

1
2 (10.00 am)
3 DR MICHAEL CURRAN (called)
4 Questions from MS ANYADIKE-DANES
5 MS ANYADIKE-DANES: Good morning, doctor. Can I check that
6 you have your CV to hand?
7 A. Yes.
8 Q. Thank you. Dr Curran, you have made only two statements
9 so far as I am aware in relation to your involvement in
10 Raychel's care, and they're both for the inquiry;
11 is that correct?
12 A. Yes.
13 Q. The series is 028, and I think you made your first
14 statement on 23 November 2011, and then you made
15 a second statement on 14 June 2012; does that sound
16 about right?
17 A. Yes.
18 Q. Can I take it that you weren't asked to and didn't make
19 a statement for the Trust at all, the hospital?
20 A. Not that I'm aware of.
21 Q. And you weren't asked to make one for the PSNI either?
22 A. I received a letter telling me that a policeman was
23 going to contact me, but that never happened.
24 Q. So you never actually produced a statement?
25 A. No.

1

1 A. It's the sheet -- the times of my pagers for that night.
2 MS ANYADIKE-DANES: Mr Chairman, it's his bleep record. I'm
3 going to ask you about that in a while. It's attached
4 to his second statement for the inquiry. So you had
5 that and what do you think the Trust had sent you?
6 A. I think the Trust had sent a statement from one of the
7 nurses. I think.
8 THE CHAIRMAN: Plus the inquiry would have made available
9 the hospital notes and records.
10 MS ANYADIKE-DANES: Yes. Did you see the medical notes and
11 records as well?
12 A. Yes.
13 Q. Since then, and as you come now to give your evidence,
14 have you seen anything else? Have you seen any expert
15 reports?
16 A. Yes, I have received the expert reports from Mr Foster
17 and Mr Orr.
18 Q. And Mr Orr?
19 A. Yes.
20 Q. Anybody else?
21 A. I've received the other -- I presume the other expert
22 witness statements as well. I read the parts that
23 I thought were relevant to me.
24 Q. Of course. Have you read any of the transcripts of
25 anybody's evidence?

3

1 Q. Thank you. I'm going to ask you, subject to anything
2 you give evidence on today, whether you accept as
3 accurate what is in those two witness statements --
4 A. Yes.
5 Q. -- broadly speaking?
6 A. Yes.
7 Q. Okay, thank you. Because you weren't asked to make
8 a statement any earlier or didn't make one any earlier
9 than 23 November 2011, can I ask you what is your
10 recollection of what happened on the evening of
11 8 June 2001?
12 A. Do you want me to take you through --
13 Q. No, no, just how well do you remember it?
14 A. I can remember certain things because, obviously, it was
15 a tragedy, but I'll answer your questions as best I can.
16 My memory won't be 100 per cent obviously, but
17 I remember certain things.
18 Q. I'm wondering what you had to help you in narrating the
19 events in those two inquiry witness statements. What
20 did you see to assist your memory?
21 A. I had a record of the pager time. I think the Trust had
22 sent out a --
23 THE CHAIRMAN: Sorry, doctor, you had a record of what?
24 A. The pager time.
25 THE CHAIRMAN: Right. What is the pager time?

2

1 A. I looked for the first time at the weekend at the
2 transcripts and, realising that some of them were 200
3 pages long, I searched for my name and I looked at some
4 parts, but to be honest with you I didn't look at --
5 didn't spend a long time doing it because I think, if
6 I read it, I'd probably get my version of events clouded
7 by reading someone else's statement.
8 Q. Exactly. You are no longer, of course, at the hospital.
9 Are you still at Limavady? We'll come to your CV in a
10 minute, but is that where you are now?
11 A. I work as a GP in Magherafelt and Limavady and as a
12 locum.
13 Q. And have you discussed your evidence with anybody prior
14 to coming -- I don't mean with your lawyers, but with
15 anybody else?
16 A. I discussed with Dr Devlin because I know he was coming
17 to the inquiry as well. But apart from that, I don't
18 think I've had any contact with any of the other doctors
19 or nurses of Altnagelvin since that time.
20 Q. Thank you very much. I wonder if we could go now to
21 your CV. It starts at 317-001-002, but perhaps if we
22 could pull up 003 and put alongside it 004.
23 THE CHAIRMAN: I think it's the middle number which is
24 wrong. It's 317-011-003 and 004.
25 MS ANYADIKE-DANES: Thank you.

