Thursday, 7 February 2013

(10.00 am)

(Delay in proceedings)

(10.20 am)

Discussion on Representation

THE CHAIRMAN: Mr Stitt, before we start, I want to come back to an issue about your representation and the DLS's representation of parties. I assume that Mr Lavery told you about the discussion I had with him yesterday evening.

MR STITT: He did, yes.

THE CHAIRMAN: Your client is what was the Altnagelvin Trust, which is now the Western Trust; is that right?

MR STITT: That's correct, and the Belfast Trust.

THE CHAIRMAN: Yes. In terms of the individual witnesses, the individual doctors and nurses who are giving evidence, are they your clients or not?

MR STITT: I'm representing them, yes.

THE CHAIRMAN: Right. There are conflicts between some of those clients, aren't there?

MR STITT: There are factual differences in recollection.

THE CHAIRMAN: For instance, just to take one example, the Trust obtained a report from Mr Orr and in Mr Orr's report he has said, in relation to doctors Devlin and

Curran, that they acted appropriately. He thinks they both acted appropriately, but that they would be heavily reliant on information from the nursing staff regarding the condition of the patients. The reference is 320/1, page 12, but if we bring up page 13 as well, please.

In particular, page 13. Page 13 and it is paragraph (r). He's dealing with the question of the nature of the communication that ought to have taken place between the nursing team and the two doctors. He said:

"I think both doctors acted appropriately. As junior doctors, they were reliant on the nursing staff to alert them to any concerns. It would therefore be unreasonable for them to be expected to provide advice and direction to the nursing team if specific issues had not been raised with them."

Do the nurses know about this report?

MR STITT: I cannot answer that question. This report came out after the detailed consultation with the nurses.

THE CHAIRMAN: Do the doctors know about the report?

MR STITT: The doctors that have given evidence so far do, yes.

THE CHAIRMAN: Among your clients who are coming to give evidence over the next week or so are these doctors and nurses. So the position is that, according to Mr Orr's

approach, if the doctors did not receive the information that they would have been expected to receive, the doctors are, to put it colloquially, in the clear --

MR STITT: That's his opinion.

THE CHAIRMAN: -- whereas the nurses aren't. It means then that the nurses carry blame whereas the doctors don't. On the other hand, if the doctors did receive advice from the nurses, then the doctors, on this approach, carry more of the blame and the nurses carry less of the blame.

MR STITT: That may be the way it works out. That is what we're here for, an inquiry.

THE CHAIRMAN: How can all of those people be your clients?

MR STITT: Because they're here to give their evidence. I do not see a difficulty with them giving their evidence and being fairly questioned about any apparent conflicts and I have absolutely no doubt that counsel for the inquiry, followed up by counsel for the family, will make sure that every possible line of questioning is put to them in a fair manner. I don't see any conflict in the Trust acting for the doctors and the nurses.

THE CHAIRMAN: I'm sorry, I don't understand that. On one analysis if the doctors are saying, "We didn't get the information from the nurses", and the nurses say, "We

did give the information to the doctors", your clients are at loggerheads.

MR STITT: No, there's a difference of opinion between the nurses and the doctors. I think that's obvious from the documents. We've read them and we can see there's obvious differences in recollection. That's, with respect, one of the central issues in this inquiry.

THE CHAIRMAN: But this is different from an employer's liability case obviously, Mr Stitt, where if the employer is being sued, then if there are differences of opinion between your witnesses, that's one of the things you have to factor into a decision about whether a case runs or how you run it. But in an inquiry, if the nurses or the doctors, for that matter, say to you, "We want you to make sure that our case is put and we want -- for instance, if you come to make a closing submission in this case on behalf of the Trust and on behalf of the doctors and on behalf of the nurses and there's a factual conflict between some of your clients, how do you address that in a closing submission?

MR STITT: I have no difficulty with that whatsoever because I'm quite certain that when any individual nurse or doctor has given evidence, all of the relevant points arising out of the documentation will have been put to them. My primary concern is to ensure that it's fairly

put to them and that if there's any points which have been overlooked, that counsel to the inquiry is reminded of that. On top of that, everyone has been reminded verbally of their rights and everyone has received, I think, three separate items of correspondence underscoring the same point.

THE CHAIRMAN: Yes. But I've already had direct experience in this inquiry of people not truly understanding that. That might seem a little odd to you and me as lawyers because this is the water in which we swim, but we've already had at an earlier stage a specific example of a nurse who had received all the CDs of documents, but hadn't understood, or maybe hadn't taken time to understand, what the repercussions were.

For instance, if there is criticism of doctors or nurses in my ultimate report and if the family chooses then to report them to the GMC or to the Nursing and Midwifery Council on the basis of that report, are they then going to turn round and say, "The person who was representing us was also representing the Trust and was also representing the doctors, who we didn't agree with".

MR STITT: I have no knowledge of anyone at this stage who has expressed or feels that that is a concern. They're obviously concerned about --

THE CHAIRMAN: But do they know enough about the process to know that that may be a concern?

MR STITT: I'm sorry for answering in apparently a vague way, but I have no reason not to believe that they don't know. I cannot answer for every -- I don't know exactly every thought that every witness has. We have done our best to set out the position and to explain the ramifications or otherwise of remaining represented by the counsel for the Trust as opposed to going to some form of protection organisation or RCN or whatever that might be, or indeed the inquiry. My duty as I see it is to, first of all, decide if there is a conflict -- I don't believe there is -- but at the same time to make sure that the rights of the individuals are communicated to them. All I can say is that, to the best of my ability, I think I have done that and I believe that the Trust's legal team have done it.

I don't want this to happen, but I cannot guarantee that at some point somebody might express a different view, but so far that view has not been expressed.

THE CHAIRMAN: Mr and Mrs Ferguson have had to wait too long for this inquiry and I don't want them to wait any longer, but I'm also anxious to ensure that the inquiry is not derailed or knocked back in some way because an issue emerges along the lines that we've been

addressing and more specifically along the lines which are set out in a letter which was sent by the inquiry solicitor on 31 December about raising more specific examples of conflicts of interest.

So for instance -- in fact for one of today's witnesses, Sister McGrath -- there's an issue between her and doctors Gund and Jamison about an instruction which she says she got to continue the pre-op fluids post-operatively.

Next week we'll have Mr Zafar and Nurse Millar talking about -- Mr Zafar says he gave an instruction about fluids which he didn't write the notes and which Nurse Millar says she didn't receive. Then you go on to doctors Curran and Devlin on the one hand and nurses on the other.

MR STITT: Yes, of course, and there's a helpful letter from the tribunal pointing out certain inconsistencies and conflicts on paper of recollection between various witnesses and that's noted and that's a matter which will be dealt with. Perhaps one of the most significant possible conflicts was that between Dr Zawislak and Mr Makar.

In fact, whilst one could argue that there was as strong argument not to represent both as one would be likely to come across, in the event both were questioned

competently and in detail and fairly and you, sir, will make your own decision about that. I would respectfully submit that neither of them in that obvious conflict situation was prevented from making their case and responding appropriately to the questions asked.

THE CHAIRMAN: Do you understand one of my concerns is that there seems to be a different approach taken in this part of the inquiry in Raychel's case than there has been in the last two segments?

MR STITT: So I understand, yes. I wasn't involved, but that's not answering your question. I understand your questioning the apparent different attitude in this section compared to a previous section or sections. I can only stand over the advice which I have given and I'm doing so.

THE CHAIRMAN: Okay. Thank you very much. Mr Quinn, have you anything to say?

MR QUINN: Nothing to add apart from that, in Mr Orr's reports, you could pick out five or six examples where there are complete clashes of interest in the case. Page 12 contains three, for example, but we don't need to go through them, Mr Chairman. You've pointed it out in general terms and I think there is going to be a conflict. I raised this informally with Mr Stitt, but if Mr Stitt is happy, he's a very experienced

professional man.

THE CHAIRMAN: He's more experienced than you or me.

MR QUINN: Exactly.

THE CHAIRMAN: I'm not sure that that relieves me of my responsibility. Ms Anyadike-Danes?

MS ANYADIKE-DANES: Thank you very much, Mr Chairman.

Mr Chairman, you have covered the issue. There is perhaps a slightly different aspect to it, and I come to it from the perspective of the quality of the evidence to be provided to the inquiry because that's my concern. A difficulty, I think, that is not too difficult to envisage is some of these nurses who are in the position that you, Mr Chairman, have just described remain employees of the Trust.

The public is paying for this inquiry, they have waited for it, as have the families, to shed insight into what happened and to have confidence again -- because that was the purpose of establishing it -- in their health system. So they are going to be in a situation where they are listening to -- in this case it turns out that the nurses' evidence is actually extremely important, I think everybody agrees, as to the conduct in two particular respects. One, the post-operative fluid management regime that they believed was in operation and which they were sanctioned

to and did institute. That's one.

The other is the one that you, Mr Chairman, have just been referring to, which is their care of Raychel over 8 June when the incidents of vomiting accumulated, if I can put it that way, and she deteriorated and suffered her eventual collapse the following morning.

So those are the two areas in which the nurses are involved and some of those nurses who are critically involved in both those aspects remain employees of the trust.

It may well be that they will want to be able to advance an argument that if the regime that we operated -- I call it a regime, the practice -- that we operated in relation to post-operative fluid management is incorrect and -- as Mr Makar said yesterday -- potentially dangerous and therefore is being criticised, as it has been by the inquiry's experts, then that is a regime that we were allowed to maintain and institute, and we were allowed to do that, they may wish to say, by our employers.

It's difficult, I think, to envisage an employee openly giving that kind of evidence whilst they remain employees and, not to put too fine a point on it, have to consider their own future position at their workplace. That is why I called it a matter of the

quality of the evidence. And you referred to instances in the past. We have seen them when employees, existing employees of a trust, have gone and received independent legal advice and their positions have changed. They have been more forthcoming about what actually happened. In one or two cases, they've actually conceded responsibility and fault and liability -- and I'm not just looking at it from that point of view, I'm just looking at it from making sure that you, Mr Chairman, have the best evidence, not only from which to determine so far as you can what happened, but also to make recommendations as to what the position ought to be. And I cannot see why it is in the interests of the Trust to wish to represent all these witnesses as opposed to allowing those witnesses' interests, which are in conflict with each other, to be represented by independent legal teams and therefore allow that degree of what I call transparency into what actually happened.

That's the concern that I have, Mr Chairman. It's one that the public might find it very difficult to understand why it is that they are seeking to represent these disparate interests, what could possibly be the benefit of the Trust in doing that when the inquiry is prepared for them to be represented individually as has happened in previous cases. Lest there be any kind of

suggestion that there is a reason that suits the Trust, I think it would be very unhelpful for that to be some sort of atmosphere, if I can put it that way, that follows this inquiry, that that happened. What we need now is the best and fullest evidence as to what happened and people need to believe and have confidence that they are getting that and there is nobody's particular interest that is being protected.

Mr Chairman, I was very grateful that you asked my learned friend Mr Stitt whether he regarded these witnesses as his clients. He said he represented them. If that's the case then it is very, very difficult to see how, even at the most basic level, the same solicitor and the same legal team can be representing people whose interests are different. Some groups are liable to be potentially open to criticism if the evidence is accepted in a particular way, others are likely not to be. Those people will be insisting on their legal team representing those interests for them. How all that can be accommodated when those interests are different, I find it very difficult to believe and the public may also.

So in the interests of the inquiry, it may be that the Trust perhaps could reflect on its position and allow that confidence that the public may want to have

in the process to be maintained, as it has been, I believe, in relation to the earlier two cases.

MR QUINN: Mr Chairman, if I could add one point that I omitted to put in and one point that has vexed myself and the family. I have opened this issue with the family and they, of course, don't want any delay. That's the fundamental point here. I can see a problem that if some of the nurses get into the witness box and the facts are gone over with them and, Mr Chairman, you take them through some reports and say there may be criticism of them and they may be reported to the NMC, I can see a situation arising where they would want separate representation and, at that stage, it's going to mean a delay of maybe four days, a week or more. I would want some sort of assurance from Mr Stitt that there isn't going to be delay because that is something the parents cannot abide with --

THE CHAIRMAN: I think the problem is that Mr Stitt couldn't possibly give that assurance and that's why I'm raising it now before we get into the witnesses. I don't believe Mr Stitt can possibly give that guarantee, but I don't want the issue to arise as we're going through the evidence of an individual nurse or we're in the middle of the nursing evidence.

MR QUINN: One point that I didn't really understand was

Mr Stitt -- I assumed it was on the record already, that Mr Stitt had told the inquiry that the nurses had Mr Orr's report, that that had been sent to them. My recollection may be flawed on that point, but my recollection is that that point was opened, I think, on Tuesday of this week and that Mr Stitt -- this point has been opened a couple of times. Mr Stitt said that they had the Salmon letters and that they had the report. I think I'm not misinterpreting Mr Stitt, but he did say today that he wasn't sure if some of the nurses did have the report or if some of the nurses did not understand the report.

What I would like is some assurance from Mr Stitt that all of the nurses have this report, that they know precisely the points of criticism raised by Mr Orr in this report, which is the report from the Trust after all, and there is a conflict in it. I just want some sort of assurance that Mr Stitt or one of his legal team have raised the issues with the nurses and they know precisely what Mr Orr is saying about their performance during Raychel's stay in hospital.

THE CHAIRMAN: As opposed to just sending them the report?

MR QUINN: That's the point I mean.

THE CHAIRMAN: That seems to me to be the problem, Mr Stitt. It's one thing to say to the nurses and the doctors,

"Here's the report to the from the inquiry, here's what Dr Foster says, he's critical about this and that, Dr Haynes is critical of this and that, Ms Ramsay is critical of this and that, and Mr Orr is now critical". But it's another thing surely, to say, "And this criticism is potentially directly of you".

MR QUINN: If I could just come in for one moment. The first point is that Mr Stitt this morning has said he's not sure that all the nurses have the report. I think that's what he said. Yet earlier in the week, so far as my recall is, he assured us that all of the nurses did have the report. We need to sort that out first of all. So we need to know: do all of the nurses who are going to give evidence in this inquiry have the report? That's point one.

THE CHAIRMAN: And next week is full of nurses at the moment.

MR QUINN: It is. That is why I am making the point now. It is full of nurses.

The second point is if they have the report, do they understand the implications of it because, as you said Mr Chairman, the legalities are a sea that we swim in, but the nurses may not fully understand that there are criticisms pointed up by Mr Orr in this report against them, while the doctors seem to be not being criticised

to such a degree, although there are criticisms of the doctors as well. But certainly the nurses seem to be getting more of it than the doctors in this report, just as an overview, and I'm concerned that they may not realise they're being criticised in a general way in this report, which is a Trust report.

THE CHAIRMAN: I'm also influenced by the fact that in the earlier cases of Adam and Claire, nurses were separately represented, despite the fact that the criticisms of them in Adam and Claire's cases were much less central --

MR QUINN: Yes.

THE CHAIRMAN: -- than they are in Raychel's case.

MR QUINN: Let me make it clear also while I am on my feet that this is no criticism of Mr Stitt because sometimes the message does not get properly interpreted on the way to those witnesses. I am not criticising Mr Stitt for the assurance he has given us, I just want to, as it were, double-up on my assurance that the nurses have been properly advised of what's in this report.

MR STITT: There's rather a lot of respond to. Before Ms Anyadike-Danes makes any further points, can I make a response, otherwise there's just a litany of issues? I have four points initially to respond to, with your permission.

THE CHAIRMAN: Of course.
MR STITT: There are separate points that have arisen and I'd like to, if I may, go chronologically, ending up with Mr Quinn, and I'll try to keep this as clear as possible so that we don't end up in a rambling or a debate which takes us nowhere and expends more time.

Firstly, Mr Quinn opened by saying that Mr Stitt seems happy in this position. "Happy" is not an adjective that I would adopt. This inquiry has got its complexities, its difficulties, its tragic outcome in terms of Raychel, so I'm not happy. I want to make that absolutely clear.

Moving on. Ms Anyadike-Danes said she couldn't understand how it was in the interests of the Trust to be representing all of the doctors and nurses. This isn't a question of whether it's in the interests of the Trust or not; this is a question of whether or not the Trust and its employees can be properly and fairly represented. In my opinion, as I've indicated, they can be.

It has been suggested that the witnesses will be more free as employed doctors or nurses to criticise the Trust if they have separate representation. I don't think there's any merit in that point. I think that anybody in the witness box with the focus which is put

on someone in an inquiry when being questioned means that they're going to hopefully give accurate and truthful responses no matter whether they're separately represented or not.
THE CHAIRMAN: Let me interrupt you. There's one striking example of a doctor in Adam's case who, let me put it this way, put his head in the sand for many years about what had gone wrong in Adam's case and the first time that he began to face up to what happened in Adam's case was when he went off and got separate representation. That may be a coincidence that he finally faced up to what he had done wrong when he sat in the witness box and accepted that he had done wrong. It was at least a coincidence that he started down that route only after he left Trust representation.
MR STITT: I accept --
THE CHAIRMAN: And having seen that rather striking example, I am concerned to ensure that anybody else who -- I am not saying that they're being coerced by the Trust or being told by DLS what to say. That isn't the point I'm on and you'll understand that, but I don't want to be misunderstood on this. Sometimes when people go off and get separate representation, as we both know from our experience in other fields, they emerge saying something different.

MR STITT: That indeed, I'm sure, can happen. I haven't been briefed in relation to the example you're talking about, so I can't respond in any meaningful way, except to say that indeed I can envisage that could happen and possibly -- I didn't say it's impossible, I just said it's unlikely that somebody would give different evidence because they are separately represented. That's an opinion and I'm giving it.

The third point and the final point in relation to Ms Anyadike-Danes is the question -- she used the expression that she cannot understand why the Trust would not allow separate representation. She used the verb "allow"; this isn't relevant.
THE CHAIRMAN: You say they're not forbidding separate representation.
MR STITT: Certainly not. We've gone so far as to actually positively put the options to the individual witnesses. There's no question of disallowing anybody. The question as to whether an individual is separately represented or not is, in many respects, of neutral value as regards the Trust. The bigger question is if the witnesses decide that we wish to remain represented by the same representation and the Trust, then is there likely to be a conflict, and in my opinion there's not.

The point that flows from that is that I have

specifically, quite apart from meeting nurses myself -- I have to confess that this was in my early involvement in Raychel's case. I had an early meeting, I'll just say this on the record, with all of the nurses, and it was a learning experience from my perspective. But nonetheless the question of separate representation was brought up at that early meeting. Then we have the correspondence and then, on top of that, I asked that a further meeting be called -- I think it was yesterday that I suggested that a further meeting be called of the nurses to reinforce the position, not the Trust's position, not the position that they should somehow be corralled in to being represented by the one team, but to let them know the updated position, given the strength of the letter from the inquiry, and to make sure they understood the terms of that fairly unequivocal letter.

I don't know if that's been done, they're all in Altnagelvin, they're all working, the hospital has to keep running.
THE CHAIRMAN: Of course.
MR STITT: I've been down here and I will hopefully find out if that meeting has taken place, but I did suggest that it be done.

That brings me to the final point, which relates to

the question of the Orr report. The penultimate point. I can't give any guarantee by any individual. All I can do is use my best judgment as to where we're going. No one wants any delay and the Trust does not want a delay.

Finally, in relation the Orr report, Mr Quinn thinks that I said that everyone had received it. The record will speak for itself. I'm not aware, as I'm standing here, that everyone had received the Orr report. There is a point that you have made, which is of validity, and I think that that is something which, if the meeting hasn't taken place, it is essential that the nurses are also made aware of the implications of a finding for, on balance, the doctors or a finding for, on balance, the nurses when it comes to reportage and recollection.

THE CHAIRMAN: I think it's also fair to say that if the nurses have separate representation, it does not follow that they are necessarily at loggerheads with the Trust on all issues or, as it may turn out, on many issues. But it gives them the assurance that to the extent that their interests or the potential criticisms of them vary from the issues which the Trust is addressing and the Trust accepts or doesn't accept that those interests are properly represented. Being separately represented doesn't mean that you're diametrically opposed to the

Trust in this case.

MR STITT: Well, without going into the detail, you may take it, sir, that we have considered in detail the likely conflict between the Trust and any individual doctor or nurse as opposed to conflict between one nurse and one doctor. We have considered that.

THE CHAIRMAN: But if I move away from the nurses, Mr Stitt, isn't there an issue between, for instance, the anaesthetists and the surgeons and the paediatricians about who is responsible in fact for post-operative fluid?

MR STITT: Yes, and it's quite clear. I think it was summed up well yesterday during the course of the evidence of Mr Makar. It was put that there were three differing views. It's an uncomfortable fact on the paper at the moment.

THE CHAIRMAN: There are not only three different views, but it looks pretty much as if there are three irreconcilable views, doesn't it?

MR STITT: I wouldn't like to comment on that at this stage without hearing the witnesses.

THE CHAIRMAN: Yes. Okay. Thank you.

MS ANYADIKE-DANES: There was just one final point I wanted to make, and firstly I should apologise to my learned friend Mr Stitt. I'm not suggesting that the Trust

allows these things. The view that I was probably unfortunately phrasing -- what I was trying to communicate was that it's possible for the Trust to simply tell these employees that are in that position, "I don't think we can represent you, you need to get separate legal representation". And that is something that solicitors for employees, solicitors for other parties do -- I wouldn't like to say day in daily, but do regularly. So it's not a matter of allowing, it's a step that the Trust could itself initiate.

But the point that I wanted to mention, Mr Chairman, is because in something that you said and my learned friend Mr Quinn said, it really has encapsulated or shown an example of the very concern that I have, which, as I hoped I had made clear, is all to do with the quality of the evidence and information that becomes available to the public inquiry and ultimately, of course, to you, Mr Chairman. The Orr report, I think sums it up nicely.

Whether or not the Orr report was circulated last week, yesterday or whenever to the nurses -- and I think in fact my learned friend Mr Lavery indicated to you yesterday when you asked him that question, I think his answer was, "I think it has been circulated, yes". But leaving aside that point, that is exactly the issue.

The Orr report should be, for the nurses and the junior doctors, an extremely important report. If those nurses were separately represented, that is a report that would be a subject of a number of consultations between them and their legal team and with the information as to what exactly is their position in the light of that sort of comment, they would be coming to this witness box fully prepared to be able to explain their position to, I would suggest, the better good of the inquiry.

Similarly, the junior doctors would be able to see where their interests lay in conflict, potentially, with those of the nurses and they would come ready prepared to explain things to you, Mr Chairman. It is of concern that such an important report is something that may only latterly have been communicated to the nurses and may not yet --

THE CHAIRMAN: The report couldn't have gone earlier because the report only came through, I think, at the weekend. So there's a very limited --

MS ANYADIKE-DANES: I'm not putting it any higher than whenever it comes, it's something that should be seen and has been seen as being of potential importance to them. The point that I'm making is that it allows those nurses to bring to you, Mr Chairman, the best explanation of their position if they have time and are

properly -- I don't say properly in a sense to say that the DLS won't properly, but somebody who is looking at that report through the prism of the nurses' eyes and their responsibilities. That level of preparation is also -- for example, Mr Makar gave evidence yesterday and it wasn't entirely clear that he had had the opportunity to prepare his answers for the inquiry on the basis of a full time to study all the papers and so forth, which are voluminous, of course, in this inquiry. It's that issue of the quality of evidence where I really have a concern for the inquiry.

THE CHAIRMAN: Thank you. I'm going to rise for a few minutes to consider this. I should say that my inclination is, whatever view I take about the nurses, my inclination, since I see Dr Jamison waiting, whatever happens today we'll hear her evidence.

MR STITT: Absolutely. One short point and it's simply this: the Orr report has been highlighted and I've accepted the relevance of the Orr report, but it shouldn't be forgotten we received it on Friday. Then we got a communication on Monday telling us that there was an issue about the inclusion of the Foster documents and quite simply there hasn't been a meeting -- as I'm standing here, I'm not aware of a meeting yet with the nurses to let them look at the report and let them ask

questions and answer those questions. We've been here Tuesday and Wednesday, so that's ...

THE CHAIRMAN: And I think also there's a shorthand way through it with the nurses. There's the inquiry opening, there's Mr Quinn's opening, which highlights some of the issues, and in a sense the Orr report is really confirming what Mr Foster and Ms Ramsay have said in some ways.

MR STITT: But I'd like it just noted that it's not a report -- even though it ideally would have been less critical of certain issues, it's of course in the public arena, where we wish it.

THE CHAIRMAN: Thank you.

MR QUINN: Mr Chairman, Mr and Mrs Roberts are here today and we thought you were going to give a decision in the --

THE CHAIRMAN: I was going to do that anyway.

MR QUINN: I'm obliged.

THE CHAIRMAN: Doctor, I'm afraid I'll have to just ask you to wait for a little while longer. But whatever happens today, I will hear your evidence. Thank you.

(11.00 am)

(A short break)

(11.55 am)

Ruling on Conflict of Interest

THE CHAIRMAN: Ladies and gentlemen, on the conflict of interest point, I have the following to say.

At present, the two trusts and all the doctors and nurses who are going to give evidence are represented by the same counsel and solicitors. My concern is that there are apparently stark conflicts between the various individuals and groups of individuals, which make it difficult for me to be reassured that all of their interests can be fully and fairly represented by a single legal team.

The sort of conflict I am referring to has been discussed in the chamber today and on previous days. I will not go through them again, they are on the record. I acknowledge that not every factual conflict between witnesses necessarily leads to separate representation or to a decision that a single legal team cannot represent everyone. However, the extent of the conflicts in this segment of the inquiry dealing with the clinical aspects of the care of Raychel Ferguson is to great that I have concluded that a single legal team cannot represent everyone on behalf of the trusts, the doctors and the nurses.

That view is reinforced by Mr Orr's expert report, which I saw on Monday this week, 4 February, but as the

earlier inquiry correspondence shows, this concern was already present. There is a further related issue about the extent of separate representation. My view at this stage is that the nurses who are to be witnesses should have separate representation in the same way as some nurses in Adam's and Claire's cases were separately represented, but at this stage I am not going beyond the nurses.

In reaching this decision, I have taken the view which is contrary to that taken by the Trust legal team led by Mr Stitt QC. I mean no disrespect to them and I assume that they will understand that, that I mean no disrespect in taking this view. I recognise their experience and their ability, however, on this issue my view is simply different to theirs.

Accordingly, what I intend to do today is to give my ruling immediately after this on the outstanding issue of Dr Sands' application in Claire's case. I will then hear Dr Jamison's evidence. After that, my intention is to adjourn the hearings with the intention that they will resume on Monday, 18 February.

In the interim period, I want the nurses to arrange separate legal representation. The inquiry's protocols provide for a payment by the inquiry of representation in certain defined circumstances and I will consider any

such request for funding as a matter of urgency.

On that basis then, the inquiry will adjourn today after we finish hearing from Dr Jamison. I will update the parties next week on the progress which has been made, but I will only convene a progress hearing at any point next week if any major problem emerges.

As I have indicated, my target date for resuming the evidence is Monday 18 February. Certain particular days after that of sitting may be affected by the availability of witnesses, but there is no reason at all why the clinical witnesses in Raychel's case cannot all be heard before Easter.

I am sure that the Ferguson family, like the other families and other individuals, have important issues that they want to see explored in other segments relating to governance, but I hope that hearing the completion of the clinical evidence in Raychel's case will reassure the Ferguson family, in particular, and the interested parties and the wider public generally of the inquiry's determination to push on so that the hearings come to an end and my report comes closer.

Mr Stitt, that's the position I've adopted.

MR STITT: I respect your position, sir, of course, and note the even manner in which it was delivered. May I ask one question and that is: could you indicate to me the

statutory basis of this decision? Is it under the Inquiries Act?

THE CHAIRMAN: No, it's not under the Inquiries Act. It is for me to conduct the inquiry under the powers that I have in whatever way I think is appropriate. I cannot see how you can possibly represent the interests of all the people who you now represent.

MR STITT: I fully understand that, sir. When I'm advising my clients as they currently are, they may well ask me under which power this decision has been made.

Am I being directed to a specific power or an inherent power?

THE CHAIRMAN: I don't have inherent powers. The powers that I have are set out in what is now a schedule to the Interpretation Act, which I will provide for you later on. Okay?

MR STITT: Thank you, sir.

THE CHAIRMAN: I'm going to move on from that, unless there are any other issues. Mr Quinn, there's nothing more to say at this stage?

MR QUINN: No, sir.

Ruling on Dr Sands' Application

THE CHAIRMAN: I'm going to move to the outstanding issue of the application which was made on behalf of Dr Andrew Sands in Claire's case.

The background to it is as follows. Dr Sands was a registrar in the Royal Belfast Hospital for Sick Children in October 1996. He is now a consultant paediatrician in the same hospital. On the evening of 21 October, Claire Roberts was admitted for treatment. She was seen by Dr Sands the following morning, probably at about 11 o'clock, when he took the ward round in the absence of the consultant paediatrician, Dr Steen. The written notes of that ward round were made in the medical records by Dr Roger Stevenson, who accompanied Dr Sands. Those notes are found in the inquiry documents at 090-022-052 and 053.

The original note made by Dr Stevenson records at one particular point that Dr Sands' impression was that Claire had non-fitting status. That was what is recorded at that point. And I should note that Dr Sands had been called to see Claire by her parents and by a nurse, who were worried about her condition.

When Dr Sands saw Claire, he was sufficiently worried about her condition that, in the continuing absence of Dr Steen, he set off to find Dr David Webb, a consultant paediatric neurologist. Dr Sands discussed Claire's case with Dr Webb, who agreed that he would come to see Claire as soon as he could. 16 years later, there is some uncertainty about precisely when Dr Sands

spoke to Dr Webb and how soon afterwards Dr Webb made his way to Claire's bedside. For the purposes of this application, that issue is not relevant.

The final version of the notes and the medical records has changed in that in addition to what Dr Stevenson had written during the ward round, the words "encephalitis/encephalopathy" have been added. Those additional two words are not in Dr Stevenson's handwriting, but rather in Dr Sands' handwriting. It is Dr Sands' evidence that he added them after speaking to Dr Webb. In addition, he says that he had discussed encephalitis in a general sense with Dr Stevenson during the ward round.

Mr and Mrs Roberts do not recall any such reference. Dr Sands says that this is entirely explicable since he may deliberately have avoided using that precise medical term in their hearing. Unfortunately, the additional entry of "encephalitis/encephalopathy" is not signed, dated or timed by Dr Sands. He accepts it should have been. There is no doubt that it is in his handwriting. The issue which has arisen is when it was written.

Before the oral hearings started in Banbridge in October 2012, the legal team representing the Roberts family had queried this addition to the notes along with a whole series of other issues. In a letter dated

13 September 2012 from their solicitors, 31 questions had been set out for inquiry counsel to put to Dr Sands. From that list, it is clear, especially from questions 12, 13, 14 and 16, for example, that they had a major concern about the note. In fact, question 14 asks whether the additional entry was only made after Claire was admitted to the paediatric intensive care unit early on 23 October, by which time her condition was irreversible.

Dr Sands gave evidence on 19 October. He was questioned about Claire's treatment generally and specifically his addition to the records. The most relevant extract from the transcript is at pages 170 to 171, which I will not repeat here.

I should note at this point, in case this issue is taken any further, that the inquiry runs on the basis that questions are asked of witnesses by counsel for the inquiry. If any legal representatives want additional questions or issues to be raised, they are typically raised initially with inquiry counsel and ultimately, if absolutely necessary, through me with the witnesses.

Mr and Mrs Roberts gave evidence together on 31 October. In that evidence, they emphasised that there had been no reference to a viral illness or encephalitis during the ward round and they are sure

that that is something that they would have remembered had there been any such discussion or reference.

Matters stood in that way at the end of the clinical evidence. When the governance hearing opened on 6 December, an opening address was presented by Mr Quinn QC on behalf of the family. That address had been circulated the previous day.

The family's opening at page 17 refers back to Dr Sands' note in the following terms:

"In relation to this entry made by Dr Sands, 'encephalitis/encephalopathy', the parents have a genuine doubt as to why this entry was made as it does not fit with the nursing notes. In fact, they will say that it fits with nothing at all in the case."

When Mr Quinn had finished his submission or his opening address on 6 December, counsel for Dr Sands, Mr Green, barrister at law, raised a concern. His concern is set out on that day's transcript from page 102 onwards. The concern raised was whether Mr and Mrs Roberts were now alleging for the first time that the addition to the notes was made by Dr Sands at a much later point than he had said in his oral evidence on 19 October.

At that stage, the matter was left on the basis that I would leave open the possibility of Dr Sands being

recalled to respond to the new allegation. Whether he needed to be recalled depended on how the evidence and the allegation developed.

Mr and Mrs Roberts gave oral evidence on the governance issues on Thursday 13 December. On that occasion, they went beyond what they had said before. Specifically, Mr Roberts said that he believed that after the 2004 Ulster Television documentary, which had prompted Mr and Mrs Roberts to contact the Children's Hospital, Dr Steen had looked at the notes of the ward round, seen that there was no reference to encephalitis and had got Dr Sands to write it in. In short, the entry in relation to encephalitis was fabricated or added only in 2004 and did not reflect what Dr Sands was thinking in 1996.

This new and somewhat dramatic allegation was widely reported. I am told that it has caused much distress to the doctors. They say in terms that it is one thing to challenge their competence, but something else entirely to challenge their honesty. On that basis, I am invited by Dr Sands, Dr Steen and the Trust to make a finding now on the allegation of fraud or dishonesty made by Mr Roberts.

It is submitted to me that even if this is an unusual request, it is both necessary and justifiable

particularly because Dr Sands and Dr Steen continue to work and treat patients in the Children's Hospital, their concern is that parents whose children they are treating may have less confidence in them because this allegation has been made and has not been the subject of a report, either accepting or rejecting it.

I regret that I cannot and do not accept that submission on behalf of the doctors and the Trust, though I understand why it is made. I have heard Dr Sands and Dr Steen give further evidence in response to Mr Roberts. I accept that the doctors are particularly wounded by this allegation. Notwithstanding their concerns, I cannot accept that it is appropriate to give rulings on specific factual disputes and issues as the inquiry progresses because of a concern about the damage to an individual's reputation or ability to work. It will soon become almost impossible to distinguish logically between circumstances in which an immediate or early ruling is justified and those where it isn't. And in this context, I think back to the dispute between Dr Taylor and Mr Keane about what exactly happened between them and what was discussed between them in the context of Adam's operation. The evidence of both of those witnesses cannot be right.

I acknowledge that there may be exceptional circumstances in which the course which I'm urged to adopt in this instance is appropriate, but I do not accept that the present circumstances are so exceptional as to bring them within that area.

I want to finish with the following four observations. The first is that I understand, as best I can, the growing disbelief and lack of faith and confidence which appear to have led Mr Roberts to make his allegation. While I regret that he has felt himself given to make it, I understand -- or I can try to understand -- how, sitting at the inquiry with his wife for a number of weeks has led him to end up with little or no faith in what he hears from the witnesses for the Trust.

The second observation is the fact that I am not making a ruling now is not in any way to be taken as an indication that I accept that Mr Roberts' allegation is well-founded. It is no such thing. I am not saying at this point whether I accept the allegation or not, but the fact that I am not making a ruling cannot in any way be interpreted as accepting that the allegation is correct.

Thirdly, there are various issues on which the families are extremely exercised and on which they would

welcome early findings. The same applies to various doctors, nurses and managers who have given evidence and who will give evidence before the inquiry. If I start to give early findings on some issues but not others, I am concerned that the inquiry will end up and everyone will end up in a rather incoherent mess.

The final observation is this. This episode reminds me, if I need to be reminded, of the need to complete the inquiry and present my report to the minister as soon as possible. That is the wish of the families, but it must also be the wish of the various other individuals and institutions who are being scrutinised and called to answer criticisms.

That is my ruling on that issue. What I now want to do is take a five-minute break and we'll start the evidence of Dr Jamison.

Doctor, your evidence will comfortably finish today, so if we start you in five minutes' time, we'll take a break at around 1 o'clock for lunch, and then we'll resume afterwards. Okay? Thank you very much.

(12.16 pm)

(A short break)

(12.25 pm)

MR REID: If I can call Dr Claire Jamison, please.

DR CLAIRE JAMISON (called)

Questions from MR REID

THE CHAIRMAN: Have a seat please, doctor.

MR REID: Good morning, doctor. You've made two witness statements to the inquiry and they are both numbered 024. The first is dated 20 November 2011 and the second is dated 15 June 2012. Subject to any oral evidence you might give this morning and this afternoon, would you like to adopt those inquiry witness statements as your evidence before the inquiry?

A. Yes.

Q. Thank you, doctor. You also gave a deposition to the coroner at the inquest, dated 5 February 2003. For reference purposes, that's 012-034-164. And you provided a statement to the Trust prior to that. We had one statement which was dated 3 February 2002, and that's 012-015-118, and yesterday we were provided with the original statement that you sent to the Trust, which is dated 10 December 2001, 316-038-002, which I think has been distributed around.

Before we get into other questions, can I ask you, you have heard the goings-on this morning in the chamber. Have you received a copy of Mr Orr's report, the surgeon on behalf of the Trust?

A. I believe so.

Q. And when did you receive that report?

A. I had communications yesterday with the new reports.

Q. If you wouldn't mind, could you just put the microphone nearer --

A. I had communications yesterday with the new reports.

Q. We have a copy of your curriculum vitae and that's at page 13 of your second witness statement, WS024/2, page 13, please. If I can bring up page 14 as well, please. We can see there that you qualified as a doctor from Queen's University Belfast in 1998 and actually if we have pages 14 and 15, we can see that you were a junior house officer for one year at the Royal; isn't that right?

A. Yes, that's correct.

Q. And then you were an SHO in anaesthesia at the Ulster Hospital for one year and, in August 2000, you moved to Altnagelvin to continue as an SHO in anaesthesia.

A. Yes, that's correct.

Q. So by June 2001, you had been an SHO in anaesthesia for almost two years and, in fact, you were only two months away from becoming a specialist registrar Altnagelvin at; is that correct?

A. I would have become a specialist registrar on the first Wednesday in August, but it would have been at

Antrim Hospital I would have taken up the post.
Q. Antrim, sorry. I apologise. And you're currently a consultant in anaesthesia and intensive care medicine at the Ulster Hospital in Dundonald; is that right?
A. Yes, that is correct.
Q. How long have you held that post for?
A. I took that post up in November 2007.
Q. So that's over five years?
A. Yes.
Q. Thank you. In terms of your experience with children, I think you were asked about that at page 2 of your second witness statement, WS024/2. You say that -- it's not quite there. I think during your witness statement you say that you anaesthetised approximately 100 children and Raychel's case would have been a common case to be involved with; is that correct?
A. Yes, that's correct.
Q. Have you had any specific paediatric attachments during your career?
A. I have had a specific paediatric anaesthesia attachment -- that was, I think, in my CV. I'll get the dates for you. August 2002 to February 2003. I spent time at the Royal Belfast Hospital for Sick Children. I have no other specific paediatric medical or anaesthesia attachments.

Q. And you hadn't had any specific paediatric or anaesthesia training prior to June 2001; is that correct?
A. Not outstanding paediatric experience within the realms of a general district hospital, no.
Q. As in the approximately 100 children you had anaesthetised by that stage?
A. Yes.
Q. We're going to hear about yourself and your fellow anaesthetist, Dr Gund, who's already given evidence to the inquiry. At the start of June 2001 in Altnagelvin Area Hospital, who was deemed to be the more senior anaesthetist between you and Dr Gund?
A. Probably myself would have been deemed to be the more senior as I was on the second on-call rota.
Q. You were on the second on-call rota?
A. Yes.
Q. What allowed you to be on that second on call rota rather than him, for example?
A. Well, I had followed through my training until that point, passed my first part of my FC -- ARCSI down in the College of Dublin. And had gained experience throughout my two years as an SHO and had recently passed an interview allowing me to be upgraded to specialist registrar.

THE CHAIRMAN: Does this mean that in terms of seniority, the first on call is more junior, may go ahead and do some work without referring up the line, but if he or she wants to refer up the line, then it's to the second on call, which is you?
A. Yes, that would be correct.
THE CHAIRMAN: And then it may not be called a third on call, but ultimately the third on call would be the consultant?
A. Yes.
THE CHAIRMAN: So the fact that you're second on call indicates your position in this hierarchy?
A. Usually, yes.
MR REID: Just to continue the point, Dr Gund had been qualified as a doctor earlier than you and he had worked in India. Is it the case that you were deemed to be more senior and more experienced because you were further along in the NHS line of experience; would that be correct?
A. I can't comment on Dr Gund's experience because I was not aware of it at the time, of his longevity of training.
Q. You had been an SHO longer and, as you say, you were a registrar-elect at that stage; is that correct?
A. I don't believe Dr Gund had been an SHO in the UK, so

yes, per se I was an SHO longer than him, yes.
Q. Just by that stage in June 2001, what was your experience with cases of acute appendicitis?
A. It was a common case that presented itself frequently on the emergency list and frequently out of hours.
Q. How many general cases of it had perhaps you been involved in?
A. I couldn't give you an exact figure.
Q. Even as an estimate?
A. Including children and adults?
Q. Yes.
A. 500, perhaps more. I would have to look at my logbook to give you an accurate number.
THE CHAIRMAN: Sorry, that's okay. We're talking hundreds rather than tens?
A. Yes.
THE CHAIRMAN: Thank you.
MR REID: In terms of children of the paediatric sub-group of that 500?
A. As I said in my statement, I had only anaesthetised approximately 100 children, so most of those would have been emergency cases and a large proportion, approximately a third, would have been appendicectomy cases, I'm estimating.
Q. So an estimate of around 30 of that 100?

A. Yes.
Q. In June 2001, what training had you had in fluid management and electrolyte balance at that stage?
A. You get training in fluid management and electrolyte balance through your years as an undergraduate at Queen's University from physiology in the first year right through your clinical biochemistry and your clinical attachments, medically, surgically, until you qualify as a houseman. Following that, it is self-directed learning as well as knowledge acquired through tutorials and teaching from seniors. And then through anaesthesia training and educational courses attached to your anaesthetic training and then postgraduate self-directed learning for your professional examinations.
Q. As an anaesthetist in particular, would you say that anaesthesia is an area in which fluid balance and electrolyte balance is particularly tested and taught within the anaesthesia curriculum?
A. Yes.
Q. Because in theatre you're the primary person prescribing fluids and ensuring balance and homeostasis; is that right?
A. Yes, that's correct.
Q. In June 2001, what was your knowledge of dilutional

hyponatraemia?
A. My knowledge of dilutional hyponatraemia is that it is a condition that -- in June 2001, it was quite early on in my career, and I do think that my future career has probably been influenced and my knowledge has been influenced by the events of that time. It's a condition that is uncommon, encountered if -- it's a very complicated topic and it can be as a result of fluid overprescription, prescription of inappropriate fluids, or it can be the result of an interaction of medical conditions.
Q. And would you have known of the dangers of dilutional hyponatraemia in June 2001?
A. It's very difficult for me to comment right now exactly what my knowledge would have been at that time. I am much more aware of it now. Probably less so at that time.
Q. It's a question you answered in your witness statement, but just to repeat it. What awareness did you have, for example, of the 1992 Arieff BMJ article or the 2001 Halberthal article on dilutional hyponatraemia.
A. I had no awareness of that at that time.
Q. And were you aware of the case or inquest of Adam Strain in June 2001?
A. No, I was not aware of that.

Q. Or the cases of Claire Roberts or Lucy Crawford?
A. No, not in 2001.
Q. And in 2001, did you know the factors that might cause electrolyte imbalance in a child post-operatively?
A. In 2001, yes, probably. To a degree which was appropriate with my level at that time.
Q. As a very brief summary, what would those factors be?
A. Those factors would be a hypotonic solution, if administered. Those factors would be the stress response to surgery, it would have a hormonal influence --
Q. SIADH, you're referring to; is that right?
A. Yes.
Q. Anything else?
A. If the patient had drunk a whole lot of water, for example, which is very unusual.
Q. And what about post-operative nausea and vomiting, would that be a factor as well?
A. That in itself causes an increase in the stress response, but I'm more aware of that now than I was at that time.
Q. Did you have any training in regard to fluid balance or electrolyte balance during your induction at Altnagelvin Area Hospital?
A. I do not recall any inclusion of that in the induction

at Altnagelvin.
Q. If we can bring up reference 316-004e-001, and also then page 19 of that document alongside it, please. This is a letter that has been asked of several of the witnesses. If you see just in the centre of that letter, just on the right-hand side there it says:
"From 1995, there have been teaching sessions timetabled each year on fluid balance and electrolyte disturbance within the medical division teaching and training programme. This formal training is delivered during the lunchtime teaching programme and aimed at all PRHOs and all other junior medical staff. This is considered a general hospital education opportunity. The lectures on fluid balance were given which an anaesthetist and the lecture on abnormal biochemical tests, including electrolyte disturbance, by our clinical biochemist."
The inquiry has been provided with a list of some of the lectures and you can see, on the left-hand side, for example, there's one on Wednesday 8 August 2001, which is "Management of fluid balance" by Dr Morrow. There's a reference separately to one in August 2000 on the same topic.
First of all, do you recall this SHO training programme, Dr Jamison?

A. No, I don't recall that.
Q. So you don't recall there being lectures on a regular basis that were available to junior house officers and senior house officers?
A. No, I don't.
Q. Do you recall being at any lecture on fluid balance at Altnagelvin Area Hospital?
A. No, I don't.
Q. Okay.
THE CHAIRMAN: Can I ask you this: whether you recall it as a formal programme, do you recall occasional lectures?
A. I don't recall any formal lectures.
THE CHAIRMAN: Right. Okay, thank you.
MR REID: Certainly nothing as formal as this schedule, you don't recall anything like that?
A. No.
Q. If I can also then --
THE CHAIRMAN: I presume, Mr Reid, that this was drawn up so that the postgraduate dean would have some reassurance about what training was being given in Altnagelvin.
MR REID: It seems to be the purpose of the letter, Mr Chairman, but I think that's perhaps an issue for governance.
THE CHAIRMAN: Okay.
MR REID: If I can also bring up reference 316-004g-001.

This is a Junior Doctors' Handbook, Altnagelvin Hospital Health and Social Services Trust, and we've been told this was the handbook that was in force, so to speak, at the time. Do you have any memory of handbooks such as these at the time, Dr Jamison?
A. I don't have any memory of that, no. Handbooks like that usually were given to the pre-registration house officers.
Q. And not yourself as a senior house officer?
A. No.
Q. You spoke earlier --
THE CHAIRMAN: Sorry. Does that mean that in any other hospital you worked as a JHO that you might have got something like that?
A. Yes.
THE CHAIRMAN: Thank you.
MR REID: You spoke earlier about being on the second on-call rota; is that right?
A. Yes.
Q. Is the hierarchy that were to understand that which maybe you explained to the chairman earlier: there's the first on-call rota, the second on-call rota and then is there a registrar and a consultant; is that the hierarchy?
A. The first on-call rota is usually an SHO, the second

on-call rota, SHO/registrar, and then the third on-call would be the consultant at home.
Q. So it's a three-tier hierarchy?
A. Yes.
Q. And you were in as an SHO/registrar?
A. Yes.
Q. And Dr Gund was in as a first on-call rota SHO?
A. Yes.
Q. What was the difference in commitments between a first on-call and a second on-call?
A. The first on-call anaesthetist is usually the doctor who covers the emergency theatre sessions and is usually in an operating theatre for the majority of his time, covering the cases on the emergency list. The second on-call anaesthetist usually has more responsibility for the intensive care unit and the labour ward. Therefore they cannot be in the intensive care unit -- or in the theatre suite for that time. If there are emergencies elsewhere in the hospital, whoever was free would go to them.
Q. And did this three-tier on-call hierarchy only apply at night or was it a general thing over the day?
A. It was a general thing, but at night-time and out of hours it was probably more prevalent because there were less people around, so the first on carried a bleep, the

second on carried a bleep, and they would be contacted by the respective parties who wished to contact them.
Q. During the day, would anaesthetists already have been allocated to elective surgeries?
A. Yes.
Q. And then you'd have the three-tier system complementing that, is that the case?
A. Yes, there's usually an emergency theatre during the day or somebody who carried the first on bleep during the day as well.
Q. Okay. If we go to 7 June 2001. On that particular night, we've heard from Dr Gund that he was a first on call and it's the case that you were the second on call that night; is that right?
A. Yes, that.
Q. Can you recall who the third on call was that night?
A. I cannot recall who the third on was that night.
Q. But as you say, it would have been a consultant of some nature?
A. Yes.
Q. And during those kind of nights, is it the case that the first and second on call are always in the hospital or are they just contactable?
A. They're always in the hospital.
Q. Were the consultants always in the hospital or were they

contactable?
A. They were not always in the hospital, but the nature of Altnagelvin was that they did spend the majority of their on-call time in the hospital. They were always contactable.
Q. But occasionally they would be at home or nearby and available on the phone?
A. Yes.
Q. First of all, do you have any direct recollection of the events of the 7th into the early hours of 8 June 2001? Do you directly recall that evening?
A. I can recall that evening given that I've been asked to make statements regarding it, but my recollections would not be pristine.
Q. But you have some recollections rather than just gleaning recollections from the notes; would that be fair?
A. I would have to say a combination of both.
Q. How did you first find out on 7 June 2001 that it was intended that Raychel Ferguson would go into surgery?
A. Dr Gund mentioned it to me. He said, "We have an appendix booked on the emergency list".
Q. And would it be usual for Dr Gund to mention to you that a surgery was going to take place?
A. Yes, that would be entirely normal.

Q. Would he always mention any surgery that would take place?
A. I hadn't worked with him a lot up until that point, so I couldn't say what was always his practice, but certainly that night he did mention that Raychel had been booked for an appendix.
Q. Do you need to know that the first on call is going to be in surgery in order to know that you have to cover their responsibilities?
A. No, I don't need to know that they are in theatre. I would normally have found that out if I was in the building, but there's no direct requirement for you to know that.
Q. Can you recall what time Dr Gund informed you of Raychel's surgery?
A. No, I couldn't recall the time.
Q. Can you recall whether at the point at which he spoke to you that the surgery was scheduled for a particular time or whether it was just that she is going to go into surgery at some point?
A. It's just that she would be presenting to theatre that evening. There was no particular time given that I recall.
Q. Was there any limit on the time?
A. It would be normal for a case like that to come to

theatre prior to midnight.
Q. And why is that?
A. Because usually after midnight, it would be a life-or-death condition.
Q. Whenever you were told then by Dr Gund of the fact that Raychel would be going to surgery, what tasks did you have to do then as a result of what he told you? Was there anything you had to do?
A. I had no direct responsibilities. I asked him had he seen Raychel, he said he had and that he was happy, he had no concerns and that he had spoken to her parents.
Q. Did you have any discussions with the surgeon, Mr Makar, during the preoperative period?
A. No, I had no discussions with the surgeons.
Q. Would you usually, as a second on-call anaesthetist, have any discussions with the surgeon prior to a surgery?
A. Not normally.
THE CHAIRMAN: Can I take it, doctor, that when you were told by Dr Gund that there was a girl with appendicitis on the emergency list for theatre that night that that wasn't in any way surprising or untoward because you've dealt with so many appendix operations and so often they are emergencies and out of hours?

A. Yes, that would be correct.
THE CHAIRMAN: Okay. So there was nothing to raise any antennae or no red flags?
A. No, I had no concerns.
THE CHAIRMAN: Thank you.
MR REID: You said that Dr Gund had spoken to you and said that he'd seen Raychel and that he'd spoken to the parents; is that right?
A. That's what he told me, yes.
Q. Are you certain that's what he said?
A. I can't be certain.
Q. But that's what you recall anyway?
A. Yes.
Q. Dr Gund gave evidence on Tuesday and said that whenever he went to assess Raychel, her parents weren't there at the time. There's an issue of whether Dr Gund had had the opportunity to speak to the parents by the time he informed you that surgery was going to take place in Raychel's case. Do you have any comment on that?
A. I have no comment, no.
Q. Could it be that perhaps you're mistaken in that aspect of your recollection, that he had spoken to the parents by that stage?
A. I cannot be 100 per cent sure that he said that, but my recollection is that he did say that he had spoken to

her parents.
Q. Whenever he spoke to you, was this -- I know you can't recall the exact time, but was this at a time close to her surgery taking place or was it a time before that?
A. My conversation with Dr Gund would have been at a time before that.
Q. Am I correct in saying that as a second on-call anaesthetist, you weren't required to be in surgery that evening?
A. Not unless Dr Gund had raised concerns or the patient was requiring -- was having a major surgery, major co-morbidities that required more senior input.
Q. And dividing the procedure up, were you present at the induction of the anaesthesia in Raychel's case?
A. Yes, I was.
Q. And given your previous answer, why were you there during the induction of the anaesthesia in Raychel's case?
A. I had been free from my other duties and was assisting and helping Dr Gund with the induction of anaesthesia.
Q. And had Dr Gund requested your assistance?
A. No.
Q. Was this a case, as you said, that required more senior input or --
A. No.

Q. Why were you there then, doctor?
A. Within anaesthetics, we work as part of a team and I was merely assisting my other team member because I was free from my other duties at that time.
Q. You were providing support; would that be fair?
A. Yes.
Q. During the time you were providing support, what is happening with your other duties?
A. I had already attended the intensive care unit and had done a ward round there. They at that time were stable and not requiring any input from me and the labour ward at that time was not requesting my presence.
THE CHAIRMAN: At this stage, Dr Gund, I think, had arrived in the UK, Altnagelvin was his first post from May 2001. So this operation we're talking about is in early June. Was the fact that he was really very new to the hospital, does that play a part in your decision to be around to help if required?
A. No, because I had no concerns about his ability as an anaesthetist.
THE CHAIRMAN: Right, thank you.
MR REID: Did you ask Dr Gund whether he contacted the third on call, the consultant.
A. No, I do not recall asking him if he had done that.
Q. Whose responsibility is it in those circumstances to --

if the consultant as going to be informed, whose responsibility is it to inform the consultant?
A. I'm not sure there are clear-cut lines about whose responsibility it is. Anybody from any tier within the team is able to contact the consultant if they feel concern. For example, if Dr Gund was in theatre with a case that he felt he needed help for and I was busy in labour ward, he could have contacted the consultant. There's no clear-cut lines as to who should --
Q. So the first on call can skip the second on call and contact the consultant himself?
A. Yes.
Q. In circumstances where you are available and the first on call wishes to get more senior support, more senior input, would it be the correct practice for him to ask you and then for you to ask the consultant if necessary?
A. If necessary, yes.
Q. In Raychel's case, you had been informed that Raychel's surgery was going ahead. Did you ask Dr Gund whether he'd informed the third on call in that case?
A. No, I do not recall asking him if he had done that.
Q. Did you think about informing the third on call?
A. No. I had absolutely no concerns with regards proceeding with the case and therefore did not feel it necessary to inform the third on.

Q. Did you contact the third on call?
A. I do not recall contacting a third on-call consultant.
Q. You didn't think it was necessary. This was a, as some have described it, a more straightforward surgery, but it was an emergency surgery nevertheless.
A. Yes.
Q. Would it not be normal practice to inform a consultant if an emergency surgery was to take place?
A. It would not be normal practice to inform a consultant if it was a case like this unless you had concerns.
THE CHAIRMAN: Does this count as major surgery? It's obviously major to the family, but in a doctor's eyes or an anaesthetist's eyes, does the removal of an appendix count as major surgery?
A. As far as I'm aware, from a surgical perspective, breaching the peritoneum is what makes surgery be classified as being major. So in those terms, yes, but it was a very routine case from an anaesthetic point of view.
MR REID: You just said that it was a routine case and so it wouldn't have been normal practice to let the consultant on call know.
You were asked in your witness statement whether you were aware of the NCEPOD report of 1989. It said that:
"Trainee anaesthetists should not undertake any

anaesthetic on a child without consultation with their consultant."

And you said that you weren't aware of that in June 2001; is that correct?

A. That's correct.

Q. You were asked as well -- and if we can bring up WS024/2, page 5 -- at the very bottom:

"Whether or not you were aware of this finding of the NCEPOD, how do you consider this conclusion applied to you in your role in Raychel's surgery? It would have been normal practice to let the consultant on call be aware of cases on the emergency list if it was a child or you had any concerns."

A few moments ago, doctor, you said it wouldn't have been normal practice because this was straightforward surgery, despite the fact it was an emergency. Can you see perhaps that that might not be consistent with what you have said at the bottom?

A. Yes, I see why that is not consistent, but I have answered that question with retrospective knowledge of the NCEPOD report and how it would have influenced practices.

Q. Because Dr Gund has said that it was his understanding that the applicable procedure was to inform the second on call consultant, that's yourself, for all cases out

of hours. And it would appear that the only anaesthetists who knew the surgery was going on were you and Dr Gund; is that right?

A. I was the second on-call SHO that night, not a consultant and, yes, I'm ... I assume that just him and I were aware that this was the case in theatre.

Q. You're currently --

THE CHAIRMAN: Sorry, Mr Reid. This answer which is on the screen, I just want to understand it. This is an inquiry question to you about whether or not you are aware of the findings of the NCEPOD report and how do you consider this conclusion applied to you in Raychel's case. And you say:

"It would have been normal practice to let the consultant on call be aware of emergency cases if it was a child."

Do I understand that you're saying now, "Looking at the NCEPOD report, that is the view which I take because that's what NCEPOD says"?

A. Yes.

THE CHAIRMAN: But that's not what you thought at the time in 2001?

A. Yes, that would be correct.

THE CHAIRMAN: Thank you.

MR REID: If we turn over the page to page 6, you're asked

on page 6, doctor, at number 3:

"Insofar as you are aware, was the on-call consultant anaesthetist informed about Raychel's admission?"

And you have said to us no. In this answer you said:

"I cannot recall specifically informing the consultant on call, but as previous stated, it would have been normal practice to let the on-call consultant be aware of a child on the emergency list."

Again, I have to ask, is there a difference between what you've said there and what you're saying now?

A. I would have to say to the chairman and apologise that I again have answered this question as a follow-on from the previous one and would have based my answer on retrospective knowledge of NCEPOD.

Q. So am I correct in saying that there in the witness statement you're saying you can't remember, but because it would be normal practice, it seems like it would have been done, but now you're saying in such a case you wouldn't be informing the anaesthetist; is that right?

A. I'm sorry, I don't --

Q. Sorry, I'll rephrase. You're saying now that it wouldn't have been normal practice in June 2001 to contact the third on-call consultant in a case such as

acute appendicitis?

A. Yes, that's what I'm saying. At that time in 2001, there were no clear guidelines about contacting the third on-call anaesthetist.

THE CHAIRMAN: I just want to work out then what you think the status of the NCEPOD 1989 document is. It doesn't, in your eyes, then represent clear guidelines?

A. No, I meant Altnagelvin had no clear guidelines at that point. But I feel that the NCEPOD report, having read it, following the questioning by the inquiry, it certainly would have influenced me at that time if I had known and I would have contacted the third on.

THE CHAIRMAN: Can I ask you this: when you moved on from Altnagelvin, what, a couple of months later, and you moved on to Antrim and you were a registrar, was the Antrim practice different about contacting a consultant?

A. I cannot recall there being clear guidelines there either, but I made it a point of contacting the consultant on call if such a case did arise.

THE CHAIRMAN: Because of your lessons from Raychel?

A. Yes.

THE CHAIRMAN: Can I ask you this: what has been your awareness before this inquiry of something like an NCEPOD report and recommendations? I'm taking it because Mr Foster referred to it that it's a document of

some standing and some status, but really what I'm gathering is that nobody seems to have been aware of it, or certainly none of the doctors so far seem to have been aware of it, and you've really confirmed that you weren't aware of it.

A. Yes. At that time I was not aware of it. I was early in my career and certainly now, many years down the line, I am much more aware of NCEPOD and its recommendations and practice in many areas.

THE CHAIRMAN: Okay, thank you very much.

MR REID: And you're a consultant anaesthetist now at the Ulster. If one of your senior house officers has a case where an appendicectomy operation is going to be done just before midnight and you were the on-call consultant, what's your policy now in terms of you being contacted?

A. I do not cover general theatres in the Ulster Hospital. I cover the intensive care unit as part of my on-call rota, so I do not have that issue.

Q. Can I ask you then, in June 2001, when you and Dr Gund were about to induce the anaesthesia in Raychel's case, do you think that a consultant should have been contacted?

A. Having gone through everything I still do not feel that it warranted a consultant being contacted because there

were no concerns with regards proceeding at all. And I feel that if I had contacted a consultant, they would not have attended. They would have been aware that the case was present, but would not have attended the building.

THE CHAIRMAN: So in a sense, it would be a pointless phone call because you'd be ringing a consultant who might not have been ecstatic to receive a phone call to say, "We're going into surgery for what appears to be a standard appendicectomy"?

A. You could take that out of it, but the consultants in Altnagelvin were very supportive of their team and encouraged phone calls at any time.

THE CHAIRMAN: Thank you.

MR REID: The last point on this issue is the view of Dr Haynes, who's the inquiry's expert on paediatric anaesthesia. If we can bring up his report at 220-002-015, please. In the centre of that middle paragraph, Dr Haynes questions how appropriate it was in 2001 for a junior trainee, such as Dr Gund, to be expected to anaesthetise, during the night, a 9 year-old child without direct supervision:

"I note that Dr Jamison was present for the induction of anaesthesia and that she also saw Raychel in the recovery room following the operation. Although

it appears that Dr Jamison was more experienced than Dr Gund, she was still a senior house officer at the time. The impression given is that the consultant anaesthetist on call was not informed of the fact that a 9 year-old girl was being anaesthetised out of hours [as you have said]. I do not think that to have been appropriate if neither trainee had significant experience and training in anaesthetising children."

And he repeats his view in his second report, which I won't bring up.

THE CHAIRMAN: Let's stick with that one. Does that seem to you to be harsh?

A. Perhaps, because that was common practice at that time. The procedures within the anaesthetic team in 2001, when Raychel came to theatre, were not uncommon.

THE CHAIRMAN: Let me ask you this: when you say they're not uncommon, you're saying that that's what was common in Altnagelvin, but are you saying it was common beyond Altnagelvin?

A. Yes.

THE CHAIRMAN: Did you find the same arrangement in Antrim when you moved there? Where else are you referring to?

A. Having been an anaesthetic trainee within Northern Ireland at that time, the SHO first on and second on being responsible for a case of an

appendicectomy -- a routine appendicectomy on the emergency list -- was not uncommon.

THE CHAIRMAN: Okay. Thank you very much.

MR REID: Just the other reference I was about to refer to in Dr Haynes' third report. At 220-003-004, he says at the top, commenting on your witness statement:

"It is my opinion that the arrangements for the provision of anaesthesia per se in a 9 year-old for a straightforward operation on 7 June 2001 at Altnagelvin Hospital were satisfactory, assuming that the consultant on call, (a), was confident in the capabilities of doctors Gund and Jamison and, (b), that he or she had been informed of Raychel's case prior to her being taken to the operating theatre."

Do you wish to make any comment about that?

THE CHAIRMAN: They're the same lines again, aren't they?

A. Yes.

THE CHAIRMAN: Okay.

MR REID: As far as you can recall, doctor, you say you were there at the induction of anaesthesia. How much of Raychel's surgery were you present for?

A. I cannot exactly recall, but I think I left prior to even the first incision was made.

Q. So were you there when she was awake?

A. Yes.

Q. And were you there when she was put under?
A. When she was induced, yes.
Q. But you don't think you were there when the first incision was made by Mr Makar?
A. No.
Q. And do you think you were there at any point during the surgery itself from the incision to the closing up?
A. No. I was not there.
Q. Do you believe that you returned to the theatre?
A. I returned to the theatre area where Raychel was being recovered because it was common for patients out of hours to be recovered in theatre, but the surgical procedure had finished at that point.
Q. When you say "recover in theatre", is that the same theatre she was being operated in she's kept in; is that correct?
A. Yes.
Q. So the bed isn't moved; would that be right?
A. Well, it's sometimes moved between the anaesthetic room and theatre.
Q. So you think you were there when she was being recovered and whenever you went there when she was being recovered was she still asleep at that stage?
A. She was asleep in the layman sense of asleep, not anaesthetised.

Q. And was she extubated at that stage?
A. Yes.
MR REID: Mr Chairman, maybe this is a good point then to break.
THE CHAIRMAN: Doctor, we'll resume at 2 o'clock. Thank you.
MR STITT: Mr Chairman, if I may, there are two points that I'd like to raise before you break for the interval. If I may indicate what they are and you can hopefully indicate if you'll allow me to make the points. The first is a matter which has been drawn to my attention just this morning, what purports to be a Salmon letter sent to a witness who was due to give evidence today, Staff Nurse Noble. I wonder, sir, do you have a copy of that? It's dated 6 February 2013.
THE CHAIRMAN: I do, but you should know that this is not a public document in the sense --
MR STITT: Then I'll bear that in mind.
THE CHAIRMAN: The Salmon letters are sent by the inquiry to the witness who faces criticism and is seen by the witness and his or her legal advisers. It's not shared with everybody else, it never goes to the website, so for instance the family doesn't know what's in the Salmon letter.
MR STITT: That's a helpful indication and I note that.

I will make my point nonetheless, but bearing that in mind. Normally, a Salmon letter comes from the tribunal and it would be signed by the chairman and it would be couched with a covering letter, which are generally in the same terms. It gives the person receiving the letter the opportunity to be made aware of the fact that there could be some areas of criticism made during the course of their evidence --
THE CHAIRMAN: Okay.
MR STITT: -- and it's couched in what one might say would be cautious, diplomatic, professional terms.
THE CHAIRMAN: These are potential criticisms that may or may not stand up.
MR STITT: And it's made absolutely clear that there's no pre-judgment of this and it is to give a timely, to quote, a timely opportunity for the person receiving it to consider the points. It's a very fair way, if I may respectfully say so, of putting someone on notice of matters which could be important. My point relating to the document to which I've referred is one both of timing and of content. Firstly, it is clear that its signature is clearly -- it's clearly a document which has come from a specific party, not from the tribunal.
THE CHAIRMAN: I am sorry, this is not the inquiry's Salmon letter you're referring to?

MR STITT: No, this is a document dated 6 February 2013, which was sent to a witness by the inquiry.
THE CHAIRMAN: So it's the family's letter of potential criticism?
MR STITT: Yes.
THE CHAIRMAN: Okay.
MR STITT: Do you have a copy of that, Mr Chairman?
THE CHAIRMAN: No, I don't. I'm not sure that there's any reason why I shouldn't, but if you want to make the point and we can pick it up after lunch.
MR STITT: I'd very much like you to have it in front of you.
THE CHAIRMAN: Okay. Let's do it after lunch. I'm anxious not to keep Dr Jamison for even longer than she has been kept waiting so far. I will get that and we can develop that point after Dr Jamison's evidence, if that's okay, after she finishes, after lunch.
MR STITT: Yes, absolutely.
THE CHAIRMAN: Do you want to alert me to what your second point is?
MR STITT: It's not a question of alerting, I'll make the second point when we get to it.
THE CHAIRMAN: Okay, thank you very much.
MR STITT: I think I should, sir, in all fairness, lest there be any criticism.

THE CHAIRMAN: Okay.
MR STITT: I have read the transcript of the discourse which took place last evening between yourself and my learned junior, Mr Lavery, and I can quote the extract, but it goes along the lines of the fact that you're saying, well, if the nurses -- it is to do with representation -- do choose to keep their own representation then there's nothing I can do about that.
THE CHAIRMAN: Mm-hm.
MR STITT: And I was wondering if that was still your view or why you had changed your mind.
THE CHAIRMAN: Okay, I'll pick that up with you after lunch.
(1.15 pm)
(The Short Adjournment)
(2.00 pm)
MR REID: Just two points regarding the evidence you have been so far, doctor. You said that Dr Gund had spoken to you, saying that Raychel was going to surgery, and that he had spoken to the parents, and we discussed that.
Was it significant to you that Dr Gund had spoken to Raychel's parents as far as you were concerned?
A. In that it would be best practice to speak to a child's parents before they went to theatre.
Q. And if he hadn't said that, would you have asked him,

"Have you spoken to the parents?"
A. Yes.
Q. It's something you would obviously expect then before the surgery. Just on the NCEPOD report that we were discussing before lunch, if I can bring up 223-002-054 --
THE CHAIRMAN: As you do that, can I assume, doctor, that there are times when an anaesthetist goes to see a child and speak to the parents and the parents just aren't there, they happen not to be there at that particular moment?
A. Yes. That happens quite frequently.
THE CHAIRMAN: It's important that the anaesthetist tries to speak to them --
A. Yes.
THE CHAIRMAN: -- but also that the anaesthetist sees the child before the operation.
A. Yes.
THE CHAIRMAN: So if Dr Gund had gone and Mr and Mrs Ferguson weren't there, but he had still seen Raychel, it's not ideal, but that's what happens from time to time, is it?
A. Yes, that is quite a frequent occurrence.
THE CHAIRMAN: Thank you.
MR REID: Doctor, you --

THE CHAIRMAN: Sorry, it's not fault on anybody's part, it's not Mr and Mrs Ferguson's fault, it's not Dr Gund's fault, it just happens sometimes.
MR REID: You still don't feel that it warranted informing a consultant, even now, about Raychel's surgery because there were no concerns with regards proceeding at all. That was your evidence before lunch; am I correct in that?
A. Yes.
Q. If I just bring up the NCEPOD report that we were referring to before lunch. The reference is 223-002-054. What you're really saying is that you don't think it warranted a consultant in the circumstances where you had no concerns about proceeding; isn't that right?
A. I had no concerns about proceeding, no.
Q. The final bullet is a recommendation we've been discussing:
"Consultant supervision of trainees needs to be kept under scrutiny. No trainee should undertake any anaesthetic or surgical operation on a child of any age without consultation with their consultant."
Looking at that bullet, would you agree that there doesn't seem to be any qualification or limitation on the surgeries or anaesthetics or concerns as regards

that recommendation?
A. I would agree with that, which is why I've written in my statement that, with retrospect, if I had known about that, it would have been normal practice to have informed my consultant.
Q. Can I take it from what you have said that it's only because of your knowledge now of the NCEPOD report that you would think that informing a consultant before surgery and before anaesthetic is required in the circumstances of Raychel's case, for example?
THE CHAIRMAN: No, I think you said that you had started to do it after Raychel's death because of lessons learned from Raychel; is that right?
A. Because of that and with reference to the NCEPOD.
THE CHAIRMAN: In the immediate aftermath of Raychel's death you weren't aware at that point of NCEPOD, were you?
A. No.
THE CHAIRMAN: Before Mr Foster's report referred to the NCEPOD report, were you aware of it?
A. Yes. Before I read his report, yes.
THE CHAIRMAN: That awareness had developed at some point over the last 10 years?
A. Yes.
THE CHAIRMAN: Thank you.
MR REID: And just finally on that, is perhaps your

knowledge of the NCEPOD report because it was asked of you in the inquiry witness statement?
A. No, over the last --
Q. You knew about it before that?
A. Mm-hm.
Q. We were discussing just before lunch which parts of Raychel's surgery you were involved in. And you said that you were definitely there during the induction of the anaesthetic, when she was awake and then when she was asleep, and you say then you weren't there when the first incision was made; is that a fair summary?
A. That's a fair summary. I don't recall being there as surgery commenced.
Q. Do you have any recollection of what Raychel's condition or form was like whenever she was in the anaesthetic room?
A. My recollection is that she was quiet, looked pale -- but I did not know if that was her normal colouring -- and looked generally fairly comfortable in the bed when she arrived in theatre.
Q. Was she chatty at all, was she talking to you or Dr Gund or Mr Makar or her parents or the nurses there?
A. As I said, I think she was quiet. I don't recall her being particularly chatty, but that would not be uncommon for a child coming to a theatre environment.

Q. Do you recall whether she was complaining of any pain at the time?
A. I do not recall her complaining of pain.
Q. Dr Gund was the main anaesthetist during the surgery; isn't that right?
A. Yes, that's correct.
Q. If we can bring up the anaesthetic form 020-009-016, please. You see at the top left of the anaesthetic record, it's noted "Dr Gund/Dr Jamison". You have said you weren't there during the actual surgery itself, during the surgical elements of it. In those circumstances, are you surprised that your name is written on the anaesthetic record?
A. Not particularly because being present at induction of anaesthesia is a significant part of the anaesthetics, so I'm not surprised to see my name there.
Q. Likewise, in the surgeon's report, 020-010-018, again Mr Makar says the handwriting's the nurse's in the field and the "anaesthetist", it's written "Doctors Jamison and Gund". In fact, in this case your name is written first. Do you think that has any significance?
A. The fact that my name is written first?
Q. Yes.
A. I don't think that has any significance, no.
THE CHAIRMAN: [Inaudible: no microphone] senior person?

A. Yes.
MR REID: Because when they gave evidence, Dr Gund and Mr Makar have different recollections as to when you were present during the surgery. So I just have to put to you the factual conflict. Dr Gund was asked on 5 February 2013, at page 152 -- if that can be brought up, please. Dr Gund was asked:
"Question: Was Dr Jamison there during the surgery?"
And he said:
"Answer: As far as I can remember, yes, she was there the whole time."
Mr Makar said that he thought that you were there at the end as well. Do you have anything to say about their recollections?
A. I can't comment on their recollections other than that I'm certain I was not there for the entire procedure. I was there for induction of anaesthesia and intubation of Raychel. And I did return to theatre to check on how things were. I cannot recall whether Dr Makar was there at that point when I returned to theatre.
Q. Can we just have the transcript on screen just for your own benefit now? As you can see in the centre:
"Question: But Dr Gund, so far as you are concerned, she was there the whole time.

"Answer: Yes. As far as I can remember, yes.
You say your recollection is different from that?
A. Absolutely.
Q. And you're certain you were not there during the surgery?
A. I'm certain.
Q. If we bring up the anaesthetic record again, 020-009-016. You can see on the left-hand side there's the different drugs that she was given prior to the surgery. What would have been the expected length of recovery period expected with the anaesthetic drugs that were used in Raychel's surgery? How quickly do you think that she would have awoken after the surgery had taken place?
A. It's a very difficult question to answer. Everybody's different in the length of time they take to metabolise agents, and when you say "awoken", do you mean to the point at which we could extubate her or the point at which she could have a conversation? It's a very broad spectrum.
Q. Let me ask you this: in terms of how Raychel recovered from the surgery in the hour or two after the surgery finished, was her recovery period as expected or was it longer than expected?

A. From my recollection, she was in recovery perhaps slightly longer than expected, but often that's the case at night-time when there's no pressure on the system and nurses in theatre aren't under pressure to get patients back to the ward, so maybe they held on to her for a little longer than would be normal during the daytime. But it was certainly not outside the realms of normality.
Q. You were in the anaesthetic room at the induction of anaesthesia; did you speak to Raychel's parents at that time?
A. No.
Q. And did you speak to Mr Makar or Dr Gund at that time?
A. I don't recall speaking to Dr Makar. I'm sure I probably spoke to Dr Gund.
Q. If you had been speaking to Raychel's parents at the start of the induction of anaesthesia and you were advising them of the length of the surgery and when they might see Raychel again, what kind of estimate would you be giving to the parents?
A. Appendicectomy surgery, in my experience, can take anything from half an hour to four hours, depending upon the surgical findings. So you would say your anaesthetic per se lasts as long as the procedure would take, and a little time for recovery afterwards to make

sure that the patient is comfortable and at that point they return to the ward for ongoing care. It's very difficult to put an actual number, time frame on it.
Q. Because Mrs Ferguson's recollection at witness statement 020/1, page 4, if that can be brought up -- I must have the wrong reference. Anyway, the comment is that a nurse told her that Raychel would be back on the ward within an hour. So it's an hour later and they were waiting on Raychel. What would you say if I said to you that a nurse said it would take an hour for her to be back on the ward. Would that be an expected time or do you think that was an underestimate of the time it would take for Raychel to be back on the ward?
A. From the time of leaving the ward to returning, having had an appendicectomy done and recovery from that, I would say an hour was an underestimate.
Q. And would it be common practice for parents to be told how long a surgery might take before their children go in for surgery?
A. It's a common question asked by people going to theatre, but it's a question that is nearly impossible to answer with any accuracy.
Q. Certainly you would expect that if yourself or if Dr Gund was asked that question that you would give a broad estimate of time, as you've given to us this

morning.
A. Yes.
Q. And would the theatre nurses be aware of those kind of broad expectations of time?
A. I would imagine theatre nurses are very experienced in the varying lengths of time various procedures take.
THE CHAIRMAN: The best-case scenario might be an hour, but there are too many variables, aren't there?
A. The absolute best-case scenario would be an hour.
THE CHAIRMAN: It's all depends how it's communicated. Sometimes a child is back in an hour, or with a bit of luck it's an hour, but if it was understood by the Fergusons to be a firmer indication than that, then that would be a bit unfortunate.
A. Yes.
MR REID: One final issue in regard to the induction of anaesthesia. We were discussing Raychel's form and you were saying that:
"I think she was pale and she was comfortable, but she wasn't particularly chatty."
Would that be correct?
A. Yes. That's my recollection.
Q. If we just look at the page we have in front of us from Mrs Ferguson's witness statement, she says that when Raychel was transferred to the children's ward, she was

still in good form and she explains what "good form" means:
"Well, her form was good, her colour it come back and, as far as I could see, she was back to her normal self, chatting away."
And at the very bottom, she was asked whether Raychel was experiencing any pain when she arrived at theatre. She said:
"Raychel did not seem to be in any pain as she was getting wheeled down into theatre. She was chatting away to the nurse about her sports day."
Is that recollection in any way different from what you recollect about Raychel's condition at the time?
A. I assume the nurse they're talking about was the one that was accompanying her from the ward to theatre. I was not there at that time, so I cannot comment on that. Often when children get to theatre, they're just overawed by the environment and I don't recall her being chatty.
Q. You say she wasn't of great colour at the time, she was a bit pale. That's your recollection?
A. That was my recollection, but I wouldn't know what was normal for Raychel.
THE CHAIRMAN: She's also probably very tired. It's 11 o'clock at night, which is, I assume, not a time that

Raychel would normally be up at, and she's also been in pain since 4-ish and has been receiving drugs.

A. Mm-hm.

MR REID: Prior to surgery beginning and during the induction of anaesthesia and so on, did you have any discussion with Dr Gund about the fluids that Raychel would be administered during the surgery?

A. No, I had no discussion about fluids administered during the surgery. It was usual practice to give Hartmann's fluid intraoperatively.

Q. So as far as you're concerned, did you have any involvement or responsibility as regards the rate or the type of fluids that were given during the surgery?

A. No, because it was usual practice to give Hartmann's solution intraoperatively.

Q. Were you aware of the fluid regime that she had been on prior to coming to surgery?

A. At that point, no. I had not looked at her fluid balance chart.

Q. You were assisting Dr Gund just at the induction of anaesthesia. In that role would you commonly read the notes and records of the patient before inducing the anaesthesia?

A. I had had a verbal handover from Dr Gund about her preoperative state. I wouldn't normally trawl through

notes unless there were concerns raised.

Q. And are you aware of what rate the Hartmann's was being administered at during the surgery?

A. I couldn't comment on that because I wasn't present.

Q. Would the intraoperative fluids be put up and connected at the time of induction of anaesthesia?

A. A fresh bag is usually run through for that new patient when it comes to theatre.

Q. What I am saying is, during the time you're there, during that induction of anaesthesia period, is that the time in which the new IV fluid, the Hartmann's, is being connected to Raychel?

A. Yes, she would have a new IV giving set attached when she got to theatre.

Q. So might you have been aware from that the rate at which the Hartmann's is being prescribed during the surgery?

A. Not from that moment. I couldn't have described her rate because it is under constant variables. If Dr Gund altered it throughout surgery, I couldn't comment on the rate.

Q. Would I be correct in saying that you set the rate at the start of surgery and you can alter during surgery?

A. It was not run through a pump, so I did not see a number visible. It's subject to rolling your thumb up and down

a little ball valve to alter the drip rate. So you're not actually getting an accurate number.

Q. But is the -- so there's no number set on this drip rate?

A. No.

Q. So are you saying that you find out what the rate is by looking to see how much fluid is given in a short period of time?

A. Yes, and with experience you know that you drip -- the drip that goes in is a slow drip or a fast drip. It's not a particular number attached to it.

Q. So you know how many droplets you can see dropping down the tube and you know a certain number is fast rate and a certain number is a slow rate?

A. Mm-hm.

Q. Do you think that's a satisfactory way of knowing what the rate is of fluid administration during surgery?

A. That is common practice for IV fluids during surgery, even now, in adults. More commonly now in paediatrics fluids are run through a drip counter, which you can set the rate to a specific number, therefore you're more sure of what you're delivering.

Q. This is different from the ward when it's put through an IV pump, which is set to a certain amount?

A. Yes, that's what I mean by drip counter.

Q. So you're saying that's commonly a practice now. Would you agree that that's perhaps a better, more accurate practice than the practice that was in use then?

A. Yes.

Q. And do you have any indication of whether it was a slow or a fast or a medium rate that was being used at the start of Raychel's surgery?

A. At the start of the surgery, it would have been a slow rate, just to flush through the drugs.

THE CHAIRMAN: The change that you've described to the current practice of using a drip counter, is that as a result of any particular incident like Raychel's death or is that just a general change over the last 10 years?

A. I think it's a combination of both. I think IV fluids in children have become more scrutinised because of the inquiry and therefore pumps are more readily available, especially in a theatre setting for children.

THE CHAIRMAN: Thank you.

MR REID: And it was simply an availability issue why pumps weren't used in surgery, but were used on the ward --

A. At that time, yes.

Q. -- rather than an anaesthetist's preference for having the drip counter?

A. No.

Q. There's no practical benefit to the drip counter over

the pump?
A. They're both the same thing.
Q. If we bring up Raychel's anaesthetic record, 020-009-016. We can see there in the centre of the page it says:
"Fluids total. Hartmann's, 1 litre."
And then there's an arrow besides that with a star. Do you see that, doctor?
A. Yes.
Q. The "Hartmann's 1 litre", is that Dr Gund's handwriting?
A. Yes.
Q. And is the arrow with a star, is that your addition?
A. The writing above is my addition. I think the arrow and star was written by Dr Nesbitt.
Q. So Dr Nesbitt wrote the arrow and the star?
A. I think so.
Q. And I presume he also wrote "witnessed by GA Nesbitt"?
A. Yes.
Q. And the rest of that retrospective note is your handwriting?
A. Yes.
Q. Can you explain why it wasn't noted how much fluid was actually administered during the surgery?
A. I cannot explain why it was.
Q. Would it have been usual practice at the time to record

how much fluid was being administered during surgery?
A. I think it was often down to whichever anaesthetist was present at that time. It wasn't by all means a set rule that you had to complete the volume of fluid given by the end of surgery.
Q. On the ward, we've seen in various cases that it's the responsibility of the nurses to record the fluid balance, normally on an hourly basis. In surgery, whose responsibility normally is it or who normally takes the role of recording what fluids have been administered during surgery?
A. That would be the role of the anaesthetist.
Q. So the anaesthetist rather than any of the nurses?
A. Yes. Often nurses keep a record of blood loss, but actual fluid in would be the anaesthetist.
Q. And I asked you whether it would be usual practice to record how much fluid was being administered. Would this have been a common thing in records, in and around 2001, that the fluids being administered during surgery weren't recorded? Would it have been common?
A. Sorry, common?
Q. Would you have seen this in various cases? Would it be a common occurrence?
A. That the total fluid was not recorded?
Q. Yes.

A. It was a variable occurrence. Some anaesthetists were vigilant, some --
Q. It occasionally happened, occasionally it didn't happen?
A. Yes.
THE CHAIRMAN: But is the point that there was no significance attached to it or not particular significance attached to it, which was why it was sometimes you do and sometimes you don't?
A. Yes.
MR REID: The anaesthetist knows themselves how much fluid they've administered or has been administered over the time of the surgery.
A. Yes.
Q. And they can look up and look at the bag and see how much has been administered; would that be right?
A. Yes.
Q. And these IV bags are marked, are they?
A. Yes. The litre bags are usually marks with 100 millilitre graduations alongside of them.
Q. So it's like looking at the side of a kettle, you can see how much water is left in it?
A. It's probably slightly less accurate than a kettle because your bag collapses.
Q. We see the "Hartmann's 1 litre" is there. Would it be usual for there to be a prescription for the Hartmann's

solution or not, a separate prescription?
A. Intraoperatively?
Q. Yes.
A. You mean separate from what would be written here?
Q. Yes.
A. No, it would usually be written on the anaesthetic chart.
Q. That's deemed to be the prescription?
A. Yes.
Q. Because if we bring up, just for comparison, if we can, the anaesthetic record in, for example, Adam Strain's case, it's 058-003-005. If we look at the Hartmann's and the fifth normal saline sections in the top third of that anaesthetic record, we can see there's a 500 between two arrows, 500 between another two arrows, 500 again and 500 above that. Would you accept that in that situation it seems that the fluids at least have been recorded over the course of the surgery?
A. Yes, it's just a different way of recording it. Each anaesthetist tends to have their own way of writing it on the chart because each anaesthetic chart is different.
Q. After the surgery, if you're a clinician or nurse and you want to know how much fluid was administered during the surgery, what would you look at in order to know how

much was administered?
A. You'd look at the bags of fluid you had given.
Q. Say you were a clinician coming in at several hours after the surgery, how would you know how much had been administered during the surgery the previous night if you hadn't been involved?
A. If it had not been recorded, you would not know.
Q. Until that retrospective note was added by yourself and witnessed by Dr Nesbitt, do you accept that no doctor or nurse following, who hadn't been involved in the surgery, would have known how much fluid was received during the surgery?
A. Yes, I accept that.
Q. And in fact, if you made a mistake, you might even think that a litre of Hartmann's had been administered during that surgery if it wasn't for the retrospective note.
A. Yes, you could take that out of it. It was common to use one-litre bags at that time.
Q. What I'm saying is it could be interpreted, if you were a clinician coming later and hadn't been involved in the surgery, that actually a total fluid of 1 litre of Hartmann's had been received during the surgery.
A. Yes, you could take that from that.
Q. Is it possible that something like that could be significant if, say, you were trying to calculate fluids

later on -- perhaps post-operatively or the next day -- if you made a mistake such as that?
A. In terms of volume, possibly, but Hartmann's solution -- even if Raychel had received the entire litre, I don't think it would have resulted in any long-term harm.
Q. And why do you say that?
A. Because it is an isotonic, balanced solution.
Q. Isotonic as in it's of the same sodium concentration as blood typically; is that correct?
A. It's slightly higher sodium concentration, yes.
Q. Just out of interest, do you know offhand what sodium concentration it is?
A. I think it's 154 millimoles in it, from the top of my head.
Q. Is it possible that if a litre was administered that you might have a case of hypernatraemia in that case?
A. Very unlikely because of the other electrolytes in the solution.
Q. We were just talking about the retrospective note there in the centre of the anaesthetic record. Do you know when that retrospective note was added?
A. On the date, 13 June 2001 --
Q. Yes.
A. -- which is recorded there.
Q. Is there any significance to that date?

A. Um ... No, other than that was the date that Dr Nesbitt asked me to do it.
Q. Had you attended a critical incident meeting after Raychel's death?
A. No, I attended no meetings after Raychel's death.
MR REID: Mr Chairman, if I can refer just to page 026-011-012, please. If we can put alongside that, please, 026-011-015. The inquiry's been informed these are handwritten notes made by Dr Raymond Fulton and they come from Dr Fulton's file as has been provided to the inquiry. Are you aware of Dr Fulton?
A. I know him by name only.
Q. Dr Fulton has said in his statement to the PSNI that a critical incident meeting was convened on 12 June 2001 and that those people named on that left-hand side of the page was a list of those who attended that meeting.
A. I would have to say that's absolutely not true. I did not get invited to or attend any meeting following my involvement with Raychel.
Q. Okay.
THE CHAIRMAN: Let's bring up that statement because this is now the second witness who was supposed to have been at this meeting who's said that they have absolutely no recollection of being at that meeting. It is 095-011-049. Doctor, this is the third page of

Dr Fulton's statement, which was made on 14 March 2006. You'll see that he says in the second line:
"The critical incident inquiry started at 4 pm on Tuesday 12 June. The staff who attended were ..."
And he goes down through them, and you'll see that your name appears as does the name of Dr Gund.
A. I see that, but I repeat: I was not invited, not aware of, nor attended. That is absolutely not true.
MR REID: He references WRC54 and the handwritten note that I've just shown you is appended to his statement as WRC54. Then also if we turn over the page to 095-011-050, please, about seven lines down:
"I recall the following discussions and have brief summary notes written shortly after the meeting, WRC55."
And again, the note that's on the right-hand side of the screen, is part of that WRC55, which is appended to his statement. And during that -- sorry, if I can --
THE CHAIRMAN: Just follow the page down. If you go halfway down the page, you'll see reference to yourself, doctor.
A. I see that.
THE CHAIRMAN: You are reported to have said that Raychel had arrived in theatre with no intravenous infusion:
"Dr Jamison had set up an IV infusion of 1 litre of Hartmann's. Dr Gund confirmed that Hartmann's was set up in theatre and thought about 200 ml was infused.

Dr Gund remembered discarding the remaining fluid and left the prescription of further fluid to ward protocols."

Whatever that says about Dr Gund, do you believe that you said that you had set up the infusion of 1 litre of Hartmann's?

A. I believe he must be referring to the statement that I gave for the PSNI, in which I state that a litre of Hartmann's solution was run through and connected. I cannot recall whether it was myself or Dr Gund or one of the nursing staff that actually ran through the litre of Hartmann's and I cannot recall who connected it. And I have not stated that in my statement.

MR REID: Let's just take this back one bit. I'm wary of going into the governance area too much. Can I ask: when did you learn of Raychel's death?

A. I think that was a Thursday night, if I recall.

THE CHAIRMAN: Yes, she was brought in on a Thursday night. Deteriorated on Friday night, had her collapse on Saturday morning and was then transferred to the Royal later on Saturday in a hopeless state and then was pronounced dead on Sunday.

A. I learned of Raychel's condition on the Saturday when I attended work again.

MR REID: So that would have been Saturday, 9 June?

A. Yes.

Q. Were you contacted by anyone to ask you what had happened in regard to Raychel's case?

A. Between the Thursday and Saturday?

Q. After the Saturday, after you learned of her death.

A. No. Other than the formal statements, I was not asked or involved in any other process.

Q. If we bring up 026-011-013, please, this seems to be the handwritten note. Again, this is part of the brief summary notes which Dr Fulton says were written shortly after the meeting. On that right-hand side, it says:

"Dr Jamison, SHO anaesthetics, IV cannula in situ, no fluids on arrival in theatre, 300 millilitres Hartmann's in theatre."

Do you know where he might have got that from?

A. My coroner's a court statement and the PSNI statement. I was not at that meeting.

Q. So you think this comes after the statement that you gave in regard to what your involvement was in the case?

A. I don't know what date that was done on, but I was not at that meeting.

Q. Okay.

THE CHAIRMAN: Is there some reason why you're so certain and specific that you weren't at that meeting?

A. Because I would remember being at a meeting regarding

this case with all those people present. I would remember that.

THE CHAIRMAN: Thank you. Doctor, have you seen Dr Fulton's statement about this meeting --

A. No.

THE CHAIRMAN: -- before now?

MR REID: If I can return then to the anaesthetic record, 020-009-016. We have the retrospective note dated 13 June 2001. I asked you when it was added and it says the 13th. Do you know why Dr Nesbitt requested that note be added?

A. I'm assuming he requested it be added to clarify the issue that it says "Hartmann's, 1 litre", but she did not receive the entire litre. It was in an attempt to clarify the volume of fluid Raychel received intraoperatively.

Q. You're saying to stop people from looking at that and thinking 1 litre of Hartmann's was administered during the surgery?

A. Probably.

Q. Why did you make the note? Why was it you who made the note?

A. Because Dr Nesbitt asked me to.

Q. Dr Nesbitt comes to you and says, "Can you add this note to Raychel's notes?" Do you ask him why he wants that

added?

A. I cannot recall specifically asking him, other than assuming that it was to clarify the volume of fluid Raychel received in theatre.

Q. Why was it you doing this note instead of Dr Gund?

A. I can't answer that.

THE CHAIRMAN: Did you ask him?

A. No, I didn't ask him.

THE CHAIRMAN: Dr Gund would have been the obvious person to ask, wouldn't he?

A. Yes.

THE CHAIRMAN: You have explained how you came to make the note. In terms of the content of the note, how did you know to insert that 200 ml, that the patient only received 200 ml?

A. Because I saw Raychel after the procedure was finished when she was in the recovery area and the bag of Hartmann's was still attached at that time, and there was approximately 200 to 300 ml out of the bag of Hartmann's.

THE CHAIRMAN: Okay. Well, this goes to, on this point, whether it was 200 or 300 ml, and it says "200". You have just said there were approximately 200 or 300 ml out of the bag, so why does the note say "200"? It doesn't say "200 to 300"?

A. No. Well, I believed it to be 200 ml.
MR REID: Why were you checking or why do you know that there was 200 to 300 ml of fluid left in the Hartmann's bag at the end of surgery?
A. It was 200 to 300 ml taken out of the Hartmann's bag, not left in the bag.
Q. Apologies. I'll correct that. Why were you checking the bag at the end of surgery?
A. I wasn't particularly checking it; I just recall looking at it and noting that those were the markings on the side of it.
Q. Is it the case really you looked at the bag and thought it's about a quarter, a fifth, a third full, and that's what you remember?
A. Yes.
Q. You remember what kind of fraction was left in the bag?
A. What fraction was out of the bag. That would have been easier to estimate.
Q. Apologies. It's a mistake I keep making. Apologies for that.
THE CHAIRMAN: Is that just something that's just part of your job that you would happen to notice that rather than having any particular reason?
A. It would just be habit, yes, rather than a particular need to look at it that evening.

MR REID: Have you ever added a retrospective note to an anaesthetic record before?
A. No.
Q. Is this the only time you've ever added a retrospective note to an anaesthetic record?
A. Yes.
THE CHAIRMAN: Did you feel uneasy about being asked to do this?
A. No, I did not feel uneasy because it was in an attempt to clarify that it was not the entire litre.
MR REID: If I can just bring up reference 316-004g-009. This is that Junior Doctors' Handbook, which you said you weren't aware of earlier. What it says on the right-hand side in terms of case note recording was, the third line down from the top:
"Retrospective alterations to the notes should only be made in exceptional circumstances, and then must be signed and dated with the original entry legible, but scored out with a single line."
In your opinion, were these exceptional circumstances?
A. Exceptional circumstances in that -- with the result that Raychel died, yes.
Q. I've referred already --
THE CHAIRMAN: Just to be completely fair, doctor, it's

obvious to everybody reading that note that it is a retrospective note.
A. Yes.
THE CHAIRMAN: You've dated it, you've signed it.
A. Yes.
THE CHAIRMAN: And the sort of issue that I had to given an interim ruling on this morning about when an alteration or an addition was made to a note doesn't arise because you have dated it and signed it and it is absolutely clear to everyone that it was not made at any other time but the day you did make it.
A. Mm-hm.
THE CHAIRMAN: Thank you.
MR REID: You were asked by the Trust in the aftermath of Raychel's death to provide a statement; do you recall that?
A. For the PSNI, yes.
Q. Yes. It was requested by Therese Brown, who's the risk manager.
A. Yes.
Q. Do you remember providing your statement to her in the first place?
A. Prior to making that note?
Q. No. Maybe if I just bring it up. It's reference 316-038-002. This is dated 10 December from yourself in

Antrim Area Hospital:
"Dear Therese Brown. Please find enclosed statement as requested regarding my involvement in the management of Raychel Ferguson."
And your signature. Do you recall writing that letter?
A. Yes.
Q. As short as it is, you recall it. And if we turn over the page to page 3, please. This then is your original statement that you were sending to Therese Brown. Do you recall that original statement, do you remember that?
A. Yes.
Q. If we then bring up alongside that, please, 012-015-118. You were asked if you could amend that statement just to provide a bit more information, and if we can bring up the two alongside each other, so if we could also bring up 316-038-003. You send in the original, which is on the left-hand side, and then Ms Brown asks you to amend it to make reference to the post entry note and she sends you a letter to that effect on 25 January. You then sent her this amended statement on 3 February; do you recall that course of events?
A. Very vaguely.
Q. Well, we have the references for that. You then send

this amended statement on the right-hand side. Can I ask, the major difference between the two letters is the sentence at the end of the second paragraph on the right-hand side on the new statement in which you add the sentence:

"A litre of Hartmann's solution was run through and connected to her cannula prior to induction of anaesthetic [you add] of which Raychel received approximately 300 ml in total during the course of the anaesthetic."

Do you agree that that line has been added to the left-hand side?

A. Yes.

Q. Can I ask you: why did you not record that line in your initial letter, which is on the left-hand side?

A. I can't answer why I didn't put it in on the left-hand side.

Q. And you then add it into the new statements, and this one says "300 ml".

A. Yes, but I think that was many years after, and I did not have access to the actual notes, so I could not recall the precise volume, but I knew it was somewhere between 200 and 300 ml.

Q. Then when you came to the inquest -- if we can keep up 012-015-118, please, and bring up 012-034-164.

THE CHAIRMAN: Did you say it was many years later? Did you say:

"Yes, but I think that was many years after."

I thought the amendment was made in February 2002; is that not right?

MR REID: Yes, that's correct.

THE CHAIRMAN: So what you were doing, you'd been asked by Therese Brown to provide a statement, you had provided that statement apparently on 10 December. You were then asked to add to it and you added to it in February 2002, unless I've got the sequence wrong; is that the right sequence?

MR REID: That's the correct sequence, Mr Chairman.

THE CHAIRMAN: So it's not an amendment, doctor, that's made many years later; it's made two months later. It's different from the retrospective note. In the scale of things, I'm not sure that the amount of Hartmann's, whether it was 200 or 300 ml, makes a difference, but one of the concerns that the other families that the inquiry have had and also that the Ferguson family have had is about the sequence of statements and, for instance, your evidence earlier, just a few minutes ago, that you absolutely were not at the meeting that you were said to have been at is bound to cause some concern. I'm just wondering here why your retrospective

note refers to 200 ml and your amended or extended statement refers to 300. Can you help me with that or not?

A. Other than I did not have access to the notes at the time of amending the statement and could not recall whether it was 200 or 300 ml.

THE CHAIRMAN: Thank you.

MR REID: Just to complete the chronology of this, you then appear at the inquest into Raychel's death on 5 February 2003; isn't that right?

A. Yes.

Q. And at that then, is it correct that you correct the statement to change it to 200 ml again?

A. Yes, at that time I had access to Raychel's notes and I corrected it.

Q. If we can leave the area of intraoperative fluids and move on to the area of post-operative fluids.

In June 2001, what was your normal practice when it came to the post-operative fluids for a patient?

A. My normal practice would have been to prescribe post-operative fluids in the initial post-operative period and usually that would have been Hartmann's solution.

Q. So as far as you're concerned, which discipline had the responsibility for the prescription of fluids after

surgery, was it the surgeons, the anaesthetists or the paediatricians?

A. Often it's a combined responsibility. The initial post-operative period is usually taken on by the anaesthetist.

Q. Were there any protocols or guidelines or any advice that you were given regarding what policies were being used in terms of post-op management at the time?

A. No.

Q. You have said that the primary responsibility was with the anaesthetist and normally you would prescribe Hartmann's post-operatively. Where did you get that practice from?

A. Just throughout my experience, day-to-day working.

Q. So by June 2001 that was your normal custom and practice?

A. If a patient required post-operative fluids, yes.

Q. And was that, as far as you were aware, the general custom and practice of the other anaesthetists at Altnagelvin Area Hospital?

A. As far as I was aware, but some did prescribe, some did not. I couldn't comment on each individual's practice.

THE CHAIRMAN: This wasn't just your experience at Altnagelvin, it's your experience elsewhere?

A. Yes.

THE CHAIRMAN: Right. Thank you.
MR REID: And even though the responsibility seems to be, you say, with the anaesthetist, would it be on every occasion that you would write a formal prescription for the post-operative fluids?
A. It's usually subject to perform(?) prescription, but often on the post-operative section of the anaesthetic record rather than a specific fluid balance chart.
Q. So you're saying either you write a new prescription on the fluid balance chart or you write it up in the post-op section of the anaesthetic record?
A. Yes.
Q. Let me ask you this. The surgeons have given their evidence. Certainly Mr Makar and Mr Zawislak have already given their evidence orally and Mr Gilliland has given his evidence in his witness statement. They have said that in their experience, the responsibility for post-operative fluids lies with the anaesthetists and that responsibility is with them for a period of time and then it reverts back to the surgical team on the ward; would you agree with that?
A. Yes. As I said, the initial post-operative period is usually subject of the anaesthetist's responsibility.
THE CHAIRMAN: So in a situation like Raychel's, let's suppose she's back on the ward at about, say, 1 o'clock,

2 o'clock, whatever the precise timing is. The fluid that she's on, you would expect to be the post-operative fluid as prescribed by the anaesthetist and then, at some later point, maybe at the ward round in the morning or maybe before that, the surgical team takes over responsibility for the fluid, does it?
A. The prescription goes with the patient to the ward. If circumstances change on the ward or the patient's condition changes on the ward, it's usually the responsibility of the team looking after the patient to then look at the fluid balance and see does it need altered or changed. And that would be, in this case, the surgical team.
THE CHAIRMAN: Right.
A. If everything goes untoward [sic], then it would be the post-op fluid prescribed by the anaesthetist to run until it was reviewed.
THE CHAIRMAN: And that review, in the absence of any problem before then, you would expect at the ward round?
A. Yes, or unless the bag had run out prior to that.
THE CHAIRMAN: If the bag runs out prior to that, then the surgical team comes in at that point?
A. The surgical team or whoever is asked. Perhaps the nursing staff asked somebody to prescribe more fluids, be it the surgical team or whoever at that time.

MR REID: If I could bring up your witness statement, WS024/2, page 7, please. There you're asked:
"Before you commenced the surgery, did you have any understanding of who was going to be responsible for prescribing Raychel's post-operative fluids. If so, who did you understand would be responsible for prescribing Raychel's post-operative fluids?"
Your answer was:
"It was commonplace for fluids to be managed on the paediatric ward if it was a post-op child."
Can you explain what you mean by that statement?
A. Usually, the anaesthetist would prescribe fluids for the post-operative period, which in usual practice would be Hartmann's solution. It had been my experience in Altnagelvin at that time that even if the anaesthetist prescribed Hartmann's solution on the post-op part of the chart, it was commonly subject to a default re-prescription of No. 18 at that time.
Q. And can you explain what you mean by "it was subject to a default re-prescription"?
A. Well, often when a patient went back to the ward the fluids were -- the post-op Hartmann's was changed to No. 18 and No. 18 was used commonly on that ward at that time.
Q. Who was it changed by?

A. I can't comment on who it was changed by. In my experience, it had been changed by both paediatric team and surgical team.
Q. Let me ask you this. Did you ever personally have your own experience where you prescribed post-op fluids and then discovered later that the patient hadn't received the Hartmann's that you had intended, but had received Solution No. 18?
A. Yes.
Q. And in those circumstances, what did you do?
A. At that point in time it did not raise great concern with me because No. 18 was a common solution used on that paediatric ward and in many paediatric wards at that time and paediatric wards are experienced with managing fluids in children.
THE CHAIRMAN: I suppose the other point is that, at that point, you're no longer responsible, are you?
A. No. If it's re-prescribed or changed, that's not my responsibility; it's the responsibility of whoever takes over that.
THE CHAIRMAN: Because you have seen the child through theatre, back on to the ward and after that, if another doctor has a different view or a different approach, that's for them --
A. Yes.

THE CHAIRMAN: -- unless you have any reason to believe that that approach is unsafe --
A. Yes.
THE CHAIRMAN: -- in which case you would intervene.
A. Yes.
MR REID: What awareness did you have of the post-operative fluid regime in Raychel's case whenever you were there in the recovery room?
A. To be absolutely honest, I did not look at the post-operative prescription for her fluid because I had no reason to believe that it needed me to look at it.
Q. Who was present there in the recovery room at the time of recovery?
A. Well, I can't actually recall, but I'm assuming that there was a theatre nurse there. Dr Gund, I'm assuming.
Q. Do you have recollection of Nurse McGrath, the theatre nurse, being there?
A. That might be who was there. I can't recall her name, the nurse who was there.
Q. Can you recall any discussions that you had with Dr Gund or theatre nurse McGrath or anybody else in the recovery room about the post-operative fluid?
A. I do not recall any specific discussion regarding Raychel's post-operative fluid. There may have been a general discussion around the fact that it had been my

experience that prescriptions often got changed when the child returned to the paediatric ward.
Q. So you might have been aware that a prescription for Hartmann's was being changed to Solution No. 18 in the recovery room following Raychel's surgery?
A. No, that would not have happened in the recovery room.
Q. At what point would that happen?
A. If the post-op fluid prescription was altered, it was usually at ward level.
Q. Dr Gund has given evidence and he says that his intention was to prescribe Hartmann's solution as the post-operative fluid; are you aware of that?
A. I am aware of it now.
Q. But were you aware of it at the time?
A. No.
Q. You wouldn't have been surprised that he was intending to use Hartmann's --
A. No, that would be entirely normal practice.
Q. He says that he was told by you to cross the prescription off because fluid management on the paediatric ward was managed by ward doctors.
A. I'm aware of Dr Gund's statements, but I do not recall ever looking at his post-operative prescription or asking him to strike it off.
Q. Would you perhaps have told him at some point that,

given your previous answer, that fluid management on the paediatric ward was often managed by ward doctors? Is that part possible?
A. It is possible that I said that it was managed by ward doctors.
Q. Is it also possible that you might have had the discussion with Dr Gund about the fact that Hartmann's was regularly cancelled in favour of Solution No. 18 once the patient reached the ward?
A. Yes, that might have been my discussion.
Q. Is it possible that Dr Gund might be saying there that he's taken those elements on of what you have said and is therefore prescribing Solution No. 18 instead of Hartmann's?
A. I cannot comment on how Dr Gund would have interpreted any discussion.
THE CHAIRMAN: But if it was happening at the recovery room stage, that would be an unusual feature in Raychel's case, wouldn't it? Because if there's any change in prescription, it normally comes at a later point when she's on the ward.
A. Yes.
MR REID: Nurse McGrath says in her first witness statement at 050/1, page 3:
"Dr Jamison was present in theatre while Raychel was

being recovered. When she woke, Raychel was not in any pain and did not feel sick and therefore she did not require any drugs in recovery. At 1.30 am, Raychel was ready to go back to the ward, so I rang for the nurse to take her back. At this stage, the infusion of Hartmann's solution was discontinued with fluids to be recommenced on the ward."
Later on:
"Finally, I checked the fluid balance chart and anaesthetist's verbal instructions, which stated that No. 18 solution, which was in progress pre-op should be recommenced on return to the ward."
Do you have any knowledge of any verbal instructions that were given to the nurses as regards the post-operative fluids in Raychel's case?
A. No, I have no knowledge.
Q. In her final four lines, theatre nurse McGrath says:
"In my experience, children were given Solution No. 18 in ward prior to surgery. In surgery and recovery, they were given Hartmann's solution. This was discontinued when they left recovery and Solution No. 18 was recommenced on ward, which, in my experience, was in accordance with normal practice."
Do those four lines sound familiar to you, doctor?
A. Well, that would be similar to what I've just said.

Q. But it wasn't you who gave, as far as you are concerned, the verbal instruction to Nurse McGrath?
A. No.
THE CHAIRMAN: On one interpretation, this is where things begin to go wrong because Raychel goes on to Solution No. 18 and there are endless opportunities to review that and correct it as Friday goes on in the hospital, which weren't taken. If we take this as a potential starting point for things going wrong, do I understand your evidence that while it regularly happened that the anaesthetist's prescription of Hartmann's post-operatively was changed by the surgical team or by somebody on the ward, you do not accept that you would have gone so far after Raychel's operation to make that change or direct that change be made yourself?
A. No, I have no experience in No. 18 and have never prescribed it, so I would not have given that. I would not have said that to the nurse.
THE CHAIRMAN: Thank you.
MR REID: The rate of fluids post-operatively was 80 ml per hour. Were you aware of the post-operative rate?
A. No. As I said, I was not aware of the post-operative prescription.
Q. If you had been aware that the rate was 80 ml per hour for a child such as Raychel, would you have any comment

to make?
A. 80 ml seems a slight overestimate for her body weight.
Q. If you'd been aware of that at the time, would you have said something?
A. Yes.
Q. Would you have said it to Dr Gund, for example?
A. Yes.
Q. Is it the case that the surgeons -- are you aware that the surgeons seemed to be relying on the anaesthetists for the post-operative fluid regime?
A. In the initial post-operative period, yes.
Q. But them taking it on at a later stage? And you are saying then that the anaesthetists go to prescribe the fluid, but that sometimes that's cancelled when it reaches the ward; is that your evidence?
A. Yes.
Q. Would it be usual to get, post-surgery, a fresh blood workup or electrolyte test in June 2001?
A. It really depends on the circumstances.
Q. Say after Raychel's surgery, for example, would it have been usual in those circumstances?
A. In June 2001, for somebody like Raychel who had had her appendix out, it would not have been normal practice to take a blood sample, no. Unless there was reason to do so.

Q. Would it have been usual practice even maybe to check bloods using a blood gas machine, which might be available in the theatre unit?
A. Prior to her leaving recovery?
Q. Yes.
A. No, that would not be usual. Unless you had reason or a potentially critically-ill patient who is going to intensive care, that would not have been usual practice.
MR REID: Mr Chairman, I have reached the end of my questioning at present, but perhaps if you would rise for five minutes, I'll be able to take some questions.
THE CHAIRMAN: Okay. Doctor, what happens at this stage is inquiry counsel has finished asking you questions, but he gathers questions in case anybody else wants to ask you some more. If you could be patient enough to wait for a few minutes and we'll come back to you. It will only be a few minutes. We'll see if there are any more questions, but you'll soon be gone.
(3.16 pm)
(A short break)
(3.35 pm)
THE CHAIRMAN: Mr Reid, are there are some more points?
MR REID: Yes, Mr Chairman, there are a number of points.
Dr Jamison, you've been quite clear in your evidence that you believe that you were there at the induction of

anaesthesia and that you were not there whenever the first incision was made; isn't that correct?
A. That is correct.
Q. And you weren't there at any other point during the actual surgery until certainly after wound closure and you were in the recovery room; isn't that right?
A. That's correct. Raychel was back in her ward bed when I saw her next.
Q. Can I ask you, if we refer to your deposition at 012-034-164, the deposition to the coroner. The next page as well, please. The statement right at the top of page 165 there:
"I remained in theatre until the procedure had commenced and was continuing uneventfully when I was called away and had to leave theatre to attend to my other responsibilities in intensive care."
How does that square, doctor, with the evidence that you have given today that you weren't there once the procedure was underway?
A. After induction of anaesthetic and intubation of Raychel, there is a period of time where there are positioning of patient, washing of patient, draping of patient, prior to the initial incision being performed. I was there during that part and then left prior to the initial surgical procedure starting.

Q. So you're saying when it was "continuing uneventfully" that it was continuing despite the fact that knife-to-skin still hadn't occurred?
A. Yes.
Q. Because some might say that it almost hadn't started then at that point.
A. Yes, that's probably an error on my part, in my English within that statement.
Q. And that statement is also present in the statement you send to the Trust and the amended statement you send to the Trust as well, isn't that right, since the basis of your deposition is those statements?
A. Yes.
THE CHAIRMAN: Doctor, after the anaesthetic is given in an operation such as this on Raychel, how long would it be before or might it be before the incision is made in terms of minutes? Are we talking about five minutes, 15?
A. It could be anywhere from 5 to 15 minutes depending upon how much positioning the patient requires.
THE CHAIRMAN: Thank you. Do you recall: had it been your intention to stay?
A. It had been, but I believe my bleep went off and that called me away.
THE CHAIRMAN: Thank you.

MR REID: If I can bring up the anaesthetic record again, please, 020-009-016. We were discussing about the "Hartmann's, 1 litre" and you said that even if 1 litre of Hartmann's had been administered, there wouldn't be any long-term effects from that; is that right?
A. I believe so.
Q. And is that a clinical point that you as a consultant anaesthetist wish to make, that you believe that 1 litre of Hartmann's administered in this situation, if it did happen, wouldn't have made any difference?
A. If 1-litre of Hartmann's had been administered to a 9-year-old girl, it would have been outside normal practice for volume, but I do not believe it would have been detrimental to her biochemistry.
THE CHAIRMAN: What would have happened to her?
A. She may have become a little bit --
THE CHAIRMAN: Obviously she wouldn't have got hyponatraemia from that.
A. No, I think she may have got a little bit swollen and oedematous because of the extra fluid in her body, but it would not have caused any major biochemical shifts.
MR REID: Would it have been noticeable? Would it have been noteworthy?
A. Well, yes, you would have made a note if it had happened by accident, yes. But at the same time, she may have

become oedematous, she may not.
Q. Is it something that if it happened, it would be so obvious to those who would see it afterwards that they would make a note about it?
A. I can't comment. If it happened when I was there, yes, I would make a note about it.
THE CHAIRMAN: But would it not have needed the rate at which she receiving the fluid to be about four times greater --
A. Yes.
THE CHAIRMAN: -- than the rate at which it was given? And that would be noticed, wouldn't it?
A. That would be noticed, yes.
THE CHAIRMAN: You were saying, from your experience, the frequency of the drip gives you an idea at what rate the fluid is being administered at and, for Raychel to have received 1 litre of Hartmann's, that would have meant whatever the drip actually was would have been multiplied by about four or maybe five.
A. Yes, you would have noticed that it was running in a lot faster than normal.
MR REID: If the administration of 1 litre of Hartmann's hypothetically wouldn't have any long-term effect, why would this be a point that you and Dr Nesbitt would be so careful to want to change through this retrospective

note?
A. I can't comment on that, other than I thought I was helping by clarifying as she hadn't received the entire litre.
Q. Can you recall how Dr Nesbitt first approached you in regard to this note?
A. He approached me and said, "Do you recall how much fluid Raychel got in theatre?", my recollection of that.
Q. So he comes to you, do you know where that was?
A. It was most likely in the theatre environment.
Q. And do you know when that was?
A. It was just before we made the note, on the 13th.
Q. So it was in the days after you'd found out about Raychel's deterioration and death and before you made the note? It happened during that period, between you finding out about her death and deterioration and --
A. He did not ask me prior to that.
Q. So he comes to you and he asks you how much fluid was administered during theatre and you say to him --
A. Approximately 200 to 300 ml.
Q. And can you recall what his response was to that?
A. No.
Q. Can you recall what he asked you to do after that?
A. Well, he asked me would I be able to write that down on the note to help clarify the volume she had received

intraoperatively.
Q. And how quickly did you act upon that?
A. I think when he asked me, we did it there and then.
Q. Did he bring the notes along with him?
A. I can't recall whether he had all the notes or just the anaesthetic chart. I can't recall.
Q. He would have had the anaesthetic record with him; you wouldn't have necessarily had with it you?
A. No, I wouldn't have had it at all.
Q. So you think he brought the note along, asked you how much had been administered, you said 200 to 300 ml, he asked you to make the note and you made that note there and then at the time of the conversation?
A. Yes.
MR QUINN: Mr Chairman, can I ask just one point so we don't have to go back? Can the witness be asked why she didn't enter 200 to 300 instead of 200?
MR STITT: Mr Chairman, I'm getting a deja vu about this. I have not intervened. I appreciate these questions are being asked at the request of another party, but for that party then to go and have them further asked, in my submission, is unreasonable. If it's being suggested --
THE CHAIRMAN: Sorry, I think that point was covered. I queried it earlier this afternoon when Dr Jamison was giving her evidence, Mr Quinn. However satisfactory you

regard the answer, we do have the answer.
MR QUINN: I thought the query was in relation to why she changed the note in the coroner's file. That was my recollection, but I might be wrong.
THE CHAIRMAN: I think I'm right to say I was asking her if it was -- how she came to write 200 rather than 300, and then subsequently --
MR QUINN: That's why my point is subtly different, sir. Because my point is she changes, in handwriting, from 300 to 200, so she changes for some reason and I am not clear of that.
THE CHAIRMAN: There's a query about the 300 note because we had understood that that was a note which was somehow made at a meeting which she says she wasn't at.
MR QUINN: Exactly. That's why I want to ask now why she didn't put down what her correct recollection was, 200 to 300.
MR REID: Maybe I can go through just quickly --
A. Mr Chairman, can I say something?
THE CHAIRMAN: Of course. You're the one we want to hear from most, doctor!
A. It's impossible to be entirely accurate about the volume of fluid that went in unless it is run through a pump or a drip counter, which are the same piece of equipment. The markings on the side are at 100 ml segregations and

somewhere between 200 and 300 ml went in. My initial recollection was that it was closer to 200. Unfortunately, in my following statement from December 2001 to February 2003 for the coroner when I did not have access to those notes, I could not recall the volume I had written down, and that is why it has been changed at that time back to the 200 ml, to be the same as the retrospective note on the anaesthetic chart.
THE CHAIRMAN: But your best estimate is that it was somewhere between 200 and 300, but you can't say where in that range it was?
A. No, you can't say with 100 per cent accuracy unless it had gone through a drip counter, which it did not.
THE CHAIRMAN: Okay.
MR QUINN: The point here, Mr Chairman, is why on earth was it altered in the first place? If the evidence is a litre of Hartmann's solution isn't going to do any harm to the child, why was it revisited? I want to know why Geoff Nesbitt revisited this and got this doctor to amend her note.
THE CHAIRMAN: We'll certainly be asking Dr Nesbitt that. This witness has said that she was asked by Mr Nesbitt about it, she thought it would be helpful to clarify that the total given was not 1 litre. When Dr Nesbitt comes to give evidence, presumably in the governance

section, we'll be asking him of all the issues to clarify about what happened to Raychel, why the amount of Hartmann's given to her in a short operation was the one which led him to ask for the note to be changed retrospectively.
MR QUINN: That's the point I'm getting at. You've got it in a nutshell.
MR STITT: My second point, Mr Chairman, is this, and it's to do with this prolonged line of questioning. If there's some allegation that this witness was party to some form of cover-up, perhaps that could be clearly put to the witness so that she has an opportunity to deal with such a claim, if it is being made. It doesn't appear to be made by the opening because at paragraph 1 --
THE CHAIRMAN: It's not and I don't think we're anywhere near making that allegation. I presume you're alerted to this by the ruling that I gave earlier today in Claire's case about --
MR STITT: One is a little sensitive perhaps.
THE CHAIRMAN: -- how the ground changed. I can assure you, Mr Stitt, at least, and that's as far as I can say, there's no allegation of any dishonest behaviour on the part of Dr Jamison.
MR STITT: It's helpful that that is clarified because

I wasn't sure where the questioning is going.

Just to finish the point, in the opening section, which ends at paragraph 142, this is dealt with at 200 to 300, and the height of the question which was raised is, having gone through the various notes and how they alter between 200 and 300 and how there's a retrospective note, and then, at 142:

"The question of precisely how much intravenous fluid was received intraoperatively will be considered further at the oral hearings."

I thought that was the issue that was before the ... If that's the case, then with great respect, I think it has been fully answered.

THE CHAIRMAN: I should say that that is an issue that's being explored. I think I should also say to you, Mr Stitt, that one of the recurring major concerns for the families and for me -- and indeed, to be fair, for many of the doctors and nurses -- is how questionable some of the record keeping has been in virtually every record we've looked at in the inquiry. The effect of that is that where children have died -- and particularly in Adam and Claire's cases, where important issues may not have been faced up to by those involved at the time -- the lack of record keeping potentially becomes an aggravating factor that not only have they

lost their child, but there has been some -- I will try to put it neutrally -- failure of those who should have responded by learning lessons to learn their lessons.

There are some differences in Raychel's case. Obviously, Raychel has died, which is why we are here, and there are some differences in what happened in Altnagelvin afterwards. It may still be imperfect, it looks as if already two witnesses are raising a major issue about the critical incident review. I think we can anticipate that however imperfect it was, it was less imperfect than what happened in the Royal in Adam and Claire's cases, but that's an issue we're looking at.

MR STITT: Very briefly, for the record, I am not challenging the inquiry going into record keeping. Obviously, it's central and important. What I am saying is that to the conduct of this questioning, which started off as a reasonable line of enquiry, I'm respectfully submitting the answers to that record keeping point have been made by the witness.

THE CHAIRMAN: Thank you. Mr Reid?

MR REID: If I can move on to some points that have arisen regarding the post-operative fluids.

Is it your evidence, Dr Jamison, that your general approach, post-operatively, was to prescribe and

administer Hartmann's solution?

A. Yes.

Q. And would you agree that that seemed to be the regular or the common approach of the anaesthetists at Altnagelvin Area Hospital to prescribe Hartmann's solution post-operatively?

A. Yes.

Q. And whenever that's done, is it the case that the bag that's being used during surgery is then -- the part-used bag is then taken on to the ward with the patient? How does that practically happen?

A. Sometimes it goes with the patient, sometimes it doesn't. If the patient's going to a paediatric ward and the post-operative fluids are being run through a drip counter/pump, they require a giving set, which is compatible with that machinery, and that's not often available in theatres. So in those instances they may go with no fluids running.

Q. Is it correct to say that different IV lines are connected to the patient depending on whether they're on the ward or they're in surgery, is that right, or is it the same sort of cannula that's used?

A. Usually, you would use the same IV access point or cannula, but often the giving set is different.

Q. So sometimes the bag will be used if the same sort of

equipment was being used and if different equipment was being used, a new bag would be used?

A. Yes.

Q. You have said that your common approach was to prescribe Hartmann's post-operatively. In that particular evening, in the early hours of 8 June, you were called, there may have been a discussion in the recovery room about what happened with fluids whenever they got to the ward; is that your evidence?

A. Yes.

Q. Can I ask you: why did that discussion take place?

A. It took place because we were taking the fluids down for Raychel to go to the ward.

Q. Can you give the inquiry any reason why you would be discussing that with Dr Gund or with theatre nurse McGrath?

A. I can give no reason other than we commonly talked about IV fluids, we commonly talked about anaesthetic issues when we were in theatre. No particular reason.

Q. Dr Gund had been in Altnagelvin for just over a month by that stage; is that right?

A. I believe so.

THE CHAIRMAN: Yes, it is right.

MR REID: And is it at all possible you were discussing what happened when fluids went down to the ward because

Dr Gund wasn't familiar with what happened to fluids when you send the post-operative patient back to the ward?
A. It's possible, but again I don't recall a specific reason that we had the discussion.
Q. You've said that sometimes you prescribe the Hartmann's and you would find that when the patient got to the ward that Solution No. 18 had been prescribed instead.
A. Yes.
Q. Would that happen more often than not or was that a less regular occurrence?
A. It would have been a more-often-than-not occurrence, but as I've previously said, it did not concern me because No. 18 was commonly used at that time in that ward, which was a paediatric ward with experience in giving fluids to children.
THE CHAIRMAN: Can I ask you, doctor, how would you know how often it was happening? Because when a child has been through theatre and has returned to the ward, in essence, and all seems to be well, in essence that's the end of your role, is it not?
A. Any case that I would have been involved with -- as the primary anaesthetist involved with, I would have followed up.
THE CHAIRMAN: Right. So you might go down to the ward the

next day?
A. It wouldn't have been every child that had gone through Altnagelvin theatres because I wouldn't have been involved with every child, but the ones that I had been involved with, that had been my experience.
THE CHAIRMAN: So on a typical day, if you had been the lead anaesthetist in Raychel's care, your normal course would have been to visit her on the ward in the morning, would it?
A. Yes.
THE CHAIRMAN: And it's from a visit like that that you know that the fluid which you have prescribed has been changed?
A. Yes.
THE CHAIRMAN: Right.
MR REID: That was your regular practice. Would that have been the regular practice of most of the anaesthetists at Altnagelvin?
A. To visit the patient the following morning?
Q. Yes.
A. I believe it would have been the practice of the majority of them. It's good practice to visit your patient the following day.
Q. Would you consider that good practice as in proper practice?

A. I personally would consider that good practice, yes.
Q. Would you consider if that wasn't done, if that follow-up wasn't done, that that would constitute unsatisfactory practice?
A. No, it's not a requirement that you do it, but it is good practice to go and visit the patient.
Q. And if you had gone --
THE CHAIRMAN: It also must depend on what the anaesthetist is doing the next day?
A. Yes, maybe they're involved in other things.
MR REID: If you'd gone the next day and found that a patient such as Raychel, a 9 year-old, was on 80 ml per hour of Solution No. 18, would you have said anything to the surgeons or the nurses or the paediatricians who were looking after her?
A. It's hard to say what I'd have done at the time, but if anything I would have drawn attention to the fact that maybe 80 ml an hour was too much.
THE CHAIRMAN: If I understand your evidence correctly, your concern wouldn't have been that the Hartmann's had been changed to Solution No. 18 --
A. No.
THE CHAIRMAN: -- because you didn't understand Solution 18 to carry a risk at that time.
A. No.

THE CHAIRMAN: But your concern would have been that if you thought 80 ml an hour was slightly high in surgery, then as the following day goes on, it's certainly too high.
A. The maintenance fluid for a 25-kilo child is around about 65 ml an hour.
THE CHAIRMAN: But it should also be diminishing, shouldn't it, because she should be coming off the fluid and taking oral intake?
A. Yes.
THE CHAIRMAN: So by later that day, at some point on the Friday, she should not have been on intravenous fluids at all.
A. I believe so.
MR REID: Would you also agree with Mr Foster's, the inquiry's expert on surgery, contention that because of the risk of post-operative SIADH that, in fact, the rate should be lower than the 65 ml recommended by the Holliday-Segar formula?
A. I don't think you can start predicting which patient will have a response, an SIADH response, more so than another patient. Therefore, the usual teaching would be to give the calculated maintenance.
Q. Which 80 exceeds?
A. Yes.
Q. The final point. You have said that more often than not

your prescription of Hartmann's might be changed to Solution No. 18 when the patient reached the ward; is that correct?
A. Yes.
Q. In those circumstances, what is the point in you, as an anaesthetist, prescribing Hartmann's if, more often than not, they're going to change it anyway?
A. Well, often our prescriptions are subject to change, given the surgical team or medical team who's looking after the patient's experiences, preferences, witnessing the day-to-day change in the patient's condition. We prescribe initially given what we are presented with and I cannot comment on why people change it. It's their practice and their prerogative within their professional realm to do that.
THE CHAIRMAN: I think the question was slightly different. I think what this question is getting at this is: if you think on the ward it's going to be changed from Hartmann's to Solution No. 18, would that not incline you to prescribe Solution No. 18 coming out of anaesthesia?
A. No, because Hartmann's would be the solution that would be more commonly used within anaesthetics.
THE CHAIRMAN: Thank you.
MR REID: The fact that that happened, was that ever

discussed among the anaesthetists in Altnagelvin or any other hospital about the fact that those solutions were being commonly changed once they reached the ward?
A. No, because it is not uncommon for prescriptions to be changed from post-op anaesthetic prescriptions when the patient gets to the ward, depending on whatever that patient required.
Q. Is it correct that Hartmann's wasn't routinely available on Ward 6, for example?
A. I can't comment on whether it was routinely available or not.
Q. Would it surprise you if Hartmann's wasn't available on Ward 6 as a regularly available fluid?
A. It would surprise me, yes.
Q. In Raychel's case, her pre-operative rate was 80 ml per hour. If you had known about that at the time, would it have surprised you that they recommenced the post-operative rate at exactly the same as the preoperative rate; would that have surprised you?
A. No.
Q. Why is that?
A. Because that was what they did at that time.
Q. They commonly continued the pre-op fluids at the same rate as post-op?
A. Yes.

Q. Is it a common occurrence that pre-op fluids sometimes take into account a fluid deficit for periods of fasting and so on?
A. Yes, that would be common.
Q. In those circumstances, if the pre-op rate is recommenced as the post-op rate, does that not therefore mean that the post-op rate is higher than it should be because it's taking into account a fluid deficit that may no longer be there?
A. It really depends what way you have calculated it and what way you plan to add your deficit and you would need to take into account your intraoperative fluid as well.
Q. Are you saying that you might recommence the rate, the pre-op rate post-op, but that you need to review it after the surgery in order to ensure that it's still a satisfactory rate?
A. Yes, you constantly need to review your IV fluids.
Q. And if the pre-op rate was recommenced without further review, would that be satisfactory?
A. I don't believe it would happen because somebody has to put the fluids up post-operatively and that would be prescribed and whoever prescribed it would commonly review the rate at which that would be.
Q. Because if we look at theatre nurse McGrath's evidence at WS050/2, page 6, she is asked:

"In the absence of a verbal or written instruction in relation to the rate, how did the nursing staff know what rate to infuse the fluid at?"
She says:
"As I recall, it was normal practice to recommence IV fluids at the same rate has had been used before surgery."
Do you have any comment to make about what theatre nurse McGrath is saying there?
A. I cannot comment on what her beliefs were or her understanding of the practice.
THE CHAIRMAN: If that was the practice, do you agree that it's highly questionable to start to have as your starting point that the post-op fluids are the pre-op fluids?
A. Yes, I believe they need to be reviewed post-operatively.
THE CHAIRMAN: Thank you.
MR REID: Who should they be reviewed by post-operatively?
THE CHAIRMAN: Whoever's prescribing them.
A. Yes.
MR REID: In most cases, is that the anaesthetist?
A. In the initial period, yes.
MR REID: Nothing further, Mr Chairman.
THE CHAIRMAN: Okay. Mr Quinn? Mr Stitt, anything?

MR STITT: Nothing arising.
THE CHAIRMAN: Doctor, thank you for your time. Unless you have anything you want to add, you're free to leave.
A. Thank you.
(The witness withdrew)
Discussion
THE CHAIRMAN: Mr Stitt, before lunch you had two points that you wanted to raise. The first was about letters alerting witnesses to potential criticism.
MR STITT: Yes.
THE CHAIRMAN: So if we do that without names, if we can.
MR STITT: I'm alive to the point and thank you for reminding me. I have essentially three documents, the only one which I think, sir, you would need to see would be the letter in question. I hand the letter in. (Handed).
THE CHAIRMAN: Right, yes. (Handed).
Just give me one second, Mr Stitt. (Pause).
Sorry, Mr Stitt, I had them and I have just mislaid them with other documents. (Pause).
MR STITT: As I understand it, under the hearing procedures protocol, as it were, under the heading "Oral evidence", at paragraph 6, there are two types of notification within that main paragraph, sub-paragraph 1:
"The first notification will come from the

tribunal."
And halfway down:
"In the event that proposed criticism comes from another person or party, then there is a procedure for that."
THE CHAIRMAN: Yes.
MR STITT: The first of those is what one might term a Salmon letter. It's accompanied by the usual pro forma letter signed by yourself, with a number of bullet points.
THE CHAIRMAN: Yes.
MR STITT: And I would make the observation at the outset that it seems an entirely appropriate way to draw a witness's attention to areas of potential criticism.
THE CHAIRMAN: Yes.
MR STITT: What I wish to do, however, is to compare and contrast that type of letter with the letter to which I'm referring, which is dated 6 February 2013. This, as I understand it, is a type of letter from an interested party, another party, and it's, in principle, a number of areas of likely criticism of a witness.
First of all, I make the point about timing, and I make it in relation to this letter, but in relation to any future letters which are proposed to be sent. I have another one, which has not yet been opened, dated

today, for another witness, which has come through the inquiry office and has been passed on apparently unopened.
It's clear from sub-paragraph 3 of paragraph 6 that:
"If anyone wishes to bring up a topic, they will do so in writing through counsel to the inquiry."
I appreciate this is a topic, it's not the same as a letter.
THE CHAIRMAN: No.
MR STITT: Nonetheless it says:
"Inquiry counsel will need a minimum of 72 hours' notice."
And it goes on, for obvious reasons.
The letter in question, that is the 6 February, was handed to a member of the Altnagelvin administrative team last night at the close of business here and was handed to the recipient, whose name appears at the top of the letter this morning.
Without getting into any detail as to when that recipient was going to give evidence, I'm making the point that it's clearly unsatisfactory.
THE CHAIRMAN: Your point is that that notice is too short for the witness to be alerted to those --
MR STITT: First of all, it's too short. And if there are any other letters to be given in the same vein, we would

ask for the same minimum of 72 hours, though I appreciate that doesn't refer to a Salmon letter, but it seems like a sensible guideline.
THE CHAIRMAN: I don't think that's objectionable.
Mr Quinn?
MR QUINN: I have no objection to that.
MR STITT: Perhaps, sir, the greater problem is the effect of this letter in its current form. Even if it's received 72 hours in advance -- I'm not going to open any of the phraseology, but I'd invite you to look at five particular paragraphs. Paragraph 1, and its first word. That is pejorative. That's not the issue. That is, if I may say so, an oppressive and even, indeed, a threatening tone of a letter, a letter which purports to put a witness on notice of certain issues. In my respectful submission, it's unfair for a person who's about to give evidence, even within 72 hours, to receive paragraphs beginning with, as one can see in paragraph 1, paragraph 3 -- that is the sort of thing one would expect to see in a fairly amateurly drafted statement of claim. It doesn't help in any shape or form, apart from filling in space.
THE CHAIRMAN: Your point is it's too vague.
MR STITT: Too vague and just adds to the general volume of the letter without helping the recipient in any way.

Paragraph 6, with respect, if one is going to make very direct -- and there's no reason why there can't be a direct reference, but it's a question of phraseology. And in my respectful submission, that sort of phraseology in paragraph 6 is inappropriate, given the nature of the recipient, the fact that the recipient is presumably not looking forward -- no one's looking forward to giving evidence in this case, but I'm acting on behalf of this particular recipient at the moment, and that's the point I make.

Number 9 is vague, doesn't help. We can probably guess what the subject is, but nonetheless it doesn't really help. And 12, again there is a point there, I can see there's a point there, but the way it's phrased and the demeanour, the tenor of the question is, in my respectful submission, inappropriate. What I'm saying is that a witness should be treated with some degree of respect. The letter is supposed to be there not to threaten them, but to give them some knowledge, advance knowledge of the issues and timing in this case.

But, in my submission, the contents of the letter are, as I say, inappropriate, and I would ask that some consideration be given that if one is going to provide such a letter under paragraph 6, sub-paragraph 1, that there be a certain -- it should resemble much more

closely the standard Salmon letter.

THE CHAIRMAN: Let me make a number of points.

First of all, I think we will have to probably review the protocol because I'm not sure that even 72 hours is sufficient, for instance, if a family wants to raise an issue which the inquiry hasn't, if I write a Salmon letter a week or so in advance and it covers points 1 to 5 and the family write an equivalent letter of criticism, which covers points, say, 3 to 7, there's an overlap, but there might be two new points entirely, and I think we can improve on that. We haven't been specific about this before, but it might be appropriate to require the same timescale for both.

Secondly, insofar as the tenor is concerned, I suspect that the tenor of this letter is affected by what happened in Claire's case when a concern hardened, as weeks of evidence went on, into a belief on the part of Mr and Mrs Roberts. And then there was some issue about why is this allegation being made so late in this way. And it may be that the formulation of this possible criticism is framed so as to avoid any suggestion that the criticisms are coming too late and not clearly enough.

I think the third point I should make to you is that the drafters of this letter that you're concerned about

will never have seen a Salmon letter which I've written.

MR STITT: No, I appreciate that.

THE CHAIRMAN: It's not helpful if they pull their punches when setting out possible criticisms. But it might be that if they knew the format or style which the inquiry adopted, they might regard that as an acceptable style with which to present their letters of criticism. So if I raise that and you can -- I'm not the only drafter in the world, you can present them in whatever way you want, Mr Quinn.

If I show you, Mr Coyle, the way in which I've -- if I draw up a sort of hypothetical one almost and show you the sort of style that we followed, then you might think it might be helpful, to do the two things which these letters are supposed to do, which is to alert a witness to potential criticisms without unduly or unnecessarily causing alarm or apprehension on the part of the witness.

MR COYLE: Yes.

THE CHAIRMAN: It's difficult. It's not a necessarily easy balance to strike.

MR COYLE: We wanted to avoid the charge of not being clear or lacking specificity. My learned friend makes remarks about tone. Certainly we didn't go and we don't intend to go out of our way to purposefully upset someone. It

would be more upsetting for them to arrive to give evidence to you, sir, and answer your counsel's questions if they didn't have the specific allegations formulated so that they can both consult documents and reflect. That was the mischief we were seeking to avoid in light of the history that you have had in terms of criticism of being opaque and then persons or witnesses saying they're surprised. We would find it very helpful if you would assist us, sir. As you say, sir, we don't -- and if this is compendious --

THE CHAIRMAN: What I might do is take a few -- because I don't think this will be objectionable -- extracts from Salmon letters which we have sent, so that you can see the style, but you won't be able to identify from them who they went to; okay?

MR STITT: No objection.

THE CHAIRMAN: If that takes care -- okay?

Mr Stitt, your second issue was whether I had changed my mind from what I said yesterday afternoon when I was -- I think you'll have seen from the transcript that if I had known you were leaving before the evidence finished yesterday, I would have raised this before you have left.

MR STITT: I'm sorry, sir, I would have re-arranged things if I had known you were going to.

THE CHAIRMAN: Okay. It's unfortunate the way it turned out. What I had said yesterday in my exchanges late yesterday afternoon with Mr Lavery was I had gone back to the concerns which we had discussed previously. What I was discussing with him yesterday was what might be a way through what I see as a real problem, but which I think you don't see as a real problem.

It is entirely correct to say that I suggested yesterday afternoon that we might take a certain course with witnesses, which would be questioning them personally before they started to give evidence about the extent to which they were aware of their rights to have either no representation or separate representation. But you'll have seen from page 238, lines 4 and 5, and 240 at line 19, that I had not a concluded view and I say it twice:

"We'll pick this up tomorrow."

So that was not intended to be a final line. And as I was working on the inquiry business last night and reflecting with increasing concern over what has happened over the last few days and what lay ahead and indeed, in a sense, we're enforced in this by Dr Jamison's evidence today because Dr Jamison has just given us evidence that she had no idea at all that she was suggested by Dr Fulton to have been at a meeting

that she wasn't at.

I have been concerned, apart from the other issues raised before, this week by a number of witnesses and the extent to which they are familiar with the events which we're investigating, the statements of other people and the expert reports which the inquiry has obtained.

This reflects what I think must be a practical difficulty on your team's part in being able to advise so many individuals and the Trust. There might be time factors in that, there might be notice factors in that, but all of this confirms or has strengthened the view which I have been setting out over the last few days and which I firmed up on this morning about the way forward.

MR STITT: Yes. I have noted that and I hadn't been aware of the 238 and 240 pages, but I see what you are saying, Mr Chairman.

You were kind enough to provide a schedule, it's actually under the Inquiries Act. I thought you had said that your decision was made under the Interpretation Act.

THE CHAIRMAN: What happened was that -- sorry, when this inquiry was initially set up, the powers which I had were set out in a schedule to the Health and Social Services Order 1972.

MR STITT: Yes.

THE CHAIRMAN: Those powers have since been removed from that schedule. I think we gave you the Interpretation Act and section 23 of the Interpretation Act provided that:

"The provisions of schedule A1 to this act shall have effect in relation to any local or other inquiry which a minister causes to be held under any enactment passed."

I'm not entirely sure if the schedule's accurate, the next schedule, but the powers which are set out in schedule A1 are, to the best of my knowledge, the powers which I have and they can be traced back to the schedule to the 1972 order. So the powers haven't changed; their location has changed, but the powers haven't.

MR STITT: It does seem, with respect -- and maybe I've misread this and misunderstood it, but it seems that you have wide powers to compel witnesses and if someone lives more than 16 kilometres away they can claim their travel and so on. I can't see how that ties into the power to compel a witness to obtain alternative legal representation.

THE CHAIRMAN: I told you this morning that I accept that I don't have an inherent power. If you want to challenge the ruling that I have made in the High Court

on that basis, Mr Stitt, you're entirely free to do so.

MR STITT: I would only challenge a ruling if I was able to advise my client that there was a good legal reason for so doing. That's why I was asking if there could be any light shed on the background to your decision, that would at least help in formulating an appropriate opinion.

THE CHAIRMAN: I'll follow up today's exchanges by arranging for a letter to be delivered to your solicitor's office tomorrow morning on this issue if there's anything further that I can add beyond the exchange today.

MR STITT: In what's a mutually helpful --

THE CHAIRMAN: I understand entirely. You and I clearly have different views on representation in this particular instance. I will follow up on this tomorrow morning. Okay? In the meantime, I'm sorry about this, I'm sorry about the fact that we are adjourning, but I am adjourning until Monday week and I'll keep everyone informed over the next week or so on how matters progress. I assume that if there is to be any challenge to this ruling, the challenge will be made immediately.

MR STITT: Oh, very much so.

THE CHAIRMAN: Because I'm absolutely certain that the Chief Justice would assign a High Court judge to hear it at short notice next week in order to allow the inquiry

to progress on whatever was the appropriate way in the same way as, in Claire's case, the Chief Justice facilitated both the inquiry and the trust by providing a judge at very short notice to hear the application about confidentiality of patients' records and to give an immediate ruling on it, and that was done to keep the inquiry as close to on track as possible.

Thank you very much. Unless you hear to the contrary, we'll resume on Monday 18 February at 10.00 am. Thank you.

(4.25 pm)

(The hearing adjourned until Monday 18 February at 10.00 am)

I N D E X