Wednesday, 4 September 2013

(10.00 am)

(Delay in proceedings)

(10.13 am)

THE CHAIRMAN: Good morning. Mr Stewart?

MR STEWART: I call Dr Raymond Fulton, please.

DR RAYMOND FULTON (called)

Questions from MR STEWART

MR STEWART: Good morning. You have sent to the inquiry three witness statements, WS043/1, on 21 June 2005, WS043/2 of 3 March of this year, and WS043/3 of 30 June of this year. Are you content that the inquiry should adopt those statements as part of your formal evidence?

A. I wish to amend the third statement, 043/3, because I've noticed last weekend a discrepancy in the dates of one committee, which I think I should clarify in advance.

Q. Yes, indeed.

THE CHAIRMAN: Go ahead. Do you have a page reference?

A. It's page 1 of the third statement.

THE CHAIRMAN: Witness statement 043/3, page 1, please.

Thank you, doctor. And the correction is?

A. The correction is the membership of the advisory panels, Altnagelvin risk management and standard committee, the dates should read November 2002 until December 2004.

MR STEWART: Thank you. That's in fact just halfway down

the list of the advisory panels and committees.

THE CHAIRMAN: Is that really fitting in with Mrs Brown's evidence, which is that that committee didn't actually start meeting until late 2002; is that right?

A. That's correct, so it didn't exist in February 2000.

THE CHAIRMAN: Thank you.

MR STEWART: You have supplied a copy of your CV, and it appears at WS043/3, page 21, and continues for many pages. I wonder, can I possibly go to page 31, WS043/3, page 31.

This sets out your managerial positions at Altnagelvin. You were chairman of the medical division from 1989 through to 1993, and you were a clinical manager in the medical division up to 1993 as well. You served as the hospital medical audit coordinator between 1994 and 1998. You were on the clinical audit steering group from 1995 to 1997.

If we go to page 33, we find that you served as the medical director in the hospital from March 1998 onwards, and that included 2001.

A. Yes.

Q. You, at that time, sat on the following various committee, the trust board itself, the hospital executive, the hospital management team, and further down at number 9, the scrutiny committee and the

clinical incident review meeting, and perhaps of relevance further on down, number 15, the Sperrin Lakeland collaboration group.

Could I ask you at this stage what that is?

A. At that time the Altnagelvin Trust and Sperrin Lakeland were two separate trusts and this was set up to discuss topics of mutual interest and co-operation, such as exchanging consultants and services.

Q. How often did the group meet?

A. Not very often from my recollection. I don't know to be exact. I was certainly a member of it, advising on any medical issues. I wasn't -- I didn't set the agenda.

THE CHAIRMAN: Were there some services, doctor, which were provided, say, in Altnagelvin to which Fermanagh people went and some services provided in the Sperrin Lakeland end to which people from the sort of greater Derry area would have gone?

A. It was mainly from Sperrin Lakeland to the Derry area. But there were lots of services which had -- that was one of them. I worked in -- as a dermatologist I had a clinic in Tyrone County, for instance, which was in the Sperrin Lakeland trust.

THE CHAIRMAN: Was that the sort of thing that the collaboration group was dealing with?

A. Yes, setting up new services mainly. Existing ones

continued or in some cases were stood down.

THE CHAIRMAN: Okay.

MR STEWART: Indeed, you append a list of your publications, which are many and varied, but including audit as an area of particular interest to you, was it?

A. Yes, my publications -- well, I'm slightly embarrassed by those now because actually I started off very enthusiastic about audit and I wrote several fairly critical papers about audit, including one in the Ulster Medical Journal, which a lot of people may not have liked because I felt that audit was going down the wrong channel and a lot of money was being wasted on it, on very unfocused audit topics, and for a while I was extremely disillusioned by audit.

Q. So it wasn't the method, it was the subject that --

A. It was the way it was carried out. The subject of audit is a very legitimate tool for examining very specific things, if it's correctly carried out, but it's very expensive, it's very time-consuming in administrative time, so it has to be very focused. People were doing unfocused audits here, there and everywhere just to say they were doing audit. I think it has to be very focused.

THE CHAIRMAN: Doctor, let's just follow that just a little bit. Dr Nesbitt suggested yesterday that in recent

times there have been -- he said he wouldn't go so far as to say that audit was now redundant but there had been changes to audit. Has the tide turned in the direction that you had wanted or is that a different point that he was making?

A. I'm not sure of the point he was making. But the point I was making is that audit -- it is better now for the simple reason that the guidelines -- it has to be based on the guidelines, you have to have a standard to audit against. It's not like financial audit, you don't look at the whole organisation. They have to be specific topics, and you have to think why you're asking for an audit topic in the first -- something has to prompt you to ask the question "Do I need to do an audit on this?"

So you need to have a guideline by a reputable body such as the Royal College or a government agency, which then sets a standard, and then you can audit against that standard. If you don't have an agreed standard, you can't really start with audit, and on many topics there are no such standards.

MR STEWART: You probably heard me asking yesterday, perhaps you have read the previous days, about audit following the death of a child because that was something that NCEPOD recommended.

A. Yes.

Q. Audit in response to a serious clinical incident, which was something that the annual report of the hospital said that it aimed to do. Was that something that was useful, was audit the tool for that?

A. If I try to remember the phraseology used in the context of multi -- perhaps we could bring that up. "In the context of multi-professional audit", I think was the phrase.

Q. Yes, 220-002-003. This is the thing I was referring to, and you'll see on the left-hand side, the third and fourth bullet points, it's specifically the fourth:

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

Do you have any views about that approach?

A. That phrase does not mean very much to mean. I wouldn't know -- that means nothing to me. I wouldn't know how to start that audit. If they'd said "against the guidelines laid down by CEPOD" or something like that, it would have directed you what to do. But as a clinician reading that, it would be difficult to know how to approach an audit.

Q. Is that because the word "audit" is used interchangeably to mean a review and some other beast which is a benchmarking exercise?

A. I think they don't know what audit is. "Review" is the correct term here. Review. A review makes sense to me.

Q. Yes, because the other references I drew the attention of the inquiry to was the annual report of the hospital, 321-004gj-042, where you'll see in the first paragraph under "Key achievements", it said on behalf of the trust that the clinical audit committee aims to encompass two major activities, and the second of which is audit in response to serious clinical incident reports.

Is that something you were involved in as medical director?

A. I'm sorry, could you repeat the question?

Q. Were you involved as a medical director in audit in response to serious clinical incident reports?

A. I was certainly involved in review of serious clinical incidents. Perhaps we used the wrong terminology as well.

Q. Did you sit on the clinical audit committee?

A. Not in 2001.

Q. Your job responsibilities, principal responsibilities, were set out in your job description, which we can find at 321-004gh-005. These were your responsibilities from --

A. Mr Chairman, could I clarify this was my job description, because I couldn't find it?

Q. It comes under a letter --

A. I'm just asking for clarification.

THE CHAIRMAN: Of course.

MR STEWART: Yes, it is.

A. I accept that.

Q. It's 321-004gh-001, which is --

A. Because I know these changed between medical director posts.

Q. Perhaps we'll just look at 321, and there is the first page of that document, which is a letter to yourself of 30 April 2001.

It says:

"The duties pertaining to the appointment are outlined in the attached job description."

That's the document that follows there on the left.

A. No, I accept that. Thank you for clarifying that.

Q. Back to the principal responsibilities of the job description. You'll see the second asterisked responsibility is to ensure through the medical audit coordinator that medical audit is conducted in accordance with agreed procedures and priorities.

That was why I asked you about the conduct of audit in response to serious clinical incident reports. Did you engage in any way in audit of any form in response to serious clinical incident reports?

A. No, I didn't formally through the medical audit committee, to my knowledge. I did not.
Q. Did you as medical director require reports to be made to you after serious clinical incidents?
A. Well, I would have been involved in actually examining them, so I would have been aware of them, but I don't remember having -- insisting on a formal report.
Q. Did you yourself have to make reports to the board or to the commissioning board, the Western Health and Social Services Board, in relation to healthcare quality matters?
A. I can recall serious clinical incidents and inquiries, not like this, but -- or one like this, but -- I'm trying to think of examples. There were certainly serious incidents. I can think of things like failure of sterilisation was a problem in the hospital, and I think I spoke to the Social Services board about that.
Q. That would have been before --
A. Before this job, yes. There's nothing I can think around this time.
Q. Would that have been your conventional practice?
A. Yes.
Q. Of course, in this case no report emerged from the review. Why was that?
A. Um, I have re-read our protocol, and that certainly was

a deficit, no report was produced. I must apologise for that. Although it was said it should be written by the risk management coordinator, I really felt I should have spotted that and I should probably have done it myself. So I accept it wasn't done.

Except there was -- I think what I thought was that there was a series of action points and follow-up points, which also were the result of multi-professional review, which we discussed earlier, and I felt that was the report, but I could see in a situation like this it was very sketchy.

THE CHAIRMAN: I think you're right, doctor, it is a deficit. I won't lose sight of the fact that the failure to produce a report doesn't negate the value of a lot of the work that was done, the action plan that was come up with and the update to the chief executive and the contact with the CMO, which led on to a lot of progress being made elsewhere. But I think the point which has been made in questioning by Mr Stewart over the last couple of days is that in order to produce a report, you have to draw together what happened and who was involved, and there may have been a couple of gaps at that end.

But then in drawing up a report, it's an opportunity to set out in fairly coherent terms what has happened,

what has been done and what remains to be done, because until we write things down, sometimes some of the ideas around the edges drift round in a rather loose or incoherent way, but when we have to write them down we tend to be more focused.
A. I accept that was a deficit.
MR STEWART: I wonder, can I just take you back to, as it were, grind through some of your responsibilities. Leadership of the medical profession within the Altnagelvin was really your responsibility.
A. Yes.
Q. Also by definition and extension, the quality of the healthcare that they provided was your responsibility as well.
A. Yes, I accept that.
Q. The trust entered into a service agreement with the Western Health and Social Services Board, and it's found at 321-028-002. That's the cover page.

If we can move to page 009. There are two sections within the service agreement, 13 and 14, that deal with monitoring and quality enhancement. The first paragraph, 13.1, deals with monthly review meetings between the parties to this agreement and the provider, that's the trust, will submit regular monitoring reports on activity levels and quality initiatives.

At paragraph 14.1:

"The provider will ensure that services provided are of the highest standard of quality achievable within available resources."

14.2:

"The provider will share details of its quality framework with the purchaser."

Were you ever involved in putting together reports or documents of quality frameworks for the board, for the Western Health and Social Services Board?
A. I have no recollection of that.
Q. Who would have done that within the trust?
A. I remember Ms Duddy, director of nursing, and her department were very active in this. There was a lot of nursing quality issues, which she addressed. I'm not qualified to talk about them. I remember that was a major part of the work, and Mrs Brown was also involved.
Q. You and Ms Duddy and Mrs Brown collaborated, worked together --
A. Yes, we did.
Q. -- in establishing clinical governance within the trust.
A. Yes.
Q. If we can go back to page 004 of this document, there is a section on clinical governance, which stresses that

it is an increasingly important consideration for the delivery of acute hospital services:

"The board [that's the commissions board] will be adopting a proactive approach to this initiative. Clinical governance ..."

It continues at paragraph 3.2:

"... places clearly defined duties and responsibilities on healthcare organisations and individuals within them, and to be effective a clinical governance programme must include key elements such as: processes for recording and deriving lessons from untoward incidents, complaints and claims."

Was there at any time any sort of monitoring of this activity, the processes for recording and deriving lessons from untoward incidents, any quality report in that respect given to the commissioning board?

A. I have no personal knowledge of that, but I knew that was being done, and there was a process for recording untoward incidents coordinated through Mrs Brown's office in risk management. I'm not -- I do not know whether she furnished that to the Western Board.

Q. Presumably, the process of monitoring was through the clinical incident committee upon which you sat.

A. Mm.

Q. Were any reports then put together of how it was working

for submission to the commissioning board?

A. I can't answer that. I cannot remember.

Q. Can I ask you, you said in your third witness statement, WS043/3 at page 3, in response to a question that you believed -- at number 2. You were asked:

"Who bore ultimate responsibility for the quality of care delivered by the trust?"

And you expressed your view that:

"Individuals are responsible for their own actions."

I wonder, could I ask you to elaborate on that a little?

A. I had trouble answering this question. I initially said -- I initially said chief executive, and then I thought -- I couldn't get away from the fact that -- I always believe individuals are responsible for their own actions. So this is one of the most difficult questions in the witness statement.

Q. Yes. It wasn't meant to be a philosophical enquiry, it was meant to be a really quite practical thing. But in terms of your leadership, you were responsible for leading the various doctors and delivering the quality of care. Were you at that time aware of the guidance of the GMC in this document, Management of Healthcare, The Role of Doctors?

A. No, I don't believe I was. I'm sorry, could I see that?

Q. Yes, of course. I can call it up at 317-031-001. It came out in 1999.

At page 002, it introduces the purpose, and I think paragraph 3 best expresses it:

"The guidance which follows responds to the questions and problems which doctors most frequently face when carrying out management responsibilities, and it starts with the premise that the principal concern of everyone involved in the delivery of Health Services must be the care, treatment and safety of patients. Registered medical practitioners continue to have a responsibility for the care of patients when they work as managers and remain professionally accountable to the GMC for their decisions."

Were you a member of any grouping or association of medical directors?

A. Yes, I was. I've forgotten the name of it now, British Association of Medical Managers. BAMM, I think it was.

Q. Yes, BAMM.

A. Yes, it was, and I went to several meetings.

Q. Yes. Well, this is precisely the sort of guidance one would imagine would be circulated through BAMM?

A. I may have seen it. I can't remember it.

Q. In terms of the structures within the trust at that time, you were answerable to the chief executive.

A. Yes.

Q. Then answerable to you were the various clinical directors of the individual directorates. Then within the individual directorates, their clinical service managers reported up to them, and that was the chain of command, as it were.

A. Yes, it was, yes.

Q. Can I ask you a little bit about the women and childcare directorate, because you probably heard me quizzing people as to how the chain of command worked in that directorate, given that Dr Denis Martin, clinical director, did not seem engaged with the paediatric department.

A. My comment on that is that I felt he should have been engaged. As is my understanding, he was engaged, that was his title, and it was rather a surprise to me to see he took that view because I understood that was his role.

Q. His understanding was pretty clear. He said:

"I have no qualifications or experience in paediatrics and I did not, as far as I am aware, have overall responsibility for the provision of paediatric care."

He said that the present clinical director of women and children's care has a formal job description, which

does not include paediatrics.

Do you know, is that right, has it been changed?

A. I don't know exactly that, but the job description did change, so all I could say is check Dr Martin's job description. But it's my understanding that they encompassed both obstetrics and paediatrics at that time. So certainly the directorate structure was -- not constantly changing, was changing, and so his successor may have had a different job description, I can quite understand that, concentrating only on paediatrics.

Q. Because, of course, Dr Martin was not involved in any way within the review into Raychel Ferguson's case, and one would suppose that he might have been as the clinical director.

A. Yes. He -- he could have been involved, but his clinical services manager was there. The clinical services manager mainly represented the nursing line.

Q. Yes. Exactly.

A. So she was there and there was a paediatrician involved in the investigation.

Q. Yes, and she, of course, was answerable to the director of nursing rather than to you.

A. Yes, she was.

Q. So if she was taking care of the paediatric department, not Dr Martin, then there was no feed through the chain

of command to you of medical matters. Was that something that you were aware of at that time or thought of?

A. Well, it's my understanding that Dr Martin was clinical lead for paediatrics and obstetrics. That was his job title, as I understand it.

Q. But in the running of the hospital, surely you would have had to have engaged yourself with the paediatric department and would have found out who was actually representing it?

A. Well, at any hospital meetings, hospital management team meetings, occasions like that, he would be there, and in my opinion representing both.

Q. Would Mrs Doherty be there?

A. Yes, she would be there.

THE CHAIRMAN: If we take Raychel's death as an example, am I right in understanding that Dr Martin wasn't involved in the events which followed Raychel's death?

A. He wasn't involved in the critical incident review.

THE CHAIRMAN: But was he involved in anything?

A. Um, no is the answer.

THE CHAIRMAN: Right. Would that suggest that whatever his job title conveyed, in reality he had effectively nothing to do with paediatrics or with Ward 6, if I put it that way?

A. Um, on this occasion, it would look like that.

THE CHAIRMAN: If he wasn't involved on this striking occasion, it might be a little hard to imagine when he would be involved.

A. I think that's ...

THE CHAIRMAN: Would that be fair?

A. That's one view, yes. I'm not criticising Dr Martin here. There's obviously a gap between his job description and the reality.

MR STEWART: Just to illustrate that point, I wonder can we go to 077-004-005. This was a consensus protocol in relation to intravenous fluid therapy for paediatric patients that was brought out in May of 2002 in the hospital, in light of the Departmental guidelines on the prevention of hyponatraemia.

You can see it's introduced into the paediatric department, and it's signed by all the people who might have anything to do with the paediatric department but it isn't signed by Dr Martin, it's signed by Margaret Doherty. All the paediatricians on the left-hand side, medical director, Margaret Doherty, two surgeons and a pharmacist.

Would that tend to confirm to you that Dr Martin didn't really have much to do with paediatrics?

A. That would be a reasonable view.

Q. Can I suggest that one of the principal objects of leadership is to ensure that those people in your team know what they're doing, know what their responsibilities are and that you likewise know what their responsibilities are?

A. Sorry, what was the question?

Q. That as leader of that medical team you should have known precisely who had responsibility for what and so should they.

A. I should have, yes.

Q. Indeed, that observation finds force from the GMC management and healthcare guidelines for doctors at paragraph 21, and that appears at 317-036-006. This is a document we looked at a moment ago. (Pause).

I'm sorry, I'll read it out to you. Paragraph 21 says:

"Healthcare is increasingly provided by multidisciplinary teams. Such collaboration brings benefits to patient care, but problems can arise when communication is poor or responsibilities are unclear. Doctors who manage teams should promote good communication, ensuring that:

"Each member of the team knows where responsibility lies for clinical and managerial issues and who is leading the team."

That seems to be advice which might have been applicable to the chain of command going down to the paediatric department.

A. Yes, I accept that.

Q. If you weren't clear who was really running the paediatric department, how could you be confident that there was an effective system for providing the services within that department?

A. Well, I thought I was clear about who was in charge of it. I thought it was Dr Martin as clinical lead, but the effective day-to-day operational management would have been Mrs Doherty.

Q. If a situation arose, as did in this case, where nurses have difficulty in getting surgical staff to come across to Ward 6 to tend to surgical children and the nurses are bringing that difficulty to their clinical services manager, who is a nurse, who sits in committees, only with paediatricians but not with surgeons, and cannot report up to a clinical lead who's a doctor, these difficulties get stymied.

A. That's a possibility, but there was day-to-day interaction between the consultant, it's mainly consultant to consultant. The paediatric nurses work very closely with the paediatric consultants and they would initially -- and the clinical services manager --

and they would -- any complaints, they would discuss it among themselves, and they would then -- they would talk on the wards, it didn't go through a management structure, it was a -- the complaints were dealt with on the ward.

Q. This is something we'll hear from Dr McCord about, I hope next week, but it seems that the nurses did speak to the paediatricians, the paediatricians thought the nurses were going to go back to speak to the surgeons, and I think the nurses thought the paediatricians were going to speak to the surgeons. So there seems to have been --

A. I can see that wasn't clear.

Q. In relation to the critical incident review that you chaired in relation to Raychel's case, it was convened pursuant to the protocol. Did you have any part in drawing up that protocol?

A. Yes, I did, because, as I've stated, Mrs Brown and I worked very closely on this, and Ms Duddy, the three of us, and as I'm sure you're aware, we organised -- Ms Duddy organised a clinical effectiveness conference at which Miriam Lugon, the author of the book on clinical governance in 1999 was the key speaker. Tribute to Ms Duddy for organising that, it was her initiative. It was based on -- that lecture -- well, it

was based on her book, mainly, the template for critical incident reporting was made, and I was -- I played a large part in that.

Q. You've probably read the questions that I asked Mrs Brown on this particular subject, because Lugon in the book gives pretty precise indication of what she thinks the serious clinical incident review process should embrace, but some part of that was left out of the Altnagelvin protocol.

A. I think she always suggested this would be a template for designing a local critical incident reporting form. I didn't think she was being prescriptive.

Q. I can understand that, but when she makes an observation like statements must be obtained, why do you choose not to import that into the Altnagelvin protocol?

A. Well, I think we did take statements.

Q. No, I'm asking about protocol, not what subsequently happened.

A. Um, no, there wasn't mentioned in the protocol.

Q. Exactly that's my point. She mentions it and she says -- and it appears at 317-034-022. This is page 94 of her book. It's the very last line:

"Staff must be interviewed and statements taken."

Why did you choose not to import that into the Altnagelvin protocol?

A. Well, I did take statements subsequently. Could I clarify?

THE CHAIRMAN: Yes. The question is: in the protocol, which clearly a lot of work went into, why is the suggestion from Dr Lugon that staff must be interviewed and statements taken, why is that left out?

A. It must have been an omission. It was no more than that. It wasn't deliberate.

MR STEWART: We can now go to the protocol, which is at 022-109-338. The large paragraph in the middle of the page, which starts:

"The critical incident meeting will endeavour to clarify the circumstances."

It goes on to say:

"Staff may be asked to complete a statement containing factual information of their involvement to assist in the investigation. Note: these statements may be discoverable in the event of future litigation."

So it looks as though there has been a deliberate decision not to go with Lugon but to rather make statements optional.

A. I think that's ... I don't remember any nuanced argument about that. I don't know how that came about.

THE CHAIRMAN: Well, I think the reason it's being raised, doctor, is this, that this wouldn't be the first time in

the inquiry that we've been informed that certain procedures had been followed because there's advice from medical insurance companies that statements are not taken or that certain steps are not taken. And the specific reference here to future litigation suggests that this may have been playing on your minds when the protocol was finalised. It may explain why there's a departure from what Dr Lugon had suggested in her book.

A. It wasn't playing on my mind. I agree, it may -- Mrs Brown may be able to answer that. Some of the drafting was hers or Ms Duddy's, but it wasn't playing on my mind, a deliberate change of protocol.

MR STITT: Might I just ask if the inquiry team have a copy of the book? I apologise, I don't have.

MR STEWART: This section begins at 317-034 --

MR STITT: I'm not suggesting you're reading sparsely from it, but if there's an opportunity to have a look at it at some stage.

MR STEWART: I do have photocopies. We got it on eBay, it was very reasonable.

MR STITT: It's obviously been well-thumbed through, so I hope the price has gone down somehow.

MR STEWART: The author, Miriam Lugon, also says that -- one of the things that she says is a file be created and

a list of the staff involved. Why was it not suggested in protocol that somebody make a list of staff involved?

A. Um, I can't answer that. We wanted to do a one-page protocol. We didn't have any other supporting evidence -- documentation.

Q. The page says at the top, part of the introduction:

"This protocol details the procedure to be followed ..."

And as we've already indicated, the matter did not end in a written report. Was this, insofar as you're concerned, just a suggestion, a guideline, or did you regard this protocol as having more force than that?

A. I regarded it as a guideline, but it was extremely helpful in the events of 2001 to have this, even though it may be open to criticism. It gives a structure to work against, which was very helpful, even though it's imperfect.

THE CHAIRMAN: Yes.

MR STEWART: Yes. The suggestion I put to Mrs Brown was that surely adherence to the protocol is very important in a very serious incident, the more serious the incident the more important it is to adhere to the agreed procedure.

A. I agree with that.

Q. There was no critical incident --

THE CHAIRMAN: I think just to confirm, Raychel's death was the first time that the protocol have been activated; is that correct?

A. That's correct, yes, over a year later.

MR STEWART: Just going through the flow chart there, and we see that the critical incident occurs, and the next thing is:

"Clinical notes completed/clinical incident form completed."

It seems that that first line doesn't appear to have been complied with in this instance. There was no clinical incident form completed.

A. I'm aware of that. I think there was a verbal report to the chief executive, was the first report that I was aware of, but it was verbal. I don't think anyone's found the critical incident form.

Q. Individual and component parts of this protocol may have themselves not been terribly important, I mean the verbal communication may have been important, but cumulatively the lack of documentation does become important.

You were clearly informed, the risk manager to inform the chief executive, medical director, director of nursing. Of course, the director of nursing wasn't informed about this. When you sat down to chair the

review that day, did you not say, "Right, report form, where's the director of nursing?"

A. No, I didn't. I felt ... the report form seemed -- we already knew what it was going to say. I felt I had to activate the process. The fact that -- the form -- I know it seems strange now in a court to say this, but the form was almost an irrelevance, we knew the facts verbally on which to proceed. So I'm sorry to dismiss this, because it's important to you, but it seemed less important to us at the time.

Q. What about the director of nursing? This case had nursing issues arising at every juncture. Did it not seem important to you that the director of nursing should be present?

A. I'd have liked the director of nursing to be present but for some reason, which I can't explain, she was not present. Whether she was unavailable or --

Q. She said she didn't even learn about the review until after it had happened.

THE CHAIRMAN: That actually might be because she was entirely off site.

A. I can't explain it. She would have been very welcome, is all I can say. She would have been very valuable. But we had the clinical services manager there.

MR STEWART: Of course, the point you make yourself, her

value to the review.

Moving on down through this, it says:

"On occasion, trust solicitors may be present."

As chairman of the review, would it have been up to you to determine whether it was appropriate for the trust solicitors to attend?

A. It didn't occur to me to have a trust solicitor there.

Q. What sort of occasion would have been appropriate, in your view, for the trust solicitor to attend?

A. I suppose if we knew there was a pending litigation, I would have to ... that'd have been the only occasion. On this occasion we didn't.

Q. In this instance, one of the reasons why you chose not to take a minute of the meeting was the various people there decided that they would like to take legal advice on that. Is that right?

A. That's correct, yes.

Q. Would that not indicate that there was, at least in the minds of those people, a feeling that litigation might ensue?

A. That's correct, yes.

Q. And this, after all, is the most serious of cases you could sit down and review. But that didn't make you think about a solicitor at that stage?

A. No, it did not occur to me until someone had raised at

the meeting that ...

MR STITT: Might I interject, if I may, hopefully helpfully? It touches on this point that we're dealing with at this exact moment, and it also touches on the protocol which is still on the screen, so just in case the protocol were to disappear. Might I come back to the Lugon book and more particularly, Mr Chairman, the reference to the italicized line, which says:

"Note: these statements may be discoverable in the event of future litigation."

And I note the observations from yourself and the questions that have been asked in relation to that. I think it's only fair, if I may, to ask that a page be called up from the book. The reference is 317-034-003.

If the bottom paragraph could be magnified, highlighted, if that's possible. Thank you.

THE CHAIRMAN: So the point is that Dr Lugon specifically recognises this issue in her text?

MR STITT: Yes, she does. It's dealing with statements, it says you must make a statement, and that is absolutely correct, as Mr Stewart has said. That's on the page before:

"Staff must be interviewed and statements taken..."

Then it goes on:

"... in case of potential litigation. This is best

done by the claims manager. It is important that they [that must mean the staff] are aware of the potential for litigation even though the trust may not have received a letter before action and may not have receive one for many months."

And it goes on to point out that statements made become discoverable and/or they should only contain factual observations.

I would suggest that perhaps the suggestion of a culture of litigation defensiveness is slightly unfair in the light of this, given the wording of the protocol.

THE CHAIRMAN: But surely the point, Mr Stitt, is that the fact that Dr Lugon's writing along these lines emphasises the culture of litigation defensiveness. Because if you're writing a book, which is effectively a governance book, and you as the author of that book are dealing with potential for litigation, and in effect what this is saying is: look, if you didn't have this review system and the claims manager took a statement from a member of staff, that would be privileged.

Now, if you're going to take a statement in the context of a critical incident review within the hospital, there will be a debate about what the dominant purpose of the statement is, whether it's for litigation purposes or whether it's for review purposes. And what

Dr Lugon appears to be saying here is, the notion of privilege may be challenged, and in the event the information gathered will have to be disclosed. So what Dr Lugon is emphasising is the risk of litigation and the -- sorry, in the context of the risk of litigation there is the potential for critical incident review statements to be discoverable.

MR STITT: Yes.

THE CHAIRMAN: And that being the case, you may consider whether to conduct your critical incident review on the basis that you don't necessarily take statements because they may become known, in this case to the Ferguson family, through the litigation process. So if your point is that it isn't just Altnagelvin which is defensive, I'll take that point, but what this is identifying is the rampant culture in the Health Service.

MR STITT: I would respectfully take issue with the adjective "rampant". Maybe it's an adverb. Nonetheless, the three things -- the first one is the actual content of the protocol, and that was my first. If it could be brought up again, 022-109-338.

It says:

"Note: these statements may be discoverable in the event of future litigation."

Now, I'm concerned lest it be left in the air that that's something which Altnagelvin put in of their own volition.

THE CHAIRMAN: I take your point because that one line encapsulate what Dr Lugon has said in longer form.

MR STITT: That's my point.

My second point then is this. When we're dealing with the exact evidence, the exact point of the evidence when I intervened, that was when Dr Fulton was dealing with the reason why no minutes were taken. In my submission, it's entirely consistent with the advice and warning given by Ms Lugon.

My third point is whether there is a rampant culture or not, the fact of the matter is I would have hold that the inquiry would have given some credit to Altnagelvin in 1999 for involving this lady in a conference to try to set up what was a new type of discipline.

THE CHAIRMAN: I'm not sure how often I've said publicly that this is all -- I mean, there's --

MR STITT: You have, sir. I accept that entirely.

THE CHAIRMAN: There will be a lot of credit given to Altnagelvin for a lot of what happened in terms of governance. The areas that went wrong are the areas that we are focusing on. Again, for the record, in case somehow this seems unfair, the fact that we're focusing

on debatable areas doesn't minimise the credit which Altnagelvin is properly entitled to and people like Dr Fulton, Dr Nesbitt, Mrs Brown are properly entitled to, Ms Duddy and others, for the developments and for the rather imaginative idea, for instance, of bringing over Dr Lugon to take a seminar in the first place.

MR STITT: That's very gracious of you, sir, to put it like that, and it is acknowledged. The point I'm simply making is that anybody listening to Dr Lugon, assuming that she was giving the same talk as contained in her book, would have received certain advices and warnings in relation to this. Thank you.

MR STEWART: It is recognised that holding a review into the death of a patient so quickly stands in very marked contrast to what has been seen elsewhere in this inquiry. So looking at this is just to look and see where things might have been done better.

THE CHAIRMAN: And just to emphasise, doctor, and to Mr Stitt, the purpose of this is not just looking backwards, it's looking forwards, and it's to say, because we're coming, as I think you're probably aware, in November to inviting the Belfast Trust and the Department to present position papers on what is now happening in the Health Service, and one of the ways in which we will test the current practices and procedures

is by putting to them some of the circumstances that happened in Raychel's case and Adam's and Claire's and Lucy's, to say, for instance: how would that be dealt with differently today? The 2000/2001 critical incident protocol from Altnagelvin, to what extent is that still followed? Have things been developed since then? And if we take some of the things that might have been improved upon in Altnagelvin in 2001, would they be still handled the same way or would they be handled differently?

Because while a lot of this inquiry is looking backwards, the point that has consistently been made on behalf of the families is that they would welcome some reassurance, which would be in the public interest, that some of the mistakes which were made, or as many as possible of the mistakes which were made in the past, will not or could not happen again now. Okay?

So I hope that sets the context for much of what we're doing.

A. Thank you, Mr Chairman.

MR STEWART: Did you have much time to prepare for the start of the review on 12 June 2001?

A. 24 hours, I was in the Omagh and Tyrone County Hospital in the morning when I was rung by the chief executive to tell me the details of Raychel's death, and I went back

to Altnagelvin that afternoon and met Mrs Brown. And we had a meeting, I don't remember the exact details of it. That's where we planned the critical incident the next day at 4 o'clock.

Q. The next day was a busy day, was it?

A. Yes, I have clinics on Tuesday morning, so I've been involved with that, because I'm a part-time medical director and part-time -- so I had a clinic -- I remember I always had a clinic on Tuesday morning.

Q. And you also attended a hospital management team meeting in the afternoon as well?

A. Did I? I don't remember that.

Q. Perhaps we'll just look at that. 316-006g-007.

(Pause).

I'm sorry, sir, I don't know what's happening.

THE CHAIRMAN: Okay, let's take it for a moment that there was a hospital management team meeting, which might explain why the critical incident review started at 4 o'clock; is that right?

MR STEWART: Yes, sir. I have a copy of the minutes here and they are the minutes of the hospital management team meeting held on Tuesday 12 June 2001 at 3 pm in the boardroom of trust headquarters. Present at that meeting was Mrs Burnside, Dr Martin, Dr Fulton, Dr Nesbitt. So many of the major -- oh, thank you.

There we are.

I've got the full set of minutes here, and they run to seven full pages, detailing core brief, business service reports, finance reports, previous minutes, long discussions on managed clinical networks and so forth. Do you remember these hospital management team meetings?

A. Yes, I do, yes. I remember their length.

Q. Especially the length?

A. Yes.

Q. I'm sure they were tedious. Do you remember individual patients or individual events being mentioned at hospital management team meetings?

A. No, it's a long time ago. I'd need to look at the minutes. I don't recall any individual examples.

Q. Because you and Dr Nesbitt and Mrs Doherty presumably all went straight from here to the review meeting into Raychel Ferguson's case?

A. We must have left that early because that would have gone on for two or three hours. Because our meetings -- the critical meetings started at 4 o'clock, I remember that, so I would have left that meeting just before 3.

THE CHAIRMAN: Just to go back a step, just to put this in context. As of 2000, the trust had a critical incident protocol, okay? Can you help me by trying to imagine this. If Raychel had died in 1999, before the protocol,

what might have been the shape or format to any internal review or investigation?

A. Well, we will have had a review for a tragedy of this magnitude. It wouldn't have been structured around that protocol, it would have been designed for that particular occasion.

THE CHAIRMAN: So as one example, it might not have meant bringing in together quite a number of the nurses, doctors and others who --

A. No, I think it would. It definitely would have. I think that was never a problem in Altnagelvin. There were good relations between doctors and nurses, they were expected to be there.

THE CHAIRMAN: Right. So the difference that the introduction of the protocol made was what?

A. Um, it allowed Mrs Brown and I to design -- think of the people who'd need to come to the meeting next day, even though it was an incomplete list as it turned out. And also, we'd had the benefit of Miriam Lugon's talk about what we should do and who we should report to.

THE CHAIRMAN: So it gives you something of a structure?

A. It's a more formal structure.

THE CHAIRMAN: Thank you.

A. Hitherto, incidents were called clinical incidents. There's a bit of trouble with the nomenclature here

clinical incidents and critical incidents they're really just merge into each other. Critical incidents by definition are very serious incidents, but there are grey areas in between.

MR STEWART: Yes. Can I ask about the documentation you got together to go into the review meeting?

A. Mrs Brown had secured the case notes, I think the previous day.

Q. Yes.

A. On the Monday afternoon -- when I first -- when I met her on Monday afternoon after returning from Omagh. So we had the case notes there. That was the main information we had at that stage.

Q. Miriam Lugon recommends that a file be opened, it should identify the patient's administrative details, it should include a list of the staff involved, and then worksheets, any other legal information, and then a chronological summary of the clinical events.

Did you have provided for you a copy of Margaret Doherty's report on Raychel Ferguson? Can I just show what you it looks like. It's at 316-085-009.

This is headed "MD copy". That could stand for medical director's copy. It might have been M Doherty herself. But do you recognise this document?

A. Not on the first reading here. Dated 9 June ...

Q. No --

A. No, sorry.

Q. The second page, if 010 could be brought up alongside it, isn't dated.

A. I don't recognise this document, but it may have been an internal nursing document.

Q. That's why I'm asking you. There's some lack of clarity about when it was produced. It includes, you'll see at the top right-hand page, the note of Staff Nurse Noble verbally reporting to Sister Little.

Sister Little telephoned Staff Nurse Noble and took a note of her recollection of the incident.

Sister Little referred that to Mrs Doherty, who included it in this report.

It might be assumed it was made for the purpose of the review.

A. On a quick reading, I don't recognise this document, and it reads, as far as I can see, as something of an internal nursing report.

Q. Okay. Would you have expected any internal nursing investigation reports, resumes, statements, interview notes, to be brought to your attention as chairman of the review?

A. Yes, I would, yes. This may have been written after the

review.
Q. That, I think, is what Mrs Doherty recollects, although Sister Little, who gathered the information, says that she was asked to do so in order that Mrs Doherty might provide a report for the review. So there's a little lack of clarity as to when it was done.
A. I can't help you any further on this document.
Q. As far as you're concerned, it was not brought to your attention at any time before or after?
A. At this stage I don't recognise that document.
Q. When you sat down to look at the notes and hear from people describing what happened, did you think "We must get a list of the people who were involved so that we can identify them all"?
A. Can I clarify this? Is this the day before you're talking about?
Q. Even when you sat down to chair the meeting, if you were trying to investigate what happened from the people who were involved, you'd want to know who those people were.
A. Yes, I did, at the meeting.
Q. Yes.
A. And I think my handwritten notes might help here. Can you show those, please?
Q. Yes, indeed. It appears at 026-011-012.
A. That's it, yes.

Q. Is this the note that you say you took on that day?
A. Yes. It is, yes. At the beginning of the meeting or throughout the meeting, but mainly at the beginning. No, the beginning of the meeting, sorry.
Q. Because reading from the top, it must have been clear to you that Dr Bernie Trainor was not at the meeting, Dr Jeremy Johnson was not at the meeting. Mr Zafar was not at the meeting. Claire Jamison was not at the meeting. Dr Gund was not at the meeting, and so forth.
So that isn't a list of people who attended?
A. No, it isn't. This has caused me to write my second witness statement, this has caused me some --
I apologise to the inquiry for this, I'm sure you'll come to this later, but this actually was really a chronology at the time of the meeting, I was trying to build up who was involved, and this fits with the people who were involved with Raychel's treatment. That emerged into an attendance list later in my memory, which is not correct.
Q. But if at the time you were making this list, it must have been clear to you then and there that there were people from whom presumably you'd wished to hear, who weren't in the room?
A. My initial aim was to investigate Raychel's death on that day. There were people in the room who were

involved in Raychel's death.
Q. Yes, but you have a note here of people who weren't in the room who were involved in Raychel's death.
A. No, but there were people in that room, their consultants who would speak on their behalf, like Dr McCord would speak on behalf of doctors Johnson and Trainor and describe their involvement in Raychel's treatment.
Q. But Mr Gilliland couldn't tell you what Mr Zafar said or thought, let alone what other doctors who aren't noted here, such as Curran and Devlin. The question is, why didn't you send out for these individuals who weren't there and ask them to come and give their account, be interviewed or make a statement?
A. Because I felt we had enough initial experience of the treatment at that meeting to make a start. I agree it was not comprehensive.
Q. Okay. So if that meeting was to make a start, did you reconvene to continue and then complete the work?
A. No, I didn't, but I asked for statements from all the people who weren't there.
Q. Mrs Brown asked for statements --
A. Yes.
Q. -- after the meeting for -- mostly nurses, two nurses', two doctors', statements were provided, and then nothing

until she followed that up much, much later with letters. So you weren't really working at the review on statements.
A. That was an agreement -- that was my -- I asked at the meeting for statements to be given, written statements --
Q. Yes.
A. -- from the people who were at the meeting and others as well who were involved. I agree, there must have been gaps in that.
Q. So you don't remember now who was at the meeting.
A. I remember some people very clearly.
Q. Yes.
A. I can tell you, if you like.
Q. Because when you made a statement earlier to the inquiry, and indeed a statement to the police, you didn't then remember who was there because you were wrong in many respects.
A. I was wrong, but I remember the senior staff well.
THE CHAIRMAN: The senior staff -- well, let's do it this way. Just for confirmation, the people who you can absolutely clearly remember being at the meeting were? Well, Dr McCord I think you have just said was one.
A. Yes. Mr Gilliland, Dr Nesbitt, and there was a junior surgeon, who I think was Mr Makar.

MR STEWART: Yes.
A. And I think that's all the medical staff. Mrs Doherty, Sister Little was definitely there, and there was -- I think one of the nurses, certainly Nurse Noble was there.
THE CHAIRMAN: Yes.
A. There was a lot of nurses there. I think it was six, I think all those nurses were there.
THE CHAIRMAN: Thank you.
MR STEWART: Okay. So in order to get people there, you'd delegated that responsibility to others to ensure that the relevant people be brought?
A. I -- well, this was -- it was -- we discussed this at the meeting the previous day, Mrs Brown and I discussed this, the key staff, as we call it, and I cannot remember the mechanism we used to locate those, or how to identify them, or how they were --
Q. Let's go to WS043/1, page 4. The second paragraph there, you tell the inquiry:
"Mrs Brown then contacted the relevant staff on the afternoon of Monday 11 June and asked them to attend a meeting at 4 pm on Tuesday 12 June. The meeting would be chaired by myself. All contacted staff agreed to attend."
How did you know that?

A. Well, I think she told me. It was Mrs Brown that did the contacting, to my recollection. I don't remember phoning anyone.
Q. Because not all staff who were contacted were able to attend.
A. That may be mistaken phraseology there. If they couldn't attend, they couldn't attend.
THE CHAIRMAN: I make a basic point, it wouldn't be easy for everyone to attend --
A. No.
THE CHAIRMAN: -- because you can't take everyone off duty.
A. Well, I wasn't surprised that a lot of people couldn't attend, they're either off duty or doing something else.
MR STITT: Mr Chairman, can I follow up on that point. May I remind the inquiry of the view of Professor Swainson in relation to this matter, it's at 226-002-023, and he deals with this point at paragraph 78, if I may read the first two sentences:
"The critical review initiated by Dr Fulton was sound. It was important to conduct this quickly so that events were fresh, and thus not possible to have everyone concerned attend, but there were sufficient people present to begin the process."
So whatever happens later, I'd suggest that there is one view, one expert's independent view that says it's

better to get on with it.
THE CHAIRMAN: Absolutely, and I am sure it is better to get on with it. I'm sure Dr Swainson's right. I don't think the questioning is unfair. When Dr Swainson comes to give evidence we can draw out or develop these points.
MR STITT: For the record, I'm not suggesting the questioning was unfair, I'm simply saying in relation to those doctors who could not be present, you, sir, had said maybe people do at short notice have other commitments, and that doctor seems to have addressed that.
THE CHAIRMAN: Yes.
MR STEWART: It's clearly a good idea to begin the process and the sooner it begins the better. That's obvious. Whether the process should have been continued I think is an issue one might wish to look at.
THE CHAIRMAN: Or how it should be continued.
MR STEWART: How it should be continued, indeed.
At WS043/1, page 6, the third paragraph, you said:
"I recall the following discussions and have brief summary notes written shortly after the meeting."
And then you go on to reveal the discussions you recall and the summary notes you made.
Well, of course, we now know, and you recognise,

that in fact you were wrong that Dr Jamison wasn't there, Dr Gund wasn't there and so forth, that you didn't recall those discussions, and your notes are not summaries of what was said at the meeting, nor were they written shortly after the meeting.
A. No, they weren't, they were a recall of the statements subsequently made.
Q. I'm sorry?
A. Sorry, I was recalling -- I discovered that I was recalling the statements that they made.
Q. Can I suggest it's very careless -- this is also what you told the police. Can I suggest it's very careless to make statements like that, which haven't been checked by you and are so inaccurate.
A. Yes, I agree. I'm not proud of it.
Q. Did you create a file, did you start a file at the meeting that day?
A. I had a file for my personal notes, all of which you have, to my knowledge. I assume Mrs Brown has a master file, statements.
Q. I presume that even though you weren't taking notes, maybe not necessarily verbatim notes of what people were saying, you were taking some notes?
A. No, apart from that first page I didn't.
Q. In order to appreciate the chronology of what happened,

you'd have to take notes?
A. No, the -- no, I carried that in my head. I intended to take notes, I must make that clear. That was my -- it's obviously preferable to take -- it's good practice to take notes. And that was my original intention, and Mrs Brown was there to do so. I remember her sitting with her book in front of her ready to take notes. I think I've explained why we didn't take notes.
Q. Yes.
A. I can go into that again if you wish.
THE CHAIRMAN: No, it's okay. Thank you.
MR STEWART: But how could you take a mental note for yourself? How could you take a note for yourself without pen and paper of who you needed to speak to, what questions you needed to ask in the future, what lines of investigation you needed to pursue, what issues were being highlighted? How could you do that without actually putting pen to paper?
A. Well, I was focusing on what happened to Raychel and the lessons to be learned. That was what I was focused on. I wasn't actually thinking much beyond that meeting. I felt we had a great opportunity to find out quickly what had happened to Raychel.
Q. Yes, I'm interested in the almost total lack of documentation. Was there anybody at that meeting who

had a biro in their hand?
A. Well, I obviously had because I made a list of people who were involved in her treatment.
Q. Did you receive a statement from Staff Nurse Gilchrist at the review meeting? It's a statement said to have been written on 10 June. 098-293-771. You see it appears to have been received by the risk management director rather later, in November 2002, and that indeed was after it had been specifically requested by letter. But was that available to you at the meeting?
A. No. I recall no statements being handed in at the meeting.
Q. At the meeting, do you recall the rumour, as it's been described, being discussed?
A. Yes, I do.
Q. A rumour that was coming back from Belfast?
A. Yes, I do.
Q. What do you remember about that?
A. One of the nurses brought this up and said that they'd heard that -- let me get this right -- that someone had told ... A nurse from Altnagelvin had contacted a nurse in the Royal after Raychel had died to find out what had happened, and she had been told by that nurse that the wrong fluid had been given. I think "wrong fluid" was the word that was used.

Q. Yes.
A. It was a rumour, and that's all we knew at the meeting. But the nurses were obviously quite upset about this. They were upset anyway by the circumstances and they were at a loss as to why the wrong fluid was given.
Q. Belfast was at a loss?
A. No, we were. The nurses were.
THE CHAIRMAN: Yes, Altnagelvin was at a loss to understand how Solution No. 18 was the wrong fluid.
A. Exactly, yes. Because hitherto they had regarded that fluid as safe.
It's important, Mr Chairman, I say that at the review meeting, from the start we knew why Raychel had died, we knew about the low sodium and the cerebral oedema. So to some extent we were working backwards. The medical people knew, were able to piece together the -- it was working backwards. The nurses at this stage had no understanding of the risks of Solution No. 18, which is why they were very shocked by this rumour.
THE CHAIRMAN: Right.
MR STEWART: And was that why Dr Nesbitt came, armed with some research and some background knowledge of --
A. Yes.
Q. -- Solution No. 18?

A. Dr Nesbitt obviously -- Dr Nesbitt, can I say, was very shaken by this whole experience, so were the nurses. The atmosphere in the room was very tense at that meeting. Everyone was extremely shocked. This was something that had never happened in their professional career. So Dr Nesbitt and the nurses especially were very shocked. Dr Nesbitt obviously, after transferring with Raychel to the Royal, had gone back and done some initial research at home, and he had some concerns about Solution No. 18.
THE CHAIRMAN: I just want to get the complete rumour. The rumour was that an Altnagelvin nurse had been told that the wrong fluid had been used. Was it also part of the rumour that the Royal had stopped using Solution No. 18 sometime before?
A. No, not at that time.
MR STEWART: Did Mr Gilliland refer to any discussions between doctors, doctors in Altnagelvin and doctors in Belfast?
A. No. The discussion he had was with his junior staff.
Q. Was there any reference to the nurse who may have been in the ambulance going to Belfast with Raychel and Dr Nesbitt, any information that she might have brought back?
A. No, we didn't consider that.

Q. In relation to the discussion about the vomiting, do you recall much of that discussion?
A. I recall quite a lot of it because it was quite -- you know, it was quite a long, long discussion, mainly by the nurses. The nurses described -- various nurses, I can't remember which nurses, described various stages of Raychel's stay in Altnagelvin, and they all described the vomiting. And some of the doctors in the meeting -- this was not like -- although I was chairman, it was cross-questioning from the consultants of the nurses and vice versa. So it was a two-way flow in this meeting. It wasn't all directed through me as the chair.

And I remember a lot of questioning of the nurses about the vomiting, and it was hard to form a clear opinion of the volume of vomit. It seemed the vomit -- it was all agreed the vomiting was -- words have been used like prolonged, it was continued, continued all afternoon. There was no disagreement about that.

The nurses felt that the volume of the vomit was not excessive at that meeting. And then they were questioned by various doctors, including myself, about the documentation of the vomit, and it was hard to interpret from the charts about the volume and the frequency as well. So there was considerable discussion about this.

Q. Was there discussion about what Raychel's parents had been telling the nurses about the vomiting?
A. Yes. To me this seems a difference of opinion about the Ferguson family's, the parents' reports of the vomiting. They considered there was a lot of vomiting, large volumes of vomiting, and what the nurses were telling me. But the nurses told me that the Fergusons had a different view. They were clear there was a difference of opinion here. So I was aware of that at the meeting. I couldn't really at that meeting appreciate which side was right, if you like. And I still don't.
THE CHAIRMAN: You've got sides coming at it from a different perspective. If it's my daughter who is sick and sick all day, I would regard that as severe vomiting -- okay? -- because I wouldn't have the expectation or knowledge about what's likely to happen in the way that a nurse who's experienced on Ward 6. So the fact that there's a different perspective between the family on the one hand and the nurses on the other is not in itself surprising.

If my daughter was sick five or six times, I might think that was prolonged and severe, and that's my perspective on it. Whereas a nurse might think that if a child on the ward vomits five or six times after

surgery, well, it's unpleasant and you want to bring it to a stop, but it's not out of line with expectations.

I think the real, the big concern about the vomiting, doctor, is that on the evidence I heard in February and March, is the response of the nurses to the vomiting, and the expert evidence I've heard is really quite clear that after the second or certainly the third vomit, there should have been what I think Mr Orr described as active observation instead of just noting in the notes that there's another vomit, that that should have led people to think "we need to check why this is happening".

So the issue about the vomiting being severe and prolonged is important, but perhaps even more important is the response of the nurses. The fact that other children have vomited as long or as much as Raychel in a sense is neither here nor there, is it? You have to deal with the child who's on the ward, and the child who's on the ward might be not that much different in some ways from another child who was on the ward a couple of weeks ago who also vomited a lot. But you don't assume that because the child two weeks previously got through things and went home fine, that the child who's in front of you today will do the same.

Isn't that the whole point about how you treat each

patient separately?
A. I agree, you have to treat each patient separately.
THE CHAIRMAN: And the criticism which was made in February and March, which was really quite unanimous between the experts, was that it was the response of the nurses to the vomiting which was one of the crucial lapses, and to a degree, that is more important than deciding whether she vomited eight, ten or 12 times, or whether plus or plus plus have a substantial difference between them, which you can't ever reconstruct at a review a few days later.

I'm saying that to you because that's what I've taken out of the evidence that I heard in February and March. Was the issue of the response to the vomiting discussed at the critical incident review in your memory as directly related to how often and how much Raychel vomited?
A. The response was discussed and it was -- I think it was Sister Millar saying at some stage "Medical help should have been called earlier", but I can't remember at what stage she suggested that should have been.
THE CHAIRMAN: Okay, thank you.
MR QUINN: Mr Chairman, before we leave this issue, could I raise a point that will certainly be in the family's mind? That is it seems from this piece of evidence that

the nurses were aware that the family were raising, if not complaints, then considerations about the level of vomiting on the ward at the time.

Now, it seems that from the best of my recollection, this is the first time that we actually have someone saying that this was raised as a considerable point at the meeting. And I think it's important also to say that this witness has been very fair in saying that there was a difference of opinion between the nurses and the family.

And I just want to make a point that if it was raised at the meeting that there was a considerable difference of opinion between the family and the nurses, then why was that not followed up at the meeting in September? Which was another issue my learned friend will come to, I'm sure. But it just strikes me that this is an issue that has to be put out in the open, that if it was being raised at a meeting only days after Raychel died, then there was a consideration that the nurses had it in their mind that the family had been raising this as a considerably important point at the time just before Raychel died.

THE CHAIRMAN: Yes, I agree, Mr Stewart will go on to that. It's a curious point, Mr Quinn, because in a sense it reflects well on the nurses that they said at the

critical incident review that the family's perception of Raychel's vomiting was different and worse to the nurses perception.

MR QUINN: Yes.

THE CHAIRMAN: It's one of the many frustrations about the governance side, is that this is a point which, to a degree, illustrates the nurses being quite open, or open to a degree at the critical incident meeting.

MR QUINN: Why I'm raising it, I'm raising it sincerely, because Mrs Ferguson has raised with me a couple of times this week that it seems that she was not believed about the level of vomiting, and Mr Ferguson has raised this point as well, and it seems to me that Altnagelvin seem to have gone with the nurses' version of it as opposed to the family's version of it, and nobody knows a child better than their mother and father.

THE CHAIRMAN: That's quite right, and one of the repeat lessons throughout the inquiry is: listen to the parents.

MR QUINN: And that's the point that I wanted to get on to the transcript because nobody does know a child better than the mother and the father, and it seems that they were not being listened to.

MR STEWART: I think, in fairness, Dr Fulton ought to respond to that.

A. Sorry, what's the question?

THE CHAIRMAN: I think the point is that since there was, to the nurses' credit, an acceptance by them at the critical incident review that the family's understanding or view about Raychel's vomiting was rather worse than their understanding or view, how was that followed up after the meeting on 12 June?

A. Because it was a nursing issue, there were subsequent nursing meetings, which I think are documented, where documentation of vomiting was -- they were documented. But there were certainly subsequent meetings between nurses and I remember one point was to call doctors promptly, or some words to that effect, and also improve the documentation of vomiting and urine.

THE CHAIRMAN: Perhaps the point's being put in this way. Did the review team ever reach a conclusion on which interpretation of events was more likely to be correct? The Ferguson interpretation or the nurses' interpretation?

A. No, no, we didn't. But both versions -- you know,either version was not dismissed, I must make that clear, Mr Chairman. The Fergusons' claim was not dismissed, certainly not by me, and not by anybody in that room.

THE CHAIRMAN: Thank you. Mr Stewart, this might be a point. Doctor, I think you know our system, we'll

break for 10 or 15 minutes and we'll resume. Thank you.

(11.45 am)

(A short break)

(12.00 pm)

MR STEWART: I wonder, might we see WS043/3, page 15. These, Dr Fulton, are your answers in relation to questions posed to you about "Issues discussed at the critical incident review".

If I might draw your attention to (j):

"Any shortcomings in the frequency of the assessment of Raychel's electrolytes."

You have answered:

"Sister Millar clearly stated that the blood electrolytes should have been checked in the afternoon because of the continued vomiting."

Was there a discussion at that time of the linkage between electrolyte loss and vomiting?

A. I think Sister Millar was more concerned about the fact that Raychel continued on intravenous fluids at the time, rather than the vomiting, but the two are connected because the reason she was on intravenous fluids was because she was still vomiting. But Sister Millar was very clear that the electrolytes should have been checked.

Q. In relation to the fluids, do you remember discussion

about the quantity or the rate of fluid?
A. I do. Dr Nesbitt, who was our anaesthetic expert there, who was key to this investigation, he said that in his calculations the rate was -- by conventional calculations the rate was too high, but given the fact she had been fasting for several hours, the initial high rate was needed.
Q. What about the rate post-operatively?
A. At that meeting, my understanding was he felt that rate was too high. I know he has gone back from that.
Q. I know he's revised his view, because at paragraph (i) you describe how:
"Dr Nesbitt calculated that using the standard formula based on weight, Raychel had been prescribed too much per hour. He thought this was acceptable before the operation but was excessive in the post-operative phase."
A. That was his view at the meeting, yes.
Q. Do you remember discussion about the documentation and any issues arising from that?
A. Yes, I do. The doctors were not -- obviously not experts in nursing charts, but there was a lot of discussion about how you recorded vomit, I think, as has been discussed before, about the plus plus plus scale. They felt that was very hard to interpret objectively.

A lot of discussion between the nurses and the doctors about alternative systems, but it was found that it was very difficult, apparently, to record vomit objectively. But they were going to look at that on the action. The point was they were going to look at the documentation.
Q. Yes.
A. And also, I think, some vomits weren't recorded, and that was mentioned.
Q. And that was one of the factors that made you undecided about the whole issue of how severe the vomiting was because there were unwitnessed and unrecorded vomits?
A. Yes.
Q. Was the issue of responsibility for the prescription and the supervision of the IV therapy discussed and debated?
A. Yes, it was in quite a lot of detail. And I think I've stated in one of my witness statements that I was not clear at the end of this, of the various responsibilities. It was not clear. And there was no written policy, though there isn't normally a written policy in most hospitals, in my experience, but there was no clear understanding, and I think this was admitted at the meeting between the surgeons, anaesthetists and paediatricians.
Q. This tragedy allowed that particular systemic problem to be identified.

A. Yes.
Q. Were you surprised that it had been allowed to exist?
A. Yes, I was surprised.
Q. Looking back now, what sort of systems would have identified that before this happened?
A. Well, what I said about audit, audit would certainly not detect it, because you wouldn't know -- to look at it, you wouldn't know to audit because no concerns had been raised about it. I think -- and it had to be an individual clinician -- I have thought long and hard about this, I think one of the opportunities might have been junior staff coming from other hospitals, who might have come with a different experience, and they might have raised this.
THE CHAIRMAN: But that's precisely what happened in Raychel's case. There was a member of staff, the anaesthetist, who had come from another hospital, but he was advised not to prescribe Hartmann's because that wasn't the practice, whereas it had been his experience to prescribe the post-operative fluid when he had worked elsewhere. That's actually part of the problem, doctor, that somebody who came in with some years' experience of working elsewhere had been steered away from his own established practice, which had been taught to him, in favour of the Altnagelvin system.

A. I'm aware of that, yes. That would have been an opportunity.
MR STEWART: What about the problems expressed or voiced by Sister Millar about getting surgical staff to come across to Ward 6?
A. Now, this is an area that I -- this is a thing that came up after the meeting, or at least raised its priority, because at the meeting I did not get a sense that this was a problem. The sense I got was there was occasional problem in summoning junior doctors, surgical doctors by bleep because they'd be tied up elsewhere in theatre or Accident & Emergency, and that's what I took out of it.
And Sister Millar, I know she said she raised it very strongly that they had trouble getting the surgeons to commit, I think, or something, to the ward. That did not come across to me at that meeting. I'm not saying she didn't say that, but the priority didn't raise itself to a high enough level in my consciousness.
THE CHAIRMAN: Are you saying that in the sense that you became aware subsequently that it was an issue of greater concern than you'd picked up from the meeting?
A. Yes, I am saying that, because I've seen subsequent nursing meeting minutes where it was minuted more forcefully. I'm not dismissing Sister Millar's concerns.

THE CHAIRMAN: No.
A. We would have incorporated them into an action point should it -- you know, if it had been a major area of discussion, and that was a great opportunity because Mr Gilliland was there, the surgeon. I don't think he picked this up either. It would have been a great opportunity to have an interchange between Mr Gilliland and Sister Millar, so I'm sorry that opportunity was missed, if indeed it was.
MR STEWART: In relation to the issue of the taking of the regular taking of U&Es, that must have been a central issue of concern and debate?
A. Yes, it was. It was identified that, you know -- I think everyone recognised that an earlier U&E would have been -- would have given early warning of hyponatraemia. That was discussed in great detail, and it was agreed that it should have been done in the afternoon.
Q. In the afternoon. There seems to have been a system whereby a surgical patient might not be subject to the same regularity of U&E review as a paediatric patient because of the way the ward take rounds were conducted and so forth.
A. Um, we didn't discuss the actual -- didn't discuss ward rounds at that meeting at all, if I remember right. My

understanding is that if there was a policy or an understanding between a doctor and a nurse, a nurse would know when to prompt investigation to be done, but it was clearly understood at the meeting that it was the responsibility of the doctor, not the nurse.
Q. Yes.
THE CHAIRMAN: Do I understand it that this was a view which had been formed, say, by Sister Millar with the benefit of hindsight that the U&Es should have been done in the afternoon? Because the evidence that I've heard is that while there's some debate about when a doctor was first called to the ward, no doctor in fact attended Raychel until about 6 pm, and that doctor, when he arrived, was in effect being steered to give an anti-emetic, but he was not being steered, nor was it being suggested to him in some way that there should be a test of Raychel's U&Es. So the steer that the nurses on the ward gave to that doctor wasn't towards U&Es, it was just to give an anti-emetic.
A. So I understand, yes.
THE CHAIRMAN: Do I then interpret it that when everyone agreed that the U&Es should have been done in the afternoon, that that was their view looking back on it as opposed to what they had thought on that Friday afternoon?

A. Well, when I say everybody, I mean the doctors and Sister Millar. I'm not sure of the views of other nurses. But Sister Millar I'm not sure was on the ward throughout that afternoon. I'm not sure about that.
MR STEWART: She went off duty at 6, if my memory's correct.
A. Sorry?
Q. I think she was on duty until 6 pm.
A. She would have been on administrative duties rather than hands-on clinical nursing.
Q. Yes.
A. But she did state that. Sister Millar has a very clear way of speaking, and I remember her clearly saying that, "Yes, her U&Es should have been done", a phrase like that.
Q. When did you sit down and draft out your action sheet, which is 026-011-014?
A. I think it was that evening after the meeting. The meeting ended about 6.00/6.30, and the handwriting looks more measured and better written, so it wasn't written during the meeting, I'm saying. I'm sure that was written that evening. I would have then discussed that with Mrs Brown and she would have typed up the various copies.
Q. It went through, I think, a couple of drafts.
A. Proofs, yes. There's one error on point 1 there. Maybe

you're going to go through this, counsel.
Q. Please point it out.
A. It says, "Change to Hartmann's". I don't know why I wrote that because my clear memory is that we would stay with Solution No. 18 until Dr Nesbitt returned with his research.
Q. That's certainly the question I was going to ask you. If we could bring up alongside this 022-108-336. This is, I think, the final version that was typed up following --
A. Solution No. 18. That's the correct version in my memory. I don't know why I wrote Hartmann's, but events overtook that anyway because he had changed by the next day to Hartmann's.
Q. Yes. Because it did look as though, and you probably heard me suggesting to Mrs Brown, that if it was agreed, point 1 on 12 June that there be a change to Hartmann's, how was it without any further meeting it managed to get expressed as agreed action the following day. It is an error, but what process of mind could have allowed you to make the error?
A. Well, I was the one who had the process and I can't explain it, so I don't know. It was a -- I don't know why I said that. There was so much discussion about Hartmann's and Solution No. 18, I transposed them.

Q. Point 4, which is "Monitor urinary output". On the left it's:

"Monitor urine [and query vomit] output."

Becomes translated as:

"Only urinary output should be measured and recorded."

What happened to the vomit?

A. I don't know. But it was clearly taken forward in the fluid balance documentation and the discussion with the nurses afterwards.

Q. Because it was the subject of lengthy discussion.

A. It was, yes. And I think I record in my first witness statement that vomits should be recorded -- it was agreed that all vomits should be recorded. I can check that, but that's my understanding of the urine and vomit. I can't explain why it was missed there.

Q. Did anyone suggest that the participants to the review should meet again within maybe, say, two weeks of the review to review its progress?

A. No, they didn't. That would have been my responsibility.

Q. In hindsight I am sure you'd agree possibly it would have been a good idea?

A. I agree it would have been a very good idea, yes.

Q. But the first opportunity, it seems, for a review to

take place was the following month when there was an update to the chief executive. After the meeting itself, did you make any form of report to the chief executive?

A. Yes. Mrs Brown and I went that evening after the meeting to the chief executive's personal office and gave her a long verbal report, including a verbal report of our actions.

Q. Did she ask for anything in writing from you?

A. No.

Q. Did you offer to give her anything in writing?

A. No, apart from the fact that a typewritten copy -- the right-hand document there would be available to her the next day, presumably.

Q. Yes. Because she has given a statement to the inquiry saying that she subjected you and Mrs Brown to her normal rigorous questioning and obtained from you a clear understanding that your review established that Raychel's care and treatment were consistent with custom and practice for a post-operative child of that age. For her to get that understanding, given the issues that you had been discussing and the issues you've included on your action sheet, is odd. Did you draw to her attention all these issues?

A. Yes. To my recollection, I did, yes. I think she might

have been focusing on the Solution No. 18 was normal practice, because that was a large part of our discussion in both the meeting and with Mrs Burnside.

Q. It would be fair to say that that focus on that issue was perhaps so great that focus was not held on other issues?

A. I think that's a fair point. That's the conclusion I've come to, that we spent a lot of time on Solution No. 18 at the meeting, and subsequently that the other issues that you've discussed and asked me about were probably given lower priority. I accept that. The Solution No. 18 revelation or the concerns about this from Dr Nesbitt were so sort of startling that it focused a lot of the attention of the meeting.

Q. Did you or did Dr Nesbitt or anybody else have any inkling of this Solution No. 18 issue at the time -- before the death?

A. I must remind you I'm a dermatologist and I wouldn't be expected to. Nobody in that room knew anything about -- Dr McCord knew about hyponatraemia and ADH secretion but in a different non-surgical situation.

Dr Nesbitt, I think, has stated he hasn't been this before and wasn't aware of it. And Mr Gilliland wasn't aware of it. And the nurses certainly weren't aware of it. And I, I think, reasonably couldn't be expected to

be aware of it. So we had no understanding of this, apart from Dr Nesbitt's initial concerns.

At the meeting someone brought along two copies of -- copies of two BMJ articles, which I was kind of speed reading during the meeting. And, you know, I still remember that, about the concerns for Solution No. 18. I think some of the BMJ articles -- you have the Halberthal and the lesson of the week one. We had those at the meeting, someone handed it in, it was either Dr Nesbitt or Dr McCord. So that kind of took up a lot of the early part of the meaning.

Q. Is it a matter of surprise that doctors in practice aren't reading the BMJ?

A. No, it's not a surprise at all. It takes a long time for what in retrospect seems very clear lessons to be learned, and this is why they're trying to focus these things into sort of things like NICE and guidelines and things. It takes many, many years for lessons like that to come through. First of all, people may not read it, they don't remember it, and they think it doesn't apply to them.

THE CHAIRMAN: And also if you're trying to break habits which have been built up over 20 or 30 years, people might need a lot of persuasion that if they haven't seen anything going wrong in their experience, what's the

need to change?
A. Yes, I think doctors don't change practice readily. That's why they changed the practice of Solution No. 18, and I can say this now -- it was very radical by Dr Nesbitt to push that through overnight. I give him full credit for this, it was unique in my experience to achieve almost unanimity about that. It normally takes weeks and months of negotiation between various clinicians to achieve that.
MR STEWART: And as you say, the issue of Solution No. 18 was looming large, that was the discovery, and that became --
A. Well, the first inklings of it, there was something wrong with Solution No. 18 in this situation, in paediatric surgery. We didn't know the full picture at that time, but it was certainly a large cause for concern and might have explained what happened to Raychel.
Q. So Dr Nesbitt then went off, and I think it was agreed that he should perhaps do some more research, and he wrote to you on 14 June to tell you about what he had learnt. That's at 022-102-317.
Actually, this is the copy that came from Mrs Brown's file, but it was sent to you as well.
A. Yes, I recognise it.

Q. He wrote to tell you that he'd contacted several other hospitals, including RBHSC, making enquiries about perioperative fluid management.
And he wrote to tell you that he'd been informed that:
"The Children's Hospital anaesthetists have recently changed their practice, have moved away from No. 18 Solution to Hartmann's. This change occurred six months ago and followed several deaths, including No. 18 Solution. Craigavon Hospital and the Ulster Hospital both use Hartmann's intraoperatively and No. 18 post-operatively, as is our practice. The anaesthetists of Craigavon have been trying to change the fluid regime to Hartmann's post-operatively but have met resistance in the paediatric wards where, as in Altnagelvin, they have followed a medical paediatric protocol."
What was your reaction when you received this information?
A. I wasn't surprised about the varying practice throughout the different hospitals because that's quite normal. Each hospital has its own practice for the use of Solution No. 18 or discontinuing Solution No. 18. It just showed varying practice, which didn't surprise me.
Q. Had he telephoned you or spoken to you to tell you this information before he wrote to you to formally put it on

paper?
A. No, I don't recall any conversation. This came -- it was very soon afterwards -- 14 June.
Q. Yes. The mention of the change away from No. 18 six months before and following several deaths, that's the phrase which leaps from the page as a startling piece of information. Was that new to you, news to you?
A. It was news to me, certainly.
Q. What was your reaction to it?
A. Well, I was aware from the publications, which I'd read in more detail since the meeting, that there were deaths after Solution No. 18, reported in the literature, so ...
Q. Could I suggest that a conventional construction, reading, of that would be: it looks as though they'd changed because of several deaths and those deaths had occurred perhaps in Belfast?
A. I read it that, yes, the deaths followed the use of Solution No. 18, or it was implicated in some way in the deaths. I didn't read it as being necessarily in Belfast, because Belfast -- well, it may have been in Belfast but they weren't necessarily Belfast patients because it's a secondary referral centre, so they may have come from elsewhere.
Q. Yes. Did you discuss this with Dr Nesbitt?

A. Um ... No, I didn't.
Q. Did you --
THE CHAIRMAN: Sorry. Does your last exchange with Mr Stewart mean that you read it in effect as Northern Ireland deaths, whether the children's treatment started in Belfast or they were referred in to Belfast from elsewhere?
A. A combination of both. They could be originating in Belfast, but because it's a secondary referral centre, you couldn't assume because they died in Belfast they were necessarily --
THE CHAIRMAN: Yes, but whatever they were, you would read that as there were several deaths in Northern Ireland?
A. I did read that, yes.
MR STEWART: Did you make any enquiries about that information?
A. No, I didn't.
Q. But you could easily as a medical director have got on the phone to other medical directors and said, "Hey, have you heard about Solution No. 18? Have you heard about deaths?"
A. Well, Dr Nesbitt was following this up, following up the -- this was the first encounter he'd had with these hospitals. I also assumed that these deaths had been investigated through the coroner, or whatever processes

were appropriate, if this was true.
Q. Was it surprising to you that the Belfast Children's Hospital should have stopped using the solution for such a very real reason, deaths, and they hadn't told you about it?
A. Well, it was disappointing but not surprising, because it goes back to what I was saying about the communication between hospitals. It's not unique to here. Communication is often very patchy in the National Health Service.
Q. But would you have expected them with an issue of such patient safety importance to have drawn it to your attention, drawn it to everybody's attention?
A. Yes, I would have expected them to.
Q. Did that irritate you?
A. The criticism that -- the rumour or the criticism that was relayed back to us irritated me more.
THE CHAIRMAN: That you were being criticised for following --
A. Hitherto normal --
THE CHAIRMAN: Practice, and you were being criticised -- the source of the criticism was someone who worked in the regional centre which had changed its practice and hadn't told anybody?
A. Yes. That, I think, hurt people more. Saying it's

a rumour, I'm well aware of rumours in hospitals, and I don't believe everything I say -- I hear, rumour. But, yes, I think they should have told people.
THE CHAIRMAN: Put it this way, if they don't tell you that, what do they tell you? If they don't tell you that children have died from what is hitherto regarded as a standard treatment, you'd wonder what you would hear from the Royal, wouldn't you?
A. Yes, but I'm saying, Mr Chairman, this might be or will be something for this inquiry, that the mechanism how they disseminate that knowledge, the regional networks, and it's not just lifting the phone, or saying -- there has to be some mechanism. And maybe there is now. I've retired now so I don't know what the correct practice is.
THE CHAIRMAN: And you don't want to be bombarded with every snippet of information --
A. No, every drug --
THE CHAIRMAN: -- because that means that actually nothing will be learnt.
A. Yes.
THE CHAIRMAN: But you need to know the important things, and if children are dying because of an identified failing or identified risk with standard treatment, then you need to know about that. And whether the Royal does

that directly or whether they do it through the Department, somebody has to be proactive to make sure the lessons reach Daisy Hill, Altnagelvin and everywhere else.
A. Such a mechanism would be very helpful.
THE CHAIRMAN: Yes.
MR STEWART: It is, nonetheless, quite easy to pick up the phone, and you knew Dr Ian Carson, the medical director down at the Royal.
A. Well, you say I knew him. I met him once or twice, or three times.
Q. But still --
A. Yes. I agree, yes.
Q. Here's a hospital criticising you. That's bad. But the effrontery of them to criticise you when they themselves could have told you in the first place, that would make you pick up the phone and say, "What is going on?"
A. I don't react like that.
Q. I'm sorry. That didn't occur to you?
A. No, it didn't occur to me.
THE CHAIRMAN: I think the doctor said he doesn't react like that. That's not your style?
A. It's not my style to do that.
MR STEWART: Okay, your style is more considered?
A. Well, I'd like to think so.

Q. Yes. I'm not in any sense suggesting that -- anyway, you let it pass and you made no further investigation into that issue?
A. No, I did not make any further investigation.
Q. Did you learn from Dr Nesbitt that he had contacted the Tyrone County Hospital?
A. No, not until I read some inquiry documents.
Q. Because he says that he did tell you about this.
A. Well, I have no recollection of that. I work there as well.
Q. Exactly. If he had told you, and because you work there --
A. I know Dr Anand.
Q. Yes.
A. I'm not saying he didn't say that, but the two hospitals he mentioned were on that page, Craigavon and the Ulster, who were still using Solution No. 18. That's my clear recollection. The first I heard of Tyrone County was when -- recently.
Q. Dr Nesbitt did make a statement to the police some time ago, indicating that he had contacted the Tyrone County and, when asked by the inquiry, he said that he did draw that information to your attention. But if you don't remember --
A. I didn't read that statement, no.

Q. Can I ask you about other things you may have done in the aftermath of the review. Mrs Brown had statements coming in to her, there were a small number from nurses and doctors involved. Did she forward those to you?
A. I think I read them in her office. I think I read them in -- I didn't actually have a separate copy of them, if I remember rightly. I read them in her office and then handed them back to you. I think I made a summary. I've certainly got a summary of those statements in my handwriting. I don't remember keeping copies, but I may have.
Q. You did have a file with your papers on this subject.
A. Yes.
Q. Because some of the letters were kept separately from Mrs Brown's. So if you had a file on it, wouldn't you ask for the statements, wouldn't you want photocopies of statements to be included in your file?
A. Well, this is my personal file. No, I'd rather they were kept with Mrs Brown, securely. I felt she was the central source, she was the risk management coordinator, and that's where these sort of statements should stay.
Q. Yes, but you, of course, were the chairman of the critical incident committee itself and this matter, we heard the other day, was considered or was mentioned at that committee.

This is a document that was referred to as a spreadsheet that emerged at the hearing on Monday. It hasn't been paginated yet, but it simply says:
"12 June 01, Ward 6. Critical incident following death of a child. Investigation undertaken."
Mrs Brown has written on it what looks like "Reinforce in writing by Raymond".
A. Sorry, what was the first word, by Raymond?
Q. It looks like "Reinforce in writing by Raymond. Research of evidence".
Can you remember --
THE CHAIRMAN: Show me the page, please, Mr Stewart.
MR STEWART: Sorry, it is not paginated.
THE CHAIRMAN: I know. We've made a decision. I should just say this, that because there are references to other patients who may or may not be identifiable, that if we can avoid circulating this, we will. But I can show this to -- sorry, Mr Stewart, would you confirm that this is the same page I have?
MR STEWART: Yes. (Pause).
That, as I say, was the clinical incident review committee. It's fairly clear that Raychel's case, the investigation, was noted and that it looks as though Raymond and Mrs Brown thought that -- that was you -- was to do something in writing.

A. It looks like "Ray infusion in writing", or "Ray reference infusion in writing. Research of evidence."
Q. Could be.
A. I'm not sure what that means. Mrs Brown would have to clarify that. It's her writing.
Q. "Re-inform", it could be, in writing. Do you recall, first of all, mention of Raychel's case in that committee?
A. Sorry, which committee is this?
Q. This is the clinical incident review committee.
MR STITT: If the matter is going to be taken further, would it be helpful if I was to take a copy of that to Mrs Brown, who's present?
THE CHAIRMAN: My note on it from Monday, Mr Stitt, which perhaps could be confirmed in a moment, just very quickly, is that -- my note is "no information" or "no inform in writing by Raymond". Is that how it reads? No?
Doctor, could you give that copy to Mr Stitt and he'll just show it quickly to Mrs Brown? (Handed).
We don't need to dwell on this, but since the point's been raised we may as well get it right. (Pause).
MRS BROWN: It's "Re infusion in writing by Raymond".
THE CHAIRMAN: Thank you very much indeed.

MRS BROWN: And "Research of evidence", is the second line.
MR STEWART: Does that make sense to you, Dr Fulton, "Re infusion in writing"?
A. It doesn't. Obviously some discussion about Solution No. 18. Was this about guidance?
Q. I'm really asking you what it was about.
A. Could I ask, remind me again, what was this relating to, this statement?
THE CHAIRMAN: This is the note that we were given about the -- it's the clinical incident spreadsheet as opposed to critical incident. So it rather looks as if, apart from Raychel's death being raised at a critical incident review meeting, you'll see on that page from various other entries that these are clinical incident entries. Raychel is mentioned on that at 12 June.
A. I see, yes.
THE CHAIRMAN: We seem to be working on the premise that whatever's written beside it is some sort of action or some sort of step which might be taken next.
A. It looks like the change from Solution No. 18 to Hartmann's, the reference, but infusion could mean ...
THE CHAIRMAN: Okay. Thank you.
MR STEWART: The bottom entry on that sheet is dated 25 June, the last entry on that sheet is 25 June, so it would seem as though the handwritten annotation

postdates 25 June. Does that help you?
A. Um ...
Q. Because the change to Hartmann's was instantaneous, was it, pretty nearly?
A. That might have just been a reference to what we decided to do.
THE CHAIRMAN: Yes.
MR STEWART: Very well. Can I refer you to the update that was prepared by Mrs Brown to the chief executive and dated 9 July, and it appears at 022-097-307.
Were you sent a copy of this?
A. Yes, I recognise this.
Q. Was a copy sent to you at the time?
A. Yes, I think it was, yes. Fairly soon afterwards, yes. I clearly remember this.
Q. Do you remember being informed about a nurses' meeting?
A. The one that's referred to there?
Q. Yes.
A. No.
Q. The nurse on the bottom right-hand corner, "Dr Fulton to discuss with paediatricians-[something]", do you recognise that handwriting?
A. Yes, it's Mrs Burnside's.
Q. Can you remember now, were you delegated to have a meeting with the paediatricians?

A. Well, this was the delegation, this was what she wanted me to do. I can't remember what I did. I think I spoke to Dr McCord or Dr McCord and Dr Nesbitt. The answer was no to the last sentence.
Q. Is that no? Not?
A. "Paediatricians maintain overall responsibility for surgical children in Ward 6".
Q. Yes.
A. And the paediatrician -- I clearly remember the paediatricians said they couldn't because they were surgical patients and they had prime responsibility for the patients, the surgeons should look after their own patients in other words, and the paediatricians would give advice but could not take over professional responsibility.
Q. Did this document find a place in your file?
A. Um ... Yes, I think I have a copy of that, yes. Yes. I do remember this document.
Q. And when you got the information about what the nurses had agreed and what it was decided Sister Millar should do and so forth, did you think at that time a meeting of everybody to confirm these steps was appropriate?
A. I didn't call a meeting, but in retrospect I should have, because that seemed to be raising an increasing concern.

Q. You did, I think, before that, go to Belfast to attend a meeting of medical directors --
A. I did.
Q. -- on 18 June. Do you remember that day?
A. I remember it very clearly, yes.
Q. Do you remember meeting Dr Kelly from the Erne Hospital?
A. I do.
Q. He has described to the inquiry a meeting, he first met with you that day at the coffee break or during a cup of coffee, and he's asked how you were and you described the death at Altnagelvin, and he told you that they'd had a similar experience at the Erne. Do you remember that?
A. No. His -- I've read that transcript and I don't recognise it. Could I explain my version, my memory of that meeting?
Q. Absolutely.
A. This was a fairly irregular meeting of medical directors and the Chief Medical Officer, it wasn't held very often. It was chaired normally by the Chief Medical Officer, but on that day -- it just came up by chance, about 10 days after Raychel's death, and I thought it was a good opportunity to bring to the attention of all the medical directors there, there was an opportunity to bring to their attention, the problem we've had in

Altnagelvin, this terrible death of Raychel, and the concerns we had about Solution No. 18.
So I went to that meeting and the agenda was -- it was chaired by Dr Carson, not by the CMO, she was away doing something else. He chaired it and there was a fixed agenda. It had been designed presumably by Dr Carson.
When we moved through the agenda, it came to the coffee break, Dr Carson then left the room. I remember the room distinctly, it was a small claustrophobic room with no windows and very hot. At the coffee break Dr Carson left temporarily. Some medical directors left, and the ones that remained, I recognised Dr Kelly because he's from the Erne, fairly near.
I started talking to him, holding a cup of tea, I remember very well, and I told him the story of Raychel. I said, "We've got concerns about Solution No. 18". And he said, "Oh, that's interesting", or words to that effect" we've had fluid balance problems in the Erne possibly due to the same solution".
And I said, "I'm aware, Dr Nesbitt has found out that the Royal have discontinued that". And he said he was talking to Dr Moira Stewart, who I'm not familiar with, and she confirmed it had been changed in the

Royal.

And I said I was going to raise it at the meeting, and I think he said something like that was a good idea or something. So we went -- then we circulated together, I think, around some of the other medical directors who had remained. Several of the medical directors at that time were anaesthetists who would obviously have a special interest in this subject, and we talked -- I remember talking to two of them, at least one I remember very well, Dr Paddy Loughran from Daisy Hill, and he said, I remember very clearly, he looked very concerned and he said, "I remember a similar case being presented at a meeting in Dublin, I'll go and check what we do in Daisy Hill tonight", and then he left.

The other -- I think he was an anaesthetist, he might have been a surgeon -- was Dr Harold MacNeill, but he was in that group. I think that's all we talked to.

And Dr Kelly then -- a lot of people then peeled off, left. So we went back into the meeting with very few people left there, very few anaesthetists, I think. Dr Carson I think came back, and I -- Dr Kelly had gone at this stage. He didn't name the child in the Erne, he didn't say it was a death. I understood it as a problem of fluid balance, in which Solution No. 18 may have been

implicated.

So I thought it was not really comparable to Raychel's death. So I went in with very few people left, maybe five or six, and Dr Carson, and I told the story of what happened to Raychel and the concerns about Solution No. 18. And I think I said I was going to raise it with the CMO because I was getting quite frustrated then because I kind of missed the boat because everyone had left, and I felt I hadn't got my message through.

That is how I remember it.

Q. Yes. Dr Kelly said apart from telling you about the death of a child --

A. No, he didn't tell me about the death of a child.

Q. That's what he says he did. He also said that a discussion amongst the anaesthetists revealed several anaesthetists there who had had experience of near misses or knew about near misses.

A. Yes, I think that's correct, yes, I agree with that. The chairman's used -- that's a horrible term, "near misses", it's borrowed from the aircraft industry, it's for, you know, potentially fatal outcomes that weren't fatal.

Q. Yes. It describes it neatly, however, clinically. And some people described -- some medical directors

described problems that they'd experienced.

A. Yes, that's true.

Q. Are you saying that there were no other cases of fatality mentioned?

A. Well, not to my recollection, no.

Q. Can I ask that we look, please, at 026-001-001. This is a draft of your statement as you were preparing it for the coroner.

You'll see in the second paragraph:

"Discussed case at MD meeting, Castle Buildings. Chaired by Dr Carson in absence of CMO. Several MD anaesthetists had heard of similar cases. Suggested regional guidelines needed."

Similar cases. What did you mean by similar cases, similar to Raychel?

A. Well, the way that reads now sounds as if it's deaths, but ... I didn't mean deaths, it could have been near misses. "Similar problems with Solution No. 18" would have been a better way of putting it.

Q. And then that's followed --

A. And I suggested regional guidelines, I forgot to say that.

Q. Yes. Indeed, that was the one very, very important aspect of that.

A. That's why I was there really.

Q. Yes. And the next paragraph is where you telephone yourself, the CMO, a little later, and you suggest -- here again to suggest regional guidelines, but in light of other cases in Northern Ireland. In light of other cases in Northern Ireland.

A. Yes.

Q. What other cases were you referring to when you wrote that?

A. I think I was referring to the cases that Dr Nesbitt had put in his letter of the 14th.

Q. So you did believe them to be in Northern Ireland?

A. I did, yes.

THE CHAIRMAN: Yes, and those are death cases.

A. That's what his letter says.

THE CHAIRMAN: So I understand from your memory that that wasn't as clear from Dr Kelly as he recalls it, though it does rather seem as if you're almost certainly talking about the same event. But you don't recall it or you didn't pick it up from him as Lucy's death. You remember it as an event rather than a death.

A. Chairman, I picked up -- I didn't pick it up as a death. I didn't -- that name meant nothing to me until very recently.

THE CHAIRMAN: But the reference here to "other cases" is a reference back to Dr Nesbitt's letter, which you

interpreted as deaths in Northern Ireland?
A. Yes.
THE CHAIRMAN: Right.
A. Sorry, can I just clarify? The reason why I rang the CMO, Mr Chairman, is because I was kind of frustrated by the meeting as medical director. I felt there wasn't enough people to take this forward and I came back and I discussed it with Mrs Burnside and I ... I ... And she suggested I should ring the CMO as well, but I think I'd already formed that opinion that I was going to do that.
THE CHAIRMAN: Thank you.
A. But regional guidelines were clearly needed here. That's what I suggested to her. She was very helpful.
MR STEWART: Could I ask you this, can we please have a look at 022-025a-068. This is the typed-up version of your statement.
I wonder, can we have that side by side with the preceding document, which was 026-001-001?
Originally, it was your intention to indicate that you had suggested the regional guidelines to the CMO in light of other cases in Northern Ireland, but when the statement was typed we see the fourth paragraph on the left-hand side:
"Rang CMO. I suggested she should publicise the

dangers of hyponatraemia and suggested she publish reasonable guidelines."
Why did you choose to omit reference to the other cases in Northern Ireland?
A. Um ... I don't know.
Q. Because I asked Dr Nesbitt yesterday why, having himself made reference to those several deaths, he chose thereafter not to make reference to them again.
A. It may have been that these were unsubstantiated deaths that we had ... It's a very radical thing to say about several deaths without any evidence of what you're talking about. That's all I can suggest at the moment.
Q. Because when you --
MR STITT: It's probably fair to point out, sir, if I may, and maybe I can do it through Mr Stewart, that in the typed version of 18 June, it remains in -- the wording is "Several MD anaesthetists heard of similar cases", so if we were trying to backtrack or erase something, then one would have expected that to have been removed if that was the object of the exercise.
MR STEWART: In which case, can we retain the left-hand side of the screen, please, and go to the next version on the right-hand side, which is 160-143-002.
We'll find on the right-hand side, 18 June:
"At a regular meeting of medical directors at Castle

Buildings, I described the circumstances of this death. There were several anaesthetists present. Some of whom said they had heard of similar situations though it was not clear if there had been fatalities."
So the idea of similar cases, i.e. similar to Raychel, has been diluted to situations, though not clear if there have been fatalities. So this seems to be a further shifting away from any possibility of connecting other people's knowledge with deaths.
I take it that was a deliberate amendment that you made, Dr Fulton?
A. It must be my minute, I can't account for that.
THE CHAIRMAN: Sorry, if that's a four-line summary of what happened at the meeting chaired by Dr Carson, is that not consistent with what you told me about that meeting a few minutes ago? Effectively you were saying at the coffee break there were several anaesthetists, some of whom, like Dr Loughran, had heard of similar situations, though it wasn't clear if there had been fatalities. And the phrase that you used a moment ago was the standard cold phrase, "near misses".
A. Yes.
THE CHAIRMAN: Thank you.
MR STEWART: Tell me, when you were at the meeting with the other medical directors and Dr Carson, did you ask

Dr Carson about what he knew as an anaesthetist from Belfast about the move away from Solution No. 18?
A. No, I didn't.
Q. That would seem a natural thing for you to have wanted to flag up for him.
A. Yes, it would in hindsight. I can't remember whether -- I have a feeling he left the room or something. There was something unsatisfactory about the ending of the meeting and I cannot remember. I was left very unsatisfied by that meeting. It wasn't wrapped up, it was like -- it's no excuse because I could have spoken to him later.
Q. Because Dr Kelly's evidence to the inquiry was that he felt that you and he were both quite annoyed, annoyed that Belfast hadn't told you about their move away from Solution No. 18.
A. I think the word "annoyed" has been used before. No, I don't recognise that. Annoyed, perhaps, or a criticism as I said before, but I wouldn't use the word "annoyed".
Q. Perhaps you were exercised by disappointment?
A. I was exercised to do something about it. I was driven like Dr Nesbitt to follow this through.
THE CHAIRMAN: You were disappointed about the criticism, I think --

A. Yes, I was definitely disappoint -- well, I was -- no, I was disappointed by the Royal not telling us. I was annoyed by the criticism. I would accept annoyance.

THE CHAIRMAN: Then when you went to the directors' meeting on 18 June, you found Dr Kelly has some sort of similar situation. Dr Loughran remembers something similar in Dublin, and other anaesthetists who are there also have bells ringing with them.

A. Yes.

THE CHAIRMAN: So what emerges from that meeting is that, if we just move it maybe on to a slightly different track, is that even in a brief conversation at a coffee break, the moment you raise an issue about Solution No. 18 there are a number of people at that meeting who recognise that there is some level of problem about Solution No. 18.

A. Yes, I agree with that. That's a clear impression I got.

THE CHAIRMAN: Right. So the concern that you were raising about Solution No. 18 didn't get the response "I've never heard of anything like that", or "That's a one-in-a-million chance". The response is gets is, "I've heard about that", or "I've encountered something like that"?

A. Yes, that was the response, yes.

MR STEWART: I wonder, could we please look at WS043/1, page 11. The first sentence:

"Around mid-June 2001 I rang Mr Martin Bradley, chief nursing officer of the Western Area Health Board, to give him details of the death."

Mr Bradley, as I understand it, knew about Lucy. Did he mention a death that he knew of?

A. Not to my recollection. The name didn't -- he didn't mention that name.

Q. Did he mention the death of a child?

A. No.

Q. In the context of Solution No. 18 or hyponatraemia?

A. No. Not to my recollection. I think I would have remembered.

Q. Do you remember being included in a circulation of an e-mail from Dr Carson to the Chief Medical Officer? It appears at 021-056-135.

There's Dr Carson, he is giving the Chief Medical Officer some background information and attachments in relation to dilutional hyponatraemia, and both you and Dr Taylor are copied into the e-mail. We can see from the top that you then, nine or ten days later, forward it on to your chief executive, Mrs Burnside. Do you remember getting this?

A. I do.

Q. Were you surprised at the contents?

A. Surprised at the number of deaths he quoted in ten years.

Q. Yes. It's a fairly arresting statistic, figure, piece of information. How did you read that at the time?

A. Well, I read the last sentence, which says -- it was copied to me for information, and since it was going -- it was going to the Chief Medical Officer, I felt that that's the place it should go to, that information.

Q. Yes.

A. It was coming down to me rather than going up.

Q. Did you speak to Dr Nesbitt about it?

A. I don't recall speaking to him about this.

Q. Because he's by this stage, I think, been asked to sit on the CMO's working group into hyponatraemia.

A. Yes.

Q. He's obviously within Altnagelvin the hyponatraemia expert because he's done the research by that stage and he's on the working party. And this looks like very relevant information that you might want to discuss with him.

A. Well, I agree, except I'd say that that meeting was not set up to investigate deaths of children, it was set up to formulate guidelines, it wasn't its remit and, I don't think they would have -- it may -- it would have

been useful background information.

Q. So you didn't discuss this information you happened to have with them because you didn't think the working party was set up to engage with the deaths and the cases and the incidents of hyponatraemia?

A. It's an explanation, but I don't know why I didn't discuss it with them. I was speaking to them nearly every day.

Q. You didn't discuss with him the several deaths that he referred you to in his letter, you didn't discuss with him the many deaths referenced to hyponatraemia that you're now told about. Were you discussing Raychel's case in the context of fatalities at all?

A. No, we were discussing Raychel's case in the context of Altnagelvin and our own particular case.

Q. Did you put this in your file of documents relating to Raychel?

A. Sorry, this document?

Q. Yes.

A. Yes, I think I must have. Yes, I do have this. I'm familiar with this.

Q. When did you first learn about the death that had been referred to the coroner in Belfast a number of years before?

A. The death of whom?

Q. The child we now know to have been Adam Strain.
A. I only heard in the context of this inquiry, very recently.
Q. Can we have a look at 026-018-033. Can you tell me, first of all, that writing in the top right-hand corner, is that your handwriting?
A. Yes.
Q. And you've written there:
"File in Raychel Ferguson's file (bottom right drawer)."
A. Yes, I think that says that, yes.
Q. And this is a letter from the coroner to Mrs Brown, in which he refers to his, the coroner's, telephone conversation with Mrs Brown on 4 December:
"... and as arranged I am enclosing a copy of the post-mortem report."
That's in Raychel's case.
Then he continues:
"As I indicated to you, I have decided to obtain an independent report from a consultant paediatric anaesthetist. Several years ago, I obtained a report in a not dissimilar case from Dr Edward Sumner, consultant paediatric anaesthetist at Great Ormond Street Hospital for Children."
So there is information which, a number of years

before, there had been a similar case, it had gone to the coroner and so forth, and it was a child. Did you put that in the file?
A. It looks as if I did, yes.
Q. Okay. So here's another death that you're now being alerted to.
THE CHAIRMAN: That's perhaps a specific death that you're being alerted to. Until it's been several deaths or other deaths, it's been rather vague. This is now a more precise reference to the death of a child, which went to the coroner for Greater Belfast several years ago. He describes it as a not dissimilar case in which he engaged a paediatric anaesthetist.
I think what you're being asked really is, would that not have alerted you to the fact that there was, to use the words, a not dissimilar death in Northern Ireland which had already been through an inquest before the coroner?
A. What was the question, chairman?
THE CHAIRMAN: Would that not have alerted you to -- well, we know that the child's name is Adam. But would that not have alerted you to the fact that here's some more specific information coming from the coroner about a specific case? That must have alerted you to, or at least added to the information which you already held.

A. Yes, it did, because I assumed this information was obviously available elsewhere. I'm not sure what I was supposed to do with this information.
MR STEWART: So as time went on, you were accumulating information. Dr Nesbitt has referred to several deaths and you refer to those as deaths in Northern Ireland. You've been included in the e-mail from Dr Carson to the CMO, which is a death in Mid-Ulster, five or six other deaths over a ten-year period. Now you're being referred to a death referred to the coroner in Belfast some years before. And that's all in the space of 2001.
When you came to give evidence to the coroner at the beginning of 2003 -- can we go to your deposition, which is at 012-039-179.
You, first of all, at paragraph -- the third paragraph down on 14 June, you refer to Dr Nesbitt's letter to you, indicating that:
"Solution No. 18 was currently used in several hospitals in Northern Ireland."
As at 14 June.
You don't mention there for the benefit of the coroner that Belfast had abandoned the use of solution -- or moved away from Solution No. 18, and you don't refer to the fact that Dr Nesbitt drew several deaths in Northern Ireland to your attention. Why did

you choose not to tell that to the coroner?
A. That's ... I have no explanation for that.
Q. And then you refer, on the following page, 180, to contact with the CMO, indeed Mrs Burnside, and so forth. Why did you choose not to tell the coroner that you knew of a reference in the e-mail, which had been forwarded to you, of five or six other deaths and a death in Mid-Ulster and various other things?
A. I think the answer is I was concentrating on Raychel, the case of Raychel.
Q. Can I ask that we see the next page, please, 181. In the light of that and in the light of the deaths that have been drawn to your attention, why did you tell the coroner in the final paragraph:
"Throughout this process I was struck by the wish of all concerned to learn from this death, which is unique in their experience."
A. Yes. I think I was referring to the people present at the critical incident meeting.
Q. The statement --
A. I agree --
Q. -- goes through your contact with the various people and what you did and what you learned and concludes you were struck by all concerned -- by the wish of all concerned to learn from this death, which is unique in their

experience.
A. I think what I meant by that is that none of them had suffered -- had witnessed a death. I know what I mean by that now. None of them had actually treated or managed a child with hyponatraemia. I don't mean the situation is unique in the world, I know what I mean by that now.
Q. It does look rather as if you are most reluctant to bring any reference to death in other cases to the attention of the coroner.
A. No, I didn't -- it didn't occur to me to mention them to the coroner. I felt my duty was to report to the coroner the circumstances around the death of Raychel Ferguson. It was not deliberate. I felt that ... It wasn't deliberate, absolutely not.
Q. Well, we've looked at the process by which your statement started off referring to other cases in Northern Ireland and slowly amends itself so as to be cleansed of any reference to other cases that might be revealed as a death. Can I ask you, do you not think it might have been relevant to the overall circumstances and issues that the coroner was considering?
A. Yes, in retrospect, it would have been.
Q. Why did you --
THE CHAIRMAN: I think for completeness, it is fair to say

that in the penultimate paragraph on the right-hand page, Dr Fulton does refer to what must be Adam's case. Isn't that right, in the context of the Chief Medical Officer not having been aware of Adam's case?
MR STEWART: Well, certainly Adam's case was discussed at the inquest.
THE CHAIRMAN: Yes.
MR STEWART: So nobody was in any doubt that Adam's case was a previous case that had been considered and known about by everyone.
THE CHAIRMAN: The query you're raising with Dr Fulton is that he -- it's entirely appropriate for him to refer to that, but what is missing is reference to other deaths or several deaths, as mentioned by Dr Nesbitt and ...
MR STEWART: And the content of the e-mail of 30 July.
THE CHAIRMAN: Thank you. Okay.
MR STEWART: You attended at the -- obviously attended the inquest.
THE CHAIRMAN: Would this be a point to stop, Mr Stewart?
MR STEWART: Yes. I really don't think I'm going to be very much longer.
THE CHAIRMAN: Okay.
MR STEWART: Ten minutes might suffice if that's convenient to you, sir, and everybody else.

THE CHAIRMAN: Doctor, are you content with that?
A. Certainly, yes.
MR STEWART: You were included in a number of -- well, you held a pre-inquest consultation, did you, on 9 April 2002? We find that at 022-029-073.
That's Mrs Brown writing to doctors Nesbitt and McCord, and surgeons Gilliland and Makar, and telling them that you, who had been medical director at the time of Raychel's death, have agreed to convene a pre-inquest meeting on Tuesday 9 April in the conference room.
Did that meeting take place?
A. I have no recollection of this meeting, nor have I documentation of it.
Q. Why would you decide to convene such a meeting?
A. I don't know. It's a ... That was the day of the review of the critical incident.
Q. Yes.
A. It's my feeling that somehow this is the same thing, but I can't say. It's a coincidence about two, I don't remember -- I have no notes of this meeting. It's not -- it's written by Mrs Brown in her language, and the people that were asked to attend the meeting look like the people re-attending the critical incident review. I don't know.
Q. Well, excepting Mrs Doherty and Mrs Witherow and so

forth who attended the critical incident review.
A. Yes. I can't -- I have no explanation for this.
Q. Very well.
A. It may not have taken place, especially if it was the same day as the critical incident review.
Q. Very well. Who decided that you should submit your statement to the coroner?
A. Mrs Brown, probably. It was all coordinated through her office.
Q. Who was considered the -- this letter on the screen before us makes it look as though you're still chairing the group who looked into Raychel's case and who was going forward to the inquest. Would you regard yourself as having leadership of that group of people?
A. No, I wouldn't. I wouldn't really be expected to. No, when I look at this, I don't know quite why I was involved with it. I'm there as a witness but not coordinating it. At this stage Dr Nesbitt was medical director.
Q. Indeed, and the letter makes that clear that you were medical director at the time but nonetheless you have agreed, almost as though graciously you've agreed to nonetheless convene the meeting. I'm asking you whether you did in fact present yourself as a senior figure overseeing the --

A. No, definitely not. I had no coordinating role in the responses to the coroner at all.
Q. In relation to the -- were you aware that a report had been obtained from Dr Jenkins?
A. No, not at that time. Subsequently.
Q. When you got to the coroner's court, were you aware then that a report had been obtained from a Dr Warde?
A. No.
Q. Was it mentioned in conversation?
A. No, I wasn't there for the full hearing and I wasn't -- I didn't see the other witness statements, so ... Dr Warde did not feature until the inquiry mentioned him.
Q. When did you first become aware that a Dr Warde had furnished an opinion to the trust?
A. When the inquiry asked me to comment on it.
Q. I see. Very well. Thank you, sir, I have no further questions.
THE CHAIRMAN: Okay. Mr Quinn? Is there anything?
MR QUINN: I haven't any questions, sir.
THE CHAIRMAN: Before I come to Mr Stitt, any questions from the floor? No?
Mr Stitt, have you anything?
Questions from MR STITT
MR STITT: Just one question. It's this, if you would

consider putting it to the witness. There's an issue about board meeting minutes not being found and we know the dates.
THE CHAIRMAN: Particularly the July 2002 meeting.
MR STITT: I wonder, could the witness be asked if he has any recollection of briefing the board in relation to the Raychel Ferguson case.
THE CHAIRMAN: Yes. There was apparently a meeting of the trust board in July 2002, not long after Raychel's death, and bizarrely, and regrettably, those minutes cannot be traced. We rather assume that Raychel's death must have been raised at that meeting. It's a meeting which you would ordinarily have expected to be at, isn't it?
A. Yes, it would, yes.
THE CHAIRMAN: First of all, do you have any recollection of that specific meeting?
A. I can't remember it in detail, but Mrs Burnside and I would have presented to the board, at the next possible board meeting. It would be primarily Mrs Burnside who would take that decision, and I would support her with the medical details, and I'm sure we did. But I also searched for the minutes and I can't find them.
THE CHAIRMAN: But is that because you don't -- you

mentioned earlier, you've retired, but is that also because you don't necessarily retain the board minutes?
A. No, I don't have -- I asked the current trust board to provide them to me and apparently they can't.
THE CHAIRMAN: Okay. And can you remember, can you give us any assistance on what might have been conveyed to the board at that meeting about Raychel?
A. Well, I would have given, you know, an outline of the -- what had happened and what we were doing.
THE CHAIRMAN: Okay. Thank you very much.
Questions from MS GOLLOP
MS GOLLOP: Sir, may I ask a question on behalf of Dr Jenkins.
Can I ask you about Therese Brown and her role in decision-making in relation to inquests touching on the deaths of patients who die in hospitals for which you're responsible. Is she in a position to make decisions and give instructions to the trust's lawyers as to what evidence is and isn't placed before a coroner?
A. Mr Chairman, I think that should be addressed to Mrs Brown. I really can't answer that. I know she had a central coordinating role and she had also a role in litigation. I don't know.
THE CHAIRMAN: But in terms of --
A. We looked to her to --

THE CHAIRMAN: So in terms of -- well, as a dermatologist, I suspect you have not been involved in very many inquests.
A. Thankfully, no.
THE CHAIRMAN: It wouldn't be part of your run of work. But for instance for Raychel's inquest, in terms of liaising with the Central Services Agency or the Directorate of Legal Services, would you have had much input into that or would that have been done by Mrs Brown.
A. No, that would be done completely by Mrs Brown, she would liaise with them, definitely.
THE CHAIRMAN: So if a decision's been taken about whether to engage an expert and which expert to call, would that have been anything into which you had an input?
A. No.
THE CHAIRMAN: Is it something you would have expected to be informed of?
A. Um ... Well, in this case I would have, yes. Depending on whether I was medical director or not. I don't know what the timescale here is.
THE CHAIRMAN: By the time the inquest took place, you weren't medical director, but for so long as you were medical director and the inquest was pending, you would have expected to at least have been kept in the loop about what was going on?

A. Not if I were not -- not if I were no longer medical director.

THE CHAIRMAN: Yes, so long as you were medical director.

A. For so long as I was medical director, yes.

THE CHAIRMAN: And the inquest does seem to have been put back on a number of occasions.

A. Yes, quite a long time.

MS GOLLOP: No more questions, thank you.

THE CHAIRMAN: Doctor, unless there's anything more that you want to say, that brings an end to your evidence to the inquiry. So you're free to leave, subject to covering any point that you haven't been asked about this morning.

A. No.

THE CHAIRMAN: Thank you very much indeed.

That finishes us for today, ladies and gentlemen. We're back on Monday at 10 o'clock with Ms Anne Doherty and Margaret Doherty. Thank you very much.

(1.23 pm)

(The hearing adjourned until 10.00 am on Monday 9 September)

I N D E X