4

1 Starting from the right-hand side, that placement
2 at August 2000 to August 2001, that's what you were
3 involved in, when Raychel was admitted, as a pre-reg --
4 A. Yes.
5 Q. -- or junior houseman. Do I understand it that that was
6 split into two six-month periods; is that right?
7 A. That's right, yes.
8 Q. The first of them was surgical, so from August 2000
9 to February 2001 you were dealing with surgical matters.
10 A. Yes.
11 Q. And then from February 2001 to August 2001, you were
12 dealing with medical matters?
13 A. Yes.
14 Q. When you dealt with surgical matters, how much
15 paediatric experience did you have within that?
16 A. Within the six months of surgery?
17 Q. Yes.
18 A. I'd be guessing, but I'd say I was on the paediatric
19 ward no more than a dozen times, maybe, in six months.
20 Q. So is it fair to say that you weren't terribly
21 experienced in paediatric matters?
22 A. Very much so.
23 Q. Then when you started your medical six months, if I can
24 call it that, that didn't involve any paediatric work,
25 did it?

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1 THE CHAIRMAN: And during the evening are you covering both
2 medical and surgical or just surgical?
3 A. No, from 5 pm it would be surgical.
4 THE CHAIRMAN: Thank you.
5 MS ANYADIKE-DANES: And that arrangement whereby you would
6 come and act as a surgical JHO, how often had that
7 happened before Raychel's admission, roughly?
8 A. When I would be working in medicine?
9 Q. Yes.
10 A. To my recollection, never. For me personally, never.
11 Q. Was that the first time after you left your surgical JHO
12 work and started your medical JHO work that you'd
13 actually been asked to do surgical JHO work?
14 A. Yes.
15 THE CHAIRMAN: How did it come about? Do you remember?
16 A. The surgical JHO that was due to be working that night,
17 I think was ill, and there would have been six surgical
18 JHOs and six medical JHOs. There would have been
19 a surgical JHO covering the Thursday night and the
20 Saturday, so they would have been unable to do it, and
21 I don't know why the other three surgical JHOs couldn't
22 do it, but for whatever reason they couldn't do it, so
23 then I was asked to do it.
24 THE CHAIRMAN: Thank you.
25 MS ANYADIKE-DANES: If you hadn't been covering the surgical

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1 A. None.
2 Q. So if we just bring it up to what you were actually
3 doing on 8 June, although we'll go into that in more
4 detail, on 8 June you were doing your normal medical
5 day?
6 A. That's right.
7 Q. As a JHO, and then in the evening you were acting
8 on-call as a surgical JHO; would that be right?
9 A. That's correct.
10 Q. So there would be the possibility that you would come in
11 contact with paediatric patients during that period of
12 time, which in fact you did with Raychel, but you
13 wouldn't have come in contact with paediatric patients
14 since that dozen or so experiences that you had had in
15 your first six months?
16 A. That's correct.
17 Q. Can I ask you --
18 THE CHAIRMAN: Sorry, so during the day you're a medical JHO
19 --
20 A. Yes.
21 THE CHAIRMAN: -- then in the evening you're on call, but in
22 effect that means you stay in the hospital, does it? It
23 doesn't mean you go home and you are on call, it means
24 you stay in the hospital.
25 A. Yes, you're in the hospital.

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1 JHO work that evening, would you have been acting as an
2 on-call medical JHO?
3 A. No.
4 Q. So you wouldn't have been on call at all that evening?
5 A. Yes, I wouldn't have been on call at all.
6 Q. When did you first know that you were going to be on
7 call, if you can remember?
8 A. I honestly can't remember, but it wouldn't have been
9 more than 24 hours beforehand.
10 Q. So it might have been that day that you found out?
11 A. I'm pretty sure it wasn't that day because obviously
12 I wasn't anticipating being on call. When you're
13 anticipating being on call, you make sure you're in bed
14 the night before. I don't think it was that day, but
15 again I don't think it was something that was planned
16 days in advance.
17 Q. Thank you. Then you stayed on Altnagelvin to be an SHO
18 and you were that for two years; is that right?
19 A. That's right, yes.
20 Q. Whilst you were being an SHO, did you do any paediatric
21 work, any surgical work at all?
22 A. During those two years?
23 Q. Yes.
24 A. The answer's probably no, but if there was a medical
25 consult required on a surgical patient it is possible

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1 that I may have attended, but normally that was carried
2 out by the medical registrar. So the answer to your
3 question is probably not. I probably hadn't been on the
4 surgical wards.
5 Q. Was your care of Raychel that evening on 8 June the last
6 time you had any involvement in a paediatric case whilst
7 you were at Altnagelvin, so far as you can remember?
8 A. Yes.
9 Q. Then after that, you go for a year to Edinburgh, also on
10 a medical rotation, and then I think your next brush
11 with paediatrics, if I can put it that way, isn't until
12 you go to Dublin, when you have about six months as
13 an SHO in paediatrics.
14 A. That's right.
15 Q. And since 2005, you have transferred into general
16 practice?
17 A. That's correct.
18 Q. Was that six months in paediatrics as part and parcel of
19 moving into general practice?
20 A. Yes, it was to get experience in paediatrics.
21 Q. Thank you. Then I just want to ask you very briefly
22 about your induction and training and general knowledge
23 of hyponatraemia and fluid balance issues prior to
24 8 June when you were treating Raychel. Just very
25 briefly, were you aware of the fact that there's an

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1 induction programme at Altnagelvin or there was at the
2 time when you were there?
3 A. Was I aware?
4 Q. Were you aware of that?
5 A. No.
6 Q. So far as you can recall -- I know it's many years now
7 and you really only have had to think about these sorts
8 of things since 2011 -- nobody drew to your attention
9 that there was an induction programme?
10 A. Not that I can recollect, no.
11 Q. I don't want to go into it in any detail at all, but let
12 me just show you something. In fairness to you,
13 Dr Curran, we may be as cross-purposes or you may not
14 appreciate what I mean. Can we pull up 316-004f-018?
15 In fact, if you can pull alongside of that 017. On the
16 left-hand side that's one for the pre-reg -- and that's
17 what you would have been, obviously -- when you came to
18 Altnagelvin. On the right-hand side is one that is
19 a general one and would be applicable to SHOs, and you
20 might have seen that as you stayed on to be an SHO. But
21 if we concentrate on the first one, did you see anything
22 like that at all when you came -- I realise this is
23 dated 31 July 2001 and you came in 2000. But did you
24 see anything like that at all when you came to
25 Altnagelvin?

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1 A. I honestly can't remember.
2 Q. That's fair enough.
3 THE CHAIRMAN: Doctor, just to help you, Dr Devlin who gave
4 evidence yesterday described remembering what he called
5 an administrative sort of induction, which fitted in
6 with some of this. For instance if you look at the
7 left-hand page towards the bottom, there's a tour of
8 laboratory facilities and hospital computer systems. In
9 other words, this is not specifically directed at your
10 medical training; it's to help you understand where
11 everything is in Altnagelvin and how the hospital works.
12 A. When I look at that there, I see it says:
13 "Death certificate/post-mortem request, Dr
14 Marie Madden."
15 I remember vaguely some, I suppose, what you might
16 call an induction when there was certainly someone
17 talking about death certificates and post-mortems. But
18 I don't remember anything else on that, no.
19 MS ANYADIKE-DANES: Thank you. Do you remember at any stage
20 being told that there was an Altnagelvin Junior Doctors'
21 Handbook?
22 A. No.
23 Q. I'll pull it up so you can see the front of it and see
24 if this is recognisable to you, 316-004g-001. There
25 we are. Something like that?

11

1 A. I don't recognise it. It's possible, but I just don't
2 recognise it.
3 Q. I think Dr Devlin did, but he said that -- I think
4 he was aware of it, but he didn't use it in particular.
5 I think he said that what he used was a Oxford pocket
6 text. Is that what you used?
7 A. Yes, a little yellow book that fits in your pocket.
8 Q. Thank you. And then if we go on very briefly about
9 lectures that might be available to you, were you aware
10 that there were seminars, lectures and so forth as part
11 of your training that were available to you at the
12 hospital and that, for that matter, you were expected to
13 attend?
14 A. I remember -- this reflects maybe more SHO experience in
15 Altnagelvin, but there were lunchtime meetings on some
16 days, which I would have attended as an SHO in
17 Altnagelvin. They were supposed to be protected time --
18 I think maybe 12.30 to 1.30 -- but most of the time or
19 at least half the time your ward work prevented you from
20 going to them. It may have been the same as a JHO,
21 there may have been lunchtime meetings, I don't remember
22 as a JHO, but certainly as an SHO in medicine there was.
23 Q. Did you attend them as an SHO?
24 A. I did, some of them, where possible.
25 Q. Just to help you -- and I know you've not had an

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1 opportunity to make an earlier statement to prompt
2 you -- but if we look very quickly at 316-004e-001, this
3 is -- for completeness' sake, pull up 002 next to it,
4 please. This is a letter which is addressed to the
5 postgraduate dean. It's an attempt to sort of clarify
6 what the arrangements were. As you can see:

7 "Whole hospital training. From 1995 [which would
8 certainly cover your period] there have been teaching
9 sessions timetabled each year on fluid balance and
10 electrolyte disturbance within the medical division
11 teaching and training programme. The formal training is
12 delivered during the lunchtime teaching programme and
13 aimed at all PRHOs ..."

14 And that would have been you, wouldn't it, when you
15 came?

16 A. Yes.

17 Q. "... and all other junior medical staff [and that's the
18 SHOs that you've referred to] and this is considered
19 a general hospital education opportunity."

20 And then it talks about:

21 "The lectures on fluid balance were given by an
22 anaesthetist and the lecture on abnormal biochemical
23 tests, including electrolyte disturbance, by our
24 clinical biochemist."

25 Do you remember anything like that at all?

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1 A. I'm just reading this now, but I can honestly say
2 I don't believe there was ever any fluid balance
3 training certainly that I ever went to in Altnagelvin.
4 Q. Well, when you would have started, would you have had
5 a supervisor, a consultant, who was there to assist you
6 and guide you and to whom you could refer back? Did
7 you have anybody like that?

8 A. Sorry, to refer back to for?

9 Q. For guidance and counselling and so forth.

10 A. If I had an issue with fluid balance?

11 Q. No, just as you were just starting your medical career,
12 if I can put it that way, were you given a supervisor?

13 A. I think there was one doctor in surgery, there'd be one
14 surgeon. That would have been a nominal title, if you
15 like, to be supervising JHOs and perhaps, at the end of
16 the year, signing off the JHO if you like.

17 Q. Can you recall who that was for you?

18 A. No, I'd be guessing.

19 Q. Okay. I take it from the way you've already answered
20 that whoever that was, if they drew to your attention
21 the fact that these lectures were going on, didn't draw
22 it sufficiently forcefully for it to stay in your mind;
23 would that be fair way of putting it?

24 THE CHAIRMAN: No, no, sorry, it depends -- you're talking
25 about lectures generally. The doctor says he does

14

1 remember some lunchtime lectures or meetings.

2 MS ANYADIKE-DANES: I meant the fluid balance ones.

3 THE CHAIRMAN: Let's be careful. You remember more as
4 an SHO rather than a JHO?

5 A. In the medical department there were lunchtime meetings,
6 which seemed to be quite structured, and you seemed to
7 have more time to go to them as an SHO. But I don't
8 recall them as a JHO in surgery.

9 MS ANYADIKE-DANES: That was the point I was putting to you.
10 You don't recall being instructed or guided that these
11 are things that you really ought to attend, we expect
12 you to attend them, you don't recall anything of that
13 sort?

14 A. No, I don't even recall they took place.

15 Q. Thank you.

16 THE CHAIRMAN: Sorry, I'm confused. When you asked that
17 question, are you talking about fluid management?

18 MS ANYADