that in the cold light of day, I felt  
10 I really should clarify and correct myself. It's my  
11 practice and understanding that legal advisers provide  
12 legal advice --  
13 THE CHAIRMAN: Yes.  
14 MR STITT: -- and that's their duty, whether they be  
15 solicitors or whether they be counsel. And then it is  
16 the responsibility of the client to either accept that  
17 advice, reject that advice, have further debate about  
18 that advice, but the decision ultimately, in my  
19 experience, would be that of the client, depending on  
20 what they thought of the legal advice. And I can say  
21 that in my fairly lengthy experience of being involved  
22 in clinical negligence cases that that has been my  
23 universal experience, and of course that is appropriate.  
24 I can speak for members of the Bar, but I can say from  
25 my own experience it's also the practice, in my

44

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

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

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

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

23 THE CHAIRMAN: Okay, thank you very much.

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

45

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

3 THE CHAIRMAN: Okay.

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

5 THE CHAIRMAN: Thank you very much.

6 Mr Stewart?

7 MR STEWART: I call Mrs Margaret Doherty, please.

8 MRS MARGARET DOHERTY (called)

9 Questions from MR STEWART

10 MR STEWART: Mrs Doherty, you have supplied the inquiry with  
11 a witness statement, which is WS336/1, dated by you  
12 13 August 2013. Are you content that the inquiry should  
13 adopt that statement as part of your formal evidence?

14 A. Yes.

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

18 A. Yes, I was.

19 Q. And you have a background in nursing?

20 A. I do.

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

25 A. Mm-hm.

46

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

3 A. Yes.

4 Q. And that post --

5 A. That's in February.

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

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

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

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

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

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

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

47

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

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

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

16 A. That's right.

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

19 A. Yes.

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

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

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

48

1 A. Mm.  
2 THE CHAIRMAN: Does that mean then when Dr Quinn was  
3 director, his emphasis from his personal perspective  
4 would have been much more in children's care rather than  
5 women's?  
6 A. It would, but they would discuss with each other. I'm  
7 sure they would have discussed with each other at the  
8 directorate meetings.  
9 THE CHAIRMAN: Thank you.  
10 MR STEWART: If we can go back to your job description,  
11 please, WS336/1, page 45. Perhaps you'll see how this  
12 confusion arises, because third line down, your  
13 description indicates that you were to report to the  
14 clinical director, which would have been Dr Martin.  
15 A. Yes.  
16 Q. But when you were asked this question when you made your  
17 witness statement, you said at WS336/1, page 2, down at  
18 1(e):  
19 "My professional line manager was the director of  
20 nursing, Ms Duddy."  
21 A. Yes.  
22 Q. So you can see where the confusion arises?  
23 A. There's a conflict there.  
24 Q. Did you liaise much with Dr Martin?  
25 A. Yes, I met him more or less every Monday morning in the

49

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

50

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

51

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

52

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

53

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

54

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

55

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

56

1 asked for my sisters' minutes meetings and my meetings  
2 with the consultant paediatricians, and because I have  
3 left, apparently everything has been put into boxes,  
4 even my diaries, everything, and cannot be sourced.  
5 Q. When did this happen?  
6 A. Well, I left -- well, I didn't leave, I went off on sick  
7 leave in 2003, the end of March 2003, because  
8 I contracted a second cancer. I decided then I was  
9 leaving because of stress and stuff like that. So  
10 it would be -- and they moved offices over to the  
11 prefabs while I was off sick. I remember there was  
12 a lot of my stuff in that prefab office when I went to  
13 see my secretaries and my colleagues. But where it's  
14 gone --  
15 Q. So it was --  
16 A. -- all that work ...  
17 Q. It was there then. When was that? When did you go back  
18 to see your secretaries and so on?  
19 A. I remember going in to see them a few times because  
20 I just wanted to keep in contact with them all. The  
21 last time -- I know my hair was grown back. So that  
22 would have been in the December. I went and they were  
23 in the prefab and I noticed some of my files there.  
24 Q. What year was that?  
25 A. Oh, that was the end of 2003.

57

1 Q. End of 2003?  
2 A. Mm-hm.  
3 Q. At that time, of course, in terms of Raychel's case, the  
4 medical negligence action had started.  
5 A. Yes, but to be quite honest with you, I wasn't following  
6 that at the time.  
7 Q. No, I can appreciate that. Tell me this: may I ask you  
8 about the documents that came to light and you found  
9 when you were sitting down to draft your responses to  
10 the witness statement request?  
11 A. Well, actually it was before I was drafting my  
12 responses. I went to see one of my staff nurses,  
13 Mary McKenna, we were chatting, and I said, "Do you  
14 know, I know I made a folder, following the risk  
15 management". Because I had to get into my head exactly  
16 what had happened. I said, "I know I made a folder.  
17 Everything of my stuff's gone". And I had it in my  
18 paediatric drawer, you know, file, with all about  
19 Beverley Allitt and everything there and the  
20 recommendations. But I couldn't -- she said, "It wasn't  
21 found", and it must have been a week later, and I told  
22 the -- Therese who was helping me to get all the records  
23 about it --  
24 Q. Is that Mrs Brown?  
25 A. No, no, no, this was Teresa McGuinness who was helping

58

1 me to get everything that I thought I needed.  
2 I remember saying that to her. And then I got a call to  
3 say that Mary had found it in the back of one of her  
4 cupboards.  
5 Q. Mary McKenna?  
6 A. Yes. She said -- how it got there, we don't know,  
7 haven't got a clue, because my office had been moved out  
8 to the prefabs, in what used to be the car park near the  
9 mortuary.  
10 Q. That was before you sat down to do your statement, was  
11 it?  
12 A. Yes. Well, I'd taken the statement -- I was trying to  
13 get all the information collated.  
14 Q. When was that?  
15 A. Oh gosh, now then ... that would have been April, May,  
16 when I got all the -- was it April?  
17 Q. It was June, in fact, that we were informed that you had  
18 requested a senior member of the trust to look for  
19 documentation to assist you with your witness statement.  
20 And the documentation was found in an old cabinet --  
21 A. Mm.  
22 Q. -- which had been used while Mrs Doherty worked for the  
23 trust.  
24 A. That wasn't in my filing cabinet.  
25 Q. It was in a file marked "complaint". How did that come

59

1 about?  
2 A. I have no idea.  
3 Q. Had you been asked by Mrs Brown to look for your  
4 records, files and documentation at any earlier stage?  
5 A. Yes. After the critical incident review or meeting,  
6 I had then thought, "I've got to get my head around  
7 this", because that morning was the first I'd heard.  
8 Q. I'm not really referring to the documents you were  
9 creating at that time. But subsequently have you been  
10 asked to get your files and documents you retained after  
11 that time?  
12 A. You mean that I'd kept in my office? Well, yes,  
13 everyone asked, "Did you have anything, do you know  
14 where it would have been?", and yes, when I met with  
15 Teresa McGuinness she said --  
16 Q. And that was June of this year?  
17 A. Yes.  
18 Q. I see.  
19 A. I hadn't been contacted.  
20 Q. Did you have any records kept on a computer?  
21 A. Well, any records that would have been kept on the  
22 computer would have been on my secretary's computer  
23 because she would have been taking notes of all the  
24 minutes of everything and they would have been on that  
25 computer.

60

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

61

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

62

1 the ward and were told that I had them.  
2 Q. Send it to who? I missed that.  
3 A. To the risk management. To send it to risk management's  
4 office. And I said I was going through the notes at the  
5 time. They said they needed them and everything was  
6 being taken over by the risk management team. I said,  
7 "I'll drop them down when I've finished", but they came  
8 for them, and later on I was asked if I would send all  
9 my information down and could I send my information that  
10 I'd collated. And you'll see in my evidence that I've  
11 given you that I had made it in report format and at the  
12 bottom, I have it typed out -- I mean, this was all in  
13 my rough handwriting. And I had then sent it to Hazel,  
14 that was my secretary, she would type it up, and I would  
15 sign it and send it off. So I know I was sending that  
16 to somebody else.  
17 Q. All right. Let's deal with this. Can we go to a report  
18 that you drafted at 316-085-011? This is the first  
19 page. Can we look at, side by side with that, another  
20 copy of essentially the same report, which is at  
21 316-085-009?  
22 As I understand it, from the witness statement of  
23 Sister Little, she was asked by you to contact, first of  
24 all, Staff Nurse Noble, which she did by telephone, and  
25 she took notes of the interview. She gave those notes

63

1 to you, you needed them to make a report, which you  
2 needed for the critical incident review meeting. So on  
3 Sister Little's recollection, you create this report  
4 before you go to the meeting.  
5 A. No, this was after.  
6 Q. That's what she says.  
7 A. Oh, sorry.  
8 Q. You say, no, you created this after the meeting.  
9 A. Mm.  
10 Q. Well, first of all, can I ask you what "MD copy" means  
11 at the top right-hand corner of the right-hand --  
12 A. That's my copy.  
13 Q. Sorry?  
14 A. This is my copy, "MD" being me.  
15 Q. So that you have kept for yourself?  
16 A. Mm-hm.  
17 Q. And you'd have circulated other copies to other people?  
18 A. No, just to the -- no, that was just to the risk  
19 management.  
20 Q. So you just kept one for yourself and sent one to risk  
21 management, to Mrs Brown?  
22 A. Mm-hm.  
23 Q. Why did you have to mark yours "MD copy" then?  
24 A. I do it on everything that I have copied.  
25 Q. If you have your file and you have your copy in your

64

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

65

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

66

1 A. No, I don't remember a debate.  
2 Q. You don't?  
3 A. No.  
4 Q. Do you remember Dr Nesbitt calculating the amount of  
5 fluid that Raychel received and concluding that she'd  
6 had more than she should have?  
7 A. I remember that being said at the meeting, but not  
8 before.  
9 Q. Does that find any reference in these reports?  
10 A. But this wasn't a report of the meeting.  
11 Q. No, but it's a report of the treatment that Raychel  
12 received whilst on Ward 6.  
13 A. Yes, from the notes.  
14 Q. And I would imagine that that would be informed by all  
15 that you heard at the meeting as well as what you read  
16 from the notes.  
17 A. No, I was listening in the meeting. I didn't take any  
18 notes whatsoever in the meeting.  
19 Q. What was the point of you writing a report which wasn't  
20 informed by all of the individuals at the meeting might  
21 have said?  
22 A. Because I wasn't taking minutes at the meeting, I was  
23 listening.  
24 Q. What's the point of you making a report if it doesn't  
25 actually reflect what you heard?

67

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

68

1 what I had to do. I would like to mention here that I  
2 used to be a staff nurse on a renal ward and I know how  
3 important fluid balance charts are. I was a stickler  
4 for fluid balance charts being correct, being well  
5 documented, and that is why straight after I spoke with  
6 Staff Nurse McKenna and said, "We have to address this  
7 fluid balance chart".  
8 Q. I'm still grappling with why on earth you would take  
9 time to draft, redraft and type a report which doesn't  
10 reflect the issues that you'd have heard about, which  
11 were very relevant to you and what you had to do.  
12 A. This was just the scene, setting the scene for me,  
13 knowing what was going on, what Raychel had experienced,  
14 what the doctors had done, what the nurses had done, any  
15 information I could collate for my information.  
16 Anything from there I would have made myself a written  
17 list of what had to be addressed.  
18 Q. Where is reference in this report to, for example, the  
19 deficiencies identified in the nursing notes?  
20 Presumably you were a stickler for the nurses keeping  
21 their nursing notes --  
22 A. I was a stickler. Documentation is so important.  
23 Q. Absolutely. Why didn't you make a note in your report  
24 here of that?  
25 A. Because I was just taking down what was written by

69

1 others, what I could see and then what needed to be  
2 done.  
3 Q. So where is the reference to what needed to be done?  
4 A. I didn't have it done there. That was sent down that  
5 evening. That was sent down about 5, 6 o'clock that  
6 evening. I'd just put it together and got Hazel to type  
7 it. And when we saw there were things missing, I went  
8 and sought them out and then copied it again, typed it  
9 again. So there's nothing sinister about that report.  
10 Q. I'm not suggesting it is sinister, I'm merely suggesting  
11 it was not, in all probability, written by you after the  
12 meeting when it would have had no purpose in its present  
13 form, but was written for the meeting.  
14 A. No. It was written for me after so I could get a clear  
15 view of what had happened.  
16 Q. Did you feel, after the meeting, that you had to report  
17 back to the director of nursing?  
18 A. The director of nursing wasn't there at that time. She  
19 had two members of her team at that meeting -- that  
20 would be Therese Brown and Anne Witherow -- who would  
21 report back to her. I would have reported back to her  
22 straightaway if she had been there, but she wasn't, and  
23 she was -- and her own staff reported to her.  
24 Q. Okay. We'll just go to your job description, WS336/1,  
25 page 45. We find here that not only are you the

70

1 individual responsible for the day-to-day management of  
2 Ward 6, but if you look at your job summary, we find in  
3 the second paragraph that you:  
4 "... support the clinical director and on occasions  
5 the postholder will be required to deputise for the  
6 director of nursing in her absence."  
7 A. Mm-hm.  
8 Q. Can I ask you, first of all, why was the director of  
9 nursing not at the review meeting?  
10 A. I don't know. She didn't discuss her diary with me, nor  
11 did she ask me to stand in for her or deputise.  
12 THE CHAIRMAN: Sorry, I don't quite understand. I don't  
13 want to make too big a fuss of this, but if you thought  
14 that Mrs Brown and Ms Witherow would be reporting to  
15 Ms Duddy, why then would you have gone straight to her  
16 if she'd been available if you have just identified the  
17 two other people who, in your words, Ms Duddy had there?  
18 A. She did have them there, yes, but I would have gone just  
19 out of respect.  
20 THE CHAIRMAN: Right. Just to make sure that the ground  
21 that you wanted to be covered had been covered and to  
22 ensure it was covered?  
23 A. Yes.  
24 THE CHAIRMAN: Okay.  
25 MR STEWART: One of your responsibilities was to ensure that

71

1 policies were followed.  
2 A. Mm-hm.  
3 Q. And I assume that you knew the policy and the protocol  
4 for critical incident reviews in the paediatric  
5 directorate, department?  
6 A. Yes, they were called "untoward incidents" at that time.  
7 "Critical review" was later.  
8 Q. Well, you know that the policy said that you, first of  
9 all, had to fill out a report form.  
10 A. Yes, that would be on the -- that's in a book and it  
11 happens at ward level.  
12 Q. And presumably, that was your job?  
13 A. No, that was the sister's job or the person reporting  
14 the incident.  
15 Q. Well, if the sister didn't do it, then it's your  
16 responsibility to find out why it hadn't been done?  
17 A. Yes. I was told an incident report had been sent down  
18 to the risk management office.  
19 Q. You were told a report had been sent?  
20 A. Mm-hm.  
21 Q. Who told you that?  
22 A. The ward sister.  
23 Q. Did you take that to be a written report?  
24 A. I took that to be the untoward incident form that is  
25 completed when there's an untoward incident.

72

1 Q. Did you ever see that?  
2 A. No, I didn't.  
3 Q. So you didn't see that. You went to the meeting, the  
4 director of nursing wasn't there, you weren't deputising  
5 for her. Did you submit to the director of nursing or  
6 the risk management coordinator the notes you received  
7 from Sister Little of her interview with Staff Nurse  
8 Noble before the meeting?  
9 A. No, because I didn't get them until after.  
10 Q. You didn't get those until after?  
11 A. No.  
12 Q. So Sister Little is quite wrong in that regard as well?  
13 A. My recollection is that I got those after the meeting.  
14 Q. Let's have a look at what Sister Little said. It's at  
15 WS345/1, page 4. She's being asked about those five  
16 pages of handwritten notes. At 2(b) she says:  
17 "I recall being asked and I strongly believe that  
18 the request came from my line manager,  
19 Mrs Margaret Doherty, in the absence of Sister Millar,  
20 to provide her with a resume of events which she  
21 required urgently for a meeting. I cannot recall the  
22 exact date when Mrs Margaret Doherty asked me to take  
23 these notes, however I believe it may have been 10 or  
24 11 June 2001 as Sister Millar was off duty and I was in  
25 charge in her absence. This was the only time I was

73

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

75

1 involved in the case."  
2 And she goes on:  
3 "I believe that Mrs Margaret Doherty asked me to  
4 take these notes as she needed them for a meeting, which  
5 I believe was to take place on Monday 11 June 2001 at  
6 2 pm."  
7 A. The meeting was on the 12th.  
8 Q. Quite right. And she goes on --  
9 THE CHAIRMAN: But that apart, you see the point that's  
10 being made?  
11 A. Oh, I can see the point there, yes. But I didn't get  
12 that information until after the meeting. I did not  
13 have anything except a wee notebook with me at the  
14 meeting.  
15 MR STEWART: And when you got that information after the  
16 meeting from Sister Little, her handwritten notes, what  
17 did you do with them?  
18 A. I put them in -- with my written information and sent  
19 that down to the risk management.  
20 Q. You see, the information didn't come to us from risk  
21 management; it came to us from a file that was left  
22 in the back of an old cabinet.  
23 A. I can't -- it wasn't in the back of my cabinet; it was  
24 right at the front of my cabinet. And that was 13 years  
25 ago in my office in the trust area --

74

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

76

1 behaving funnily; would you not think that had been  
2 useful?  
3 A. I didn't have that written down.  
4 Q. Well, it came to us from you, and it appears --  
5 A. It says here --  
6 Q. -- at 316-085-013.  
7 A. Appendix 23.  
8 Q. You see at the bottom:  
9 "Approximately 12.30 am, Fiona Bryce reported to  
10 Anne that Raychel was behaving funny, query confused."  
11 A. I see it there, yes.  
12 Q. Quite a number of things in this report which are  
13 relevant, which you didn't put in your report, and which  
14 you obviously should have passed on to the  
15 people conducting the investigation.  
16 A. I should have, yes. I stand corrected.  
17 Q. So why didn't you?  
18 A. I don't know. I have no reason.  
19 Q. You must have had a reason because you've asked this  
20 individual, a senior sister, to go and do this for you.  
21 Then you have no reason not to go something with it;  
22 why?  
23 A. But I did do something with it. I kept that so that I  
24 could know what was happening, this is what that was all  
25 about. I had then be told that they were then all

77

1 giving their statements and that -- and I forgot about  
2 it. I must have forgotten about it in the drawer  
3 because I was then told that it was being taken over by  
4 risk management and I had no more involvement.  
5 Q. You see, that would be all very well if these documents  
6 were your only means of finding out and knowing what was  
7 happening, but you were at the meeting.  
8 A. Yes.  
9 Q. You knew what was going on.  
10 A. Some of it, yes. It was very confusing at that meeting.  
11 Q. Did you go to the director of nursing and tell her what  
12 had happened at the meeting in her absence?  
13 A. No.  
14 Q. Why didn't you?  
15 A. I have already said, because she had two people there,  
16 she wasn't there. If she'd been there I would have gone  
17 down out of respect and explained what had happened.  
18 Q. Did you ask her if she wanted a briefing note?  
19 A. No. I don't recall.  
20 Q. So you just assumed that somebody else would do it and  
21 that --  
22 A. No, I didn't assume somebody else would do it. I knew  
23 they were reporting back.  
24 THE CHAIRMAN: Okay, just one final point on this. The risk  
25 management said that they wanted your report, the report

78

1 that you were doing; is that right?  
2 A. It wasn't really a report, it was just for my own ...  
3 THE CHAIRMAN: Your own note?  
4 A. So that I could go and find out just what had taken  
5 place and look at everything else and investigate.  
6 THE CHAIRMAN: Were you helped in doing that report by what  
7 had been sent up to you by Sister Little?  
8 A. Well, I took it really from the charts and the notes.  
9 And then I got those sent to me, and I mean, that's --  
10 and I copied them for this inquest as soon as I found  
11 them. Well, I didn't find them. As soon as they were  
12 found.  
13 THE CHAIRMAN: Okay.  
14 A. To be quite honest with you, I'd forgotten all about  
15 that, that I'd taken all that.  
16 THE CHAIRMAN: Let me make it clear, I'm not surprised that,  
17 in 2013, you'd forgotten. I think what Mr Stewart was  
18 questioning you more about was what you had and  
19 forwarded to risk management in 2001.  
20 A. Mm.  
21 THE CHAIRMAN: And you had --  
22 A. That report.  
23 THE CHAIRMAN: You had more information than you provided to  
24 risk management, was really his question.  
25 A. That was ... That wasn't done on purpose.

79

1 THE CHAIRMAN: Okay.  
2 MR STEWART: Can we go back to your report again to look  
3 at the second page again at 316-085-010? Do you see  
4 that you've entered the information at the end, the  
5 information taken from notes and verbal statements from  
6 staff?  
7 A. Mm.  
8 Q. Which notes are you referring to?  
9 A. Raychel's notes and anything that was in Raychel's notes  
10 that I could see was relevant to it.  
11 Q. And which statements were you referring to?  
12 A. That must have been these.  
13 Q. That's just the verbal statement of Staff Nurse Noble as  
14 relayed via Sister Little?  
15 A. Mm.  
16 Q. Any others?  
17 A. I don't think I -- I can't remember. I honestly can --  
18 it's not there, but I can't ... That must have been  
19 from ... It's obviously that's from there.  
20 Q. Did you ask anybody else to give you their recollection  
21 of what had happened?  
22 A. I asked for any information from the staff that was on  
23 on the night that this occurred.  
24 Q. When did you ask them?  
25 A. I asked Sister Little for that information, and she had

80

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

81

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

82

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

83

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

84

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

85

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

86

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

87

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

88

1 A. But that was the process that we did. I mean, it would  
2 be circulated and comments would come back and then the  
3 form would be reviewed and updated.  
4 THE CHAIRMAN: Okay. If we look at this, I'm looking at the  
5 relationship between 4 and 6. 4(a) says:  
6 "The following has been agreed: fluid balance sheet  
7 must be correctly completed ..."  
8 And so on.  
9 A. Mm-hm.  
10 THE CHAIRMAN: And 6 says:  
11 "The fluid balance documentation currently in use  
12 will continue to be used. The documentation will be  
13 kept under review by Mrs Witherow."  
14 A. Mm. That was the one that we were -- the trial.  
15 THE CHAIRMAN: Okay, that's the trial. So paragraph 6 is  
16 referring to --  
17 A. The trial documentation.  
18 THE CHAIRMAN: -- the trial improved documentation and you  
19 were going to see how well that worked --  
20 A. Mm-hm.  
21 THE CHAIRMAN: -- and Mrs Witherow would keep that under  
22 review and if it needed to be tweaked again or improved  
23 again --  
24 A. We'd have got together again, mm-hm.  
25 MR STEWART: I wonder if we can have a look at another

89

1 document, which is 316-085-004, and it might be placed  
2 alongside this one.  
3 Is this your handwriting, can I ask you first of  
4 all?  
5 A. Yes.  
6 Q. Could this document have been created by you in  
7 preparation for the meeting described at paragraph 4?  
8 A. It could have been.  
9 Q. Because certainly you're dealing with the fluid balance  
10 charts and exactly what they should contain and how they  
11 should be filled out, and you have made a note, in  
12 handwriting, as to the timeliness of a second U&E test  
13 and at the bottom you have written:  
14 "SHO, JHO and [presumably] reg in surgery under  
15 pressure. No lead clinician in surgery."  
16 A. Yes, now, that must have been reported to me. That must  
17 have been said to me by somebody because I've taken  
18 a note of that and that must have been for me to speak  
19 to somebody.  
20 Q. Okay.  
21 A. To speak to probably Dr ...  
22 Q. Do you now remember when this note was made by you?  
23 A. Do you know, I ... I think I may have done that  
24 from ... I think I may have done that from the  
25 clinical -- the critical incident.

90

1 Q. The critical incident review?  
2 A. Yes, I might have ... You see ...  
3 Q. Do you see the questions there posed at number 2:  
4 "Same bag of Solution No. 18 --  
5 A. That's what's making me think:  
6 "-- recommended post-operatively."  
7 And:  
8 "What solution was commenced at 200 --  
9 Q. Because those look like questions you'd want to address  
10 at the review itself.  
11 A. Yes. I can't make out the second -- on the last line,  
12 "if" ... Is that "if"?  
13 Q. "If 3 litres erected, who prescribed third litre?"  
14 That's about the actual fluids themselves.  
15 A. I'll tell you what that is: that's probably what I've  
16 done after reading the notes.  
17 Q. After you read the notes?  
18 A. Mm.  
19 Q. Would that be what you'd done after the meeting?  
20 Because that seems to be informed by the review  
21 meeting --  
22 A. Yes.  
23 Q. -- unlike your report, which doesn't seem to be informed  
24 by it.  
25 A. No, the report was taken from the notes. That seems to

91

1 me to be from the meeting.  
2 THE CHAIRMAN: What pressure were the doctors under in  
3 surgery?  
4 A. Apparently there was a few emergency admissions that  
5 needed to go to theatre.  
6 MR STEWART: This was at the time of Raychel's collapse, was  
7 it?  
8 A. Mm. Yes, but I must have got that information there at  
9 that meeting.  
10 THE CHAIRMAN: Sorry, just clarify it because Mr Stewart and  
11 I are not sure which time you're referring to. When it  
12 says about the doctors who are under pressure in  
13 surgery, is that at the time of Raychel's appendix being  
14 removed or is that after she's collapsed on Ward 6 in  
15 the early hours of Saturday morning?  
16 A. I think that was when she collapsed. I'm not sure.  
17 I can't be certain because it's just a jot that I've  
18 made in my writing and I've had that written out.  
19 THE CHAIRMAN: Then when it says, "No lead clinician in  
20 surgery", is that -- when Raychel collapsed, it wasn't  
21 surgery that was really being discussed, sure it wasn't.  
22 A. No.  
23 THE CHAIRMAN: So surely the reference to surgery --  
24 A. But then again, you see, they couldn't be removed from  
25 surgery. I'm only surmising here. It says:

92

1 "The senior house officer and junior house officer  
2 and reg were in surgery under pressure, no lead  
3 clinician in surgery."  
4 So they couldn't leave.  
5 THE CHAIRMAN: And the effect of them not leaving was what?  
6 A. They didn't get to the ward. I don't know. I don't  
7 really want to be quoted on saying anything like that  
8 because I don't know and I don't want it to be misread.  
9 THE CHAIRMAN: I agree. I don't want you to start guessing  
10 what your note means.  
11 A. Yes.  
12 THE CHAIRMAN: I'm trying to get you to remember as best you  
13 can what your note means.  
14 A. I wish I could. I really wish I could and I know I've  
15 jotted that down and I know someone must have just said  
16 that and I've written it down on there because that is  
17 my writing, that is my paper.  
18 THE CHAIRMAN: Okay.  
19 MR STEWART: Can we just see that right-hand page in its  
20 full size, please? You see the bottom left-hand corner,  
21 that page has come to us from the DLS. That page wasn't  
22 in your file that was recovered from the old cabinet.  
23 A. Sorry?  
24 Q. Can you explain how this page was not in your old file?  
25 A. I don't know. I don't know because I don't even know

93

1 why my file would have gone missing. I don't know why  
2 it was missing for 13 years, for all those years.  
3 THE CHAIRMAN: Mr Stewart, it's 1.30. We'll break.  
4 We are going to break for lunch. I'm sorry this  
5 morning has been a bit up and down for everybody, that  
6 we haven't quite kept to the timetable as we have been  
7 doing for the last few weeks. We'll finish your  
8 evidence this afternoon. I know you've come some  
9 distance and I want you to have a chance to get a bite  
10 to eat. Can we start again at 2.20? Is that okay,  
11 50 minutes?  
12 A. Yes.  
13 THE CHAIRMAN: Thank you very much.  
14 (1.30 pm)  
15 (The Short Adjournment)  
16 (2.20 pm)  
17 MR STEWART: Mrs Doherty, looking back now after the review,  
18 were you able to identify nursing issues that you  
19 thought required attention?  
20 A. Yes.  
21 Q. What were those?  
22 A. Well, the completion of the fluid balance charts, to  
23 start with, and the kardex -- well, I call it the  
24 kardex -- but the patients' charts, you know, the  
25 patients' information sheets, and also the continuation

94

1 sheets where the nurses write information so that the  
2 next nurse that comes on knows exactly what's happening.  
3 Q. Were you able to incorporate any of that information  
4 into the education of nurses in Ward 6?  
5 A. We had quite a few meetings with the staff to see how  
6 they felt, but these weren't minuted; this was just me  
7 going on to the ward and suggesting to the senior staff  
8 that we should discuss with the nurses where they needed  
9 training. And I mean, apart from that also, the IPRs  
10 would have also told us where they needed training too,  
11 that was the individual performance reviews. But at  
12 that specific time I just felt they really needed an  
13 awful lot of information on how documentation should be  
14 presented.  
15 Q. Because one of your responsibilities was the induction  
16 courses given to nurses when they took up their posts.  
17 A. Mm.  
18 Q. And in fact it was a teaching hospital?  
19 A. It is.  
20 Q. And it was used for teaching, not only medical students,  
21 undergraduate students, but nursing students. I wonder  
22 can I ask you about this, this was something you  
23 exhibited to your witness statement. It's a copy of the  
24 benchmarking exercise undertaken by the  
25 Altnagelvin Hospital in November 2000.

95

1 A. Yes.  
2 Q. And at page WS336/1, page 67, this compared and  
3 contrasted Altnagelvin against other hospitals in the  
4 north of Ireland -- there's Craigavon, Antrim, Ulster.  
5 What it concluded was that Altnagelvin had a  
6 significantly lower percentage of qualified staff within  
7 the children's unit compared to the other hospitals  
8 benchmarked.  
9 A. Yes.  
10 Q. And you can see there it is 76 per cent and the others  
11 are well over 80 per cent.  
12 A. Mm-hm.  
13 Q. Did this highlight to you the necessity to incorporate  
14 ongoing education?  
15 A. Yes, of course, but the 76 per cent of qualified staff  
16 that's represented there, it -- we had an ongoing  
17 problem of recruitment at that time, and we -- if you  
18 look at the other part of the benchmarking -- had also  
19 stated that we had the higher number of staff per bed  
20 than the other hospitals. So we couldn't recruit  
21 qualified paediatric nurses, children's nurses, because  
22 they seemed to stay in the Belfast area or go across to  
23 the mainland.  
24 Q. Does that not emphasise the point I was trying to make,  
25 that you should then be educating those nurses you have

96

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

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

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

97

1 it, was very well staffed.

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

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

9 And you indicate there that:

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

15 A. Yes.

16 Q. We have seen, Mrs Doherty, that the fluid balance charts  
17 were not completed correctly --

18 A. No.

19 Q. -- in this instance.

20 A. No, they weren't.

21 Q. So the obvious question is: what went wrong with the  
22 teaching if it didn't actually find effect in practice?

23 A. Well, nurses are taught from the minute they start  
24 nursing about fluid balance charts and how to document  
25 and everything, and you are taught that all the way

98

1 through your training. Even when you're on placement in  
2 wards they're taught it, and they were inducted into how  
3 to complete a fluid balance chart. I can't explain why  
4 they didn't fill that in correctly. However I did speak  
5 very sharply, as you mentioned earlier -- and now I'll  
6 say how sharply. I spoke very sharply to those nurses,  
7 I told them that they would be retrained in fluid  
8 balance charts. I also spoke very sharply to the sister  
9 of the ward. But following that then, I had to step  
10 back because I was not reviewing the situation. But  
11 they knew exactly what they had to do.

12 Q. You say you spoke sharply to them after the event. Did  
13 you have any prior warning, prior warning  
14 before June 2001, that the fluid balance charts were not  
15 being completed properly?

16 A. If I had had warning before, I would have spoken before  
17 to them. I would have brought it up at the sisters'  
18 meeting, and I am sure I did bring it up on many  
19 occasions at the sisters' meetings, if I could find the  
20 records -- I did bring up about the importance of  
21 completing charts correctly and timely.

22 Q. I wonder can we see, please, WS323/1, page 45? This  
23 comes also from that benchmarking exercise,  
24 November 2000. You can see this is about fluid balance  
25 charts, amongst other things, the second section:

99

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

3 Second bullet point:

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

6 A. That's terrible.

7 Q. Yes. This is seven months before Raychel. I assume  
8 this benchmarking report came to you.

9 A. Yes.

10 Q. There was an area that needed to be addressed, that area  
11 was the fluid balance chart, what did you do about it?

12 A. I had brought that up at the sisters' meeting to all of  
13 the sisters when I got that benchmarking because it was  
14 about all of the wards, but it was particularly about  
15 this ward here, and I brought it up to all of them and  
16 I spoke very, very straight.

17 Q. You speak to these people sharply after the event, but  
18 seven months before the event this is flagged up to you  
19 as something that just needs addressed?

20 A. No, what I said just then was I brought this up then  
21 at the sisters' meeting about the benchmarking and we  
22 went through this thoroughly and I told them quite  
23 clearly at the sisters' meeting to ensure that the  
24 charts had been filled in correctly.

25 Q. And what steps did you take --

100

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

101

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

102

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

103

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

104

1 a problem might have been that this system which you  
2 were operating at the time about having then on computer  
3 rather than at the end of the bed, might not have worked  
4 terribly well. Is that --  
5 A. It may not have done. I'll be quite honest with you,  
6 I'd have preferred the written documentation rather than  
7 the computer because the written documentation -- you  
8 could write everything.  
9 THE CHAIRMAN: Did you go back to the written documentation  
10 or did you stay on computer after 2001?  
11 A. It remained on computerised.  
12 THE CHAIRMAN: It remained on computer so that you couldn't  
13 go to the end of a child's bed and see the care plan?  
14 A. No, I don't think -- no, we didn't have them at the end  
15 of the bed, the care plans. Charts, you know, were at  
16 the end of the bed, but not the care plan.  
17 THE CHAIRMAN: So potentially, on a worst-case scenario, the  
18 gaps in this that are that a doctor who's called to the  
19 bedside of a child won't have a care plan immediately  
20 before him or her, they have to go back to the station  
21 because it's on the computer there and not at the end of  
22 the bed.  
23 A. Probably, yes.  
24 THE CHAIRMAN: And it means that if a nurse who's on the  
25 ward wants to see the care plan, they too have to go to

105

1 the station to the computer; is that right?  
2 A. Mm-hm, but there were three stations on the ward.  
3 THE CHAIRMAN: Yes, okay. This is an issue which goes  
4 beyond Raychel.  
5 A. Yes.  
6 THE CHAIRMAN: Would you have still have been in the  
7 old-fashioned camp that you would like a written care  
8 plan at the end of the bed?  
9 A. Yes, I would to be quite honest with you, because you  
10 write everything when the doctor attended, what he  
11 prescribed. Everything would be there.  
12 THE CHAIRMAN: And why was that system moved away from?  
13 A. Because of the DM Nurse.  
14 THE CHAIRMAN: Because of the --  
15 A. The computer system being introduced.  
16 THE CHAIRMAN: And the view was taken this should be better?  
17 A. This is moving forward.  
18 THE CHAIRMAN: But in your view, on this occasion, moving  
19 forward didn't actually mean moving forward?  
20 A. No, not to me.  
21 THE CHAIRMAN: Okay.  
22 MR STEWART: Did you have any prior warning, warning prior  
23 to June 2001, that there was a need to update and to  
24 change the episodic care plans in line with the patient  
25 and the treatment?

106

1 A. Sorry, can you repeat?  
2 Q. Did you have any prior warning, warning prior  
3 to June 2001, that there were areas of deficiency in the  
4 episodic care plan which required change?  
5 A. No, not really.  
6 Q. I'm just going to go back, if we may, to the same  
7 benchmarking exercise that was brought to your attention  
8 in November of the preceding year, to page WS323/1,  
9 page 50.  
10 This is all about Ward 6 and we go down to the third  
11 paragraph:  
12 "It will be necessary to make nurses aware of the  
13 need to update and change care plans when there is  
14 a change in treatment and not just evaluate."  
15 A. Mm-hm.  
16 Q. So what did you do about that?  
17 A. I would have brought that to their attention, I'm sure  
18 of it.  
19 Q. It's all very well just bringing things to people's  
20 attention. But in order to effect a change you have to  
21 actually attend upon it --  
22 A. Yes.  
23 Q. -- and make sure there is a change.  
24 A. Yes.  
25 Q. What did you do?

107

1 A. I had H grades, who were in management situations at  
2 that time. I had F grades and G grades on that ward.  
3 And when I went to meet with them and said, "This has to  
4 change", and, "I want this, this, and this done", and  
5 then went back to check that it was done, that they've  
6 spoken to the staff and that they have educated them in  
7 how they should be doing it, then I take their word  
8 unless I see something myself or somebody from the ward  
9 face tells me this isn't working and then I go back and  
10 readdress it.  
11 Q. But if you have a system of delegation where in effect  
12 you wash your hands of something once you have told  
13 someone about it --  
14 A. No, I'm not washing my hands.  
15 Q. -- you must have a system whereby you can check,  
16 otherwise you might be deluding yourself and others.  
17 A. No. I was not washing my hands of anything. I was very  
18 into the wards, I was doing ward rounds, I was speaking  
19 to patients, I was speaking to members of staff, I had  
20 an open-door policy. I worked extra hours and I did not  
21 wash my hands of anything.  
22 THE CHAIRMAN: Just in fairness so that you understand this  
23 questioning, because the conclusion at the bottom of  
24 this page, just for the record, it confirms that:  
25 "This study demonstrated that the standard of care

108

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

109

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

110

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

111

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

112

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

4 THE CHAIRMAN: Right.

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

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

11 Second paragraph:

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

16 A. Mm.

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

20 A. It wasn't ignored.

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

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

113

1 meeting that we sat with Ms Ryan and discussed it and  
2 said it was impossible, but this was in a report and  
3 named nurses should be there and named midwives, and it  
4 was the protocol. And we did our best to implement it.  
5 But as I say, 12-hour shifts and three-and-a-half days,  
6 and granted they didn't even work three-and-a-half days  
7 sometimes. It was quite a long time to work 36,  
8 37 hours on the go. They would have split days off,  
9 they might have only worked two days and had two days  
10 off and come back for one-and-a-half days. It was  
11 impossible, impossible -- well, virtually impossible to  
12 be a named nurse. You would have a named nurse, that's  
13 why I brought in part-time staff so that there was  
14 a link and that you would have the full-time nurse would  
15 be the named nurse and the part-time nurse would be the  
16 link between the two.

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

19 A. That's how I made that work.

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

22 A. Oh, it is.

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

25 A. Mm, under the Patients' Charter.

114

1 Q. Indeed. And let's have a look at that. It's  
2 306-085-010:

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

6 Second one:

7 "A named nurse."

8 And that was 1992.

9 A. Yes.

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

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

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

17 A. Yes, I would.

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

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

25 THE CHAIRMAN: So the intention is fine?

115

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

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

5 A. Days off, annual leave, sick leave.

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

8 A. No.

9 THE CHAIRMAN: So --

10 A. But it was brought --

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

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

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

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

116

1 a ward and you divide it into sections and say there's  
2 six patients there, six patients there, you had one  
3 nurse that should somebody want to have any information,  
4 she would have all the information. It used to be the  
5 ward sister knew everybody, everything about every  
6 patient. I know that's what it was like when I was  
7 a ward sister.  
8 THE CHAIRMAN: Yes.  
9 A. And the relatives would be directed to the ward sister  
10 and she would be able to say what was happening with the  
11 patient, what tests were about to be done, everything.  
12 But then it got, I suppose, so wide, the area of  
13 responsibility, that it took more people. And that's  
14 where you lose --  
15 THE CHAIRMAN: You mean the ward sister's responsibility got  
16 so wide, so she knew a bit less about the patients who  
17 were on the ward?  
18 A. I would say a bit less, yes. She wouldn't be so  
19 involved with each patient. She would know all about  
20 each patient, but she wouldn't be that involved. She  
21 wouldn't be like, you know, I would be, when I was  
22 a ward sister, I would be nursing the patients as well.  
23 So I would know them all very well.  
24 THE CHAIRMAN: I'm not sure if we can go much further than  
25 this, but one of the frustrations that I understand the

117

1 A. To have them to talk to, yes. But when you're working  
2 12-hour shifts, it's impossible.  
3 THE CHAIRMAN: I can understand what the government is  
4 aiming at. I also understand entirely why there are  
5 severe limitations on that system working properly.  
6 A. On the entrance to the children's ward, I had a big  
7 board put up with everybody's photograph on, all the  
8 members of staff that were on that ward, so that nobody  
9 came near a child that wasn't a member of staff and that  
10 you didn't recognise. My photograph was up there and my  
11 title. You know, I would have had an open-door policy  
12 for -- I would speak to anybody.  
13 THE CHAIRMAN: Okay.  
14 MR STEWART: Indeed, Professor Swainson makes the point. He  
15 says that had there been a named nurse, it might have  
16 allowed better communication with Mr and Mrs Ferguson.  
17 A. Mm. Well, they had a named nurse, but it was in name  
18 only.  
19 Q. In name only?  
20 A. Yes.  
21 Q. Had there been one, perhaps they would have known who to  
22 speak to.  
23 A. Well, there were other staff that they could have asked  
24 to speak to me, to contact me, because I would have even  
25 come to the ward.

119

1 Fergusons have is that they felt they weren't being  
2 listened to and they felt there wasn't enough  
3 recognition of what was going on on the ward. If there  
4 had been a named nurse, or some other person with  
5 a similar title who they could have gone to to say,  
6 "Look, you're Raychel's named nurse, these are the  
7 problems that we see and nobody seems to be doing  
8 anything about them, nobody seems to have recognised  
9 them", that might make it easier for a family in the  
10 position of Mr and Mrs Ferguson to be able to speak to  
11 somebody who could expect to be able to help them.  
12 A. I understand what you're saying.  
13 THE CHAIRMAN: I'm afraid that's not what happened.  
14 A. I know they spoke with the sister, did they? Why did  
15 they not ask to speak to me?  
16 THE CHAIRMAN: I'm not sure if the Fergusons knew who to ask  
17 to speak to because they were -- part of their  
18 concern -- and Mr Coyle will correct me if this is  
19 a wrong summary -- was they felt the nurses were not  
20 responding to the concerns which they had about Raychel  
21 and to her deterioration. Is that a fair --  
22 MR COYLE: That's one of the concerns the family had, sir,  
23 about vomiting and the child's general condition.  
24 THE CHAIRMAN: I think that's where the government's idea  
25 comes from about having a named nurse.

118

1 Q. I wonder can we look again at the protocol itself, which  
2 is at 317-042-001? This is the final paragraph. So you  
3 find yourself unable to comply with the right granted to  
4 patients and the government diktat. The last paragraph  
5 here says:  
6 "Each ward or department has a responsibility to  
7 produce its own guidelines and establish their own  
8 standard on the implementation of the named nurse and  
9 ensure audit on a yearly basis."  
10 So if you found yourselves unable to comply with the  
11 Altnagelvin protocol, all you had to do was to amend it,  
12 apply your own standards by way of guidelines and see  
13 that they were audited. Was that considered?  
14 A. I did. I brought in part-time staff that would be the  
15 links --  
16 Q. No, sorry, did you produce your own guidelines and  
17 establish your own standards that you could comply with?  
18 A. I didn't make guidelines, no. I discussed it with the  
19 staff and that's how we did it on every ward.  
20 Q. Because one of your specific job responsibilities -- if  
21 we go back to your job description and responsibilities  
22 again to WS336/1, page 46 and page 47, side by side.  
23 You'll see there at paragraph 2.12 on the left-hand side  
24 it is your responsibility:  
25 "To ensure compliance with trust policies and

120

1 maintenance of statutory requirements as laid down  
2 by ..."  
3 And the next page at the top, paragraph 3.3, it is  
4 your responsibility:  
5 "To ensure that directorate and trust policies are  
6 implemented in the process of establishing and  
7 monitoring standards of service provision."  
8 So I suggest to you that your job responsibility  
9 makes it fairly clear that you should have been adhering  
10 to this protocol and actually getting your own  
11 guidelines and standards if you couldn't comply with  
12 these.  
13 A. I should have put it into guidelines, but I did have  
14 linked nurses on every ward and in the midwifery  
15 department and the children's ward, but I should have  
16 made it into guidelines and I failed there, but it was  
17 in practice.  
18 Q. It was in practice?  
19 A. Yes.  
20 Q. Did you commit to writing any of your communication or  
21 information in relation to Raychel after that meeting of  
22 the 7th, or rather after the nurses' meeting which was  
23 noted in the 9 July update? After 9 July were you  
24 engaged in anything --  
25 A. I wasn't engaged in that at 9 July. I wasn't invited to

121

1 that.  
2 Q. Sorry, I beg your pardon, the update I'm talking about  
3 is that document we looked at earlier at 022-097-307.  
4 That's the 9 July update which refers back to a nursing  
5 meeting. Just to refresh your memory, there's the  
6 nursing meeting that you're at with Mrs Witherow and all  
7 the others.  
8 A. Oh, you mean the meeting with Anne Witherow? Did I put  
9 it into writing?  
10 Q. No, after that, did you put anything into writing  
11 relating to Raychel's case?  
12 A. No.  
13 Q. You received -- I think you mentioned it earlier --  
14 a note from Mrs Brown to indicate to you that the  
15 inquest was going to happen but that no nurses were  
16 required.  
17 A. Mm.  
18 Q. I think that's at 316-085-003.  
19 A. That's the one.  
20 Q. Mrs Brown's note to you:  
21 "Margaret, just to let you know that  
22 Raychel Ferguson's inquest is on 10 and 11 April."  
23 That's 2002:  
24 "None of the nursing staff have been asked to  
25 attend. I will keep you advised."

122

1 Were you surprised that none of the nursing staff  
2 were going to be asked to give evidence at the inquest?  
3 A. Yes.  
4 Q. Why did it surprise you?  
5 A. Because of the fluid balance charts and things like  
6 that. I thought that would be raised.  
7 Q. When did you first become aware that nurses were going  
8 to have to give evidence?  
9 A. It was quite a while after that. Ms Duddy informed me  
10 that they were to go. I think it was the time --  
11 Q. Sorry?  
12 A. Ms Duddy, the director of nursing, informed me. It  
13 wasn't Therese that informed me then, it was Ms Duddy  
14 that informed me and I think that was the time I met her  
15 on the corridor and I said I want to go to that, asked  
16 Therese to mention to you that I want to go to that and  
17 that's when Ms Duddy told me that she was going and  
18 Therese was going.  
19 Q. Did Ms Duddy go to the inquest?  
20 A. Yes, as far as I know.  
21 Q. You didn't?  
22 A. No. I wasn't --  
23 Q. Do you know why the nurses were asked to go to the  
24 inquest? Why it was then decided they should attend the  
25 inquest?

123

1 A. I think it was because of documentation. I can't  
2 remember fully the conversation Ms Duddy and I had, but  
3 I asked why were they going suddenly, and I think she  
4 mentioned -- I think it was the documentation.  
5 MR STEWART: I see. Thank you, Mrs Doherty. I have no  
6 further questions.  
7 THE CHAIRMAN: There's one issue I'm not very clear about.  
8 You said that you wanted to be involved with risk  
9 management, but you weren't.  
10 A. No, I would have liked to have been involved.  
11 THE CHAIRMAN: Yes, but you weren't actually involved. You  
12 then went on to tell me that apart from not going to the  
13 inquest, you had been involved in working with a new  
14 fluid balance chart, which was tried out, and then  
15 drawing up a new IV fluids policy.  
16 A. I wasn't involved in the IV fluid, no. That was  
17 Ms Duddy, I think. She had a group.  
18 THE CHAIRMAN: If the answer to your concern was, look,  
19 everybody can't be involved in everything, we've got  
20 a team of managers at different levels here; is there  
21 any particular contribution that you think you could  
22 have made or are you satisfied that even though you  
23 weren't directly involved in this, there was action  
24 taken afterwards which was positive and helpful?  
25 A. Oh yes, oh yes. I know there was positive action.

124

1 I don't mean to say I would have made a great  
2 difference, but it was my directorate and I did feel  
3 that I should know more about what had happened, what  
4 lessons could be learned, what I could do personally.  
5 Just, you know, for that reason, and ...  
6 THE CHAIRMAN: Right. The reason that some nurses did go to  
7 the inquest was because they were challenging the view  
8 which had been given to the coroner that Raychel's  
9 vomiting had been severe and prolonged. Did --  
10 A. They were challenging about the vomiting?  
11 THE CHAIRMAN: Yes.  
12 A. I didn't know that.  
13 THE CHAIRMAN: There was a report to the coroner that said  
14 that Raychel had suffered from prolonged and severe  
15 vomiting, and the Directorate of Legal Services wrote to  
16 the coroner to say that that view was challenged and  
17 that it would be appropriate for the coroner to hear  
18 from nurses. And it was that step which led to the  
19 nurses giving evidence.  
20 A. Mm.  
21 THE CHAIRMAN: You didn't hear about that?  
22 A. No, I didn't.  
23 THE CHAIRMAN: Were you unaware of it until I just told you?  
24 A. Mm. I thought it was the documentation of the charts.  
25 But having said that, the inquest ... No, that

125

1 didn't -- that was before. I'm just thinking -- no,  
2 I wasn't there from 2003. So it could have been after  
3 that and it could have been when I was off with surgical  
4 procedures.  
5 THE CHAIRMAN: But again, we'll hear more about this perhaps  
6 over the next few days, but if it was your directorate  
7 and the nurses were giving evidence about a specific  
8 issue, unless you were off sick at that time when the  
9 decision was taken, it's something you might have been  
10 expected to know about?  
11 A. Mm.  
12 THE CHAIRMAN: Okay. Mr Coyle?  
13 MR STEWART: Sir, I have one question arising.  
14 THE CHAIRMAN: Of course.  
15 MR STEWART: Can you recall now when you were off work --  
16 A. Yes.  
17 Q. -- with your illness?  
18 A. I know when I was off, yes. Do you want to know the  
19 dates?  
20 THE CHAIRMAN: Yes.  
21 A. Oh yes, definitely. I went off -- the first time I had  
22 acute cholecystitis and had to have a cholecystectomy.  
23 THE CHAIRMAN: I --  
24 A. You don't want to know why? Fair enough.  
25 THE CHAIRMAN: Frankly, it's not our business. If you were

126

1 off work, you were off work for a good reason, so don't  
2 feel obliged to tell us the details. What Mr Stewart  
3 was asking for was the periods when you were off.  
4 A. I was off from ... I was -- 4 April.  
5 THE CHAIRMAN: In 2002?  
6 A. 2002 until the end of June 2002. And the following time  
7 I was off from ... I had my operation again on  
8 4 April 2003 and I retired then in 2004. I didn't come  
9 back because I had ...  
10 THE CHAIRMAN: Thank you very much.  
11 MR STEWART: And after the Department of Health published  
12 its guidelines on the prevention of hyponatraemia in  
13 children, an IV fluid therapy policy consensus statement  
14 was put out in your directorate.  
15 A. Mm.  
16 Q. And can we go to 077-004-005? This is it. I'm not  
17 entirely certain of the date, it does look  
18 like May 2002, which of course was --  
19 A. Could have been before --  
20 Q. -- you were on sick leave?  
21 A. I went on sick leave on the 4th, the day I was admitted  
22 to hospital.  
23 Q. We can see you're signing there.  
24 A. Mm-hm.  
25 Q. There appears to be no attempt for Dr Martin to sign

127

1 that as clinical director of the directorate.  
2 A. No.  
3 Q. So it would look as though you --  
4 A. Almost all the paediatricians and the surgeons and  
5 the --  
6 Q. Surgeons, anaesthetists, paediatricians --  
7 A. Yes.  
8 Q. -- and a pharmacist and you.  
9 A. Mm. I may have signed that when I came back, you know.  
10 Q. It isn't dated.  
11 A. Mm.  
12 MR STEWART: Thank you.  
13 THE CHAIRMAN: Mr Coyle, is there anything?  
14 MR COYLE: No, sir.  
15 THE CHAIRMAN: No questions from the floor?  
16 Questions from MS GOLLOP  
17 MS GOLLOP: Can I just get clear in my mind to whom you sent  
18 the document that you compiled after the critical  
19 incident meeting on 12 June? You sent it to  
20 Therese Brown; is that right?  
21 A. I think so, yes.  
22 Q. Did you send it to anybody else?  
23 A. No, I couldn't recall whether it was to the director of  
24 nursing or to the risk management team. But then when  
25 I got my memory back, so to speak, Irene was off, so

128

1 it would have been to the risk management. But I knew  
2 I sent it to somebody because there was a signature  
3 place and a copy for me.  
4 Q. Did you go to the meeting on 3 September 2001 between  
5 the doctors and the nurses and Mrs Ferguson?  
6 A. No, I wasn't invited.  
7 Q. Last question. At the end of 2002, while you were at  
8 work, the trust obtained an expert report, and one of  
9 the things the expert wanted to know was further details  
10 about relevant nursing and medical procedures and  
11 management in relation to fluid administration and  
12 post-operative monitoring of fluid intake, urine output  
13 and other losses such as vomiting. Did anybody come and  
14 ask you about that?  
15 A. No.  
16 MS GOLLOP: Thank you.  
17 THE CHAIRMAN: Unless there's anything else, Mr Lavery,  
18 Mr Stitt? Mr Campbell?  
19 Thank you very much for coming, and unless there's  
20 anything more that we haven't asked you, you're now free  
21 to leave.  
22 A. Thank you very much.  
23 (The witness withdrew)  
24 THE CHAIRMAN: Ladies and gentlemen, that brings an end to  
25 today's evidence. We've got doctors Jenkins and McCord

1 tomorrow. I think that the intention is to take  
2 Dr Jenkins first, if that can be arranged, from  
3 10 o'clock. Thank you very much.  
4 (3.13 pm)  
5 (The hearing adjourned until 10.00 am the following day)  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

I N D E X

1  
2 MRS ANNE DOHERTY (called) .....1  
3 Questions from MR ANDERSON .....1  
4 MRS MARGARET DOHERTY (called) .....46  
5 Questions from MR STEWART .....46  
6 Questions from MS GOLLOP .....128  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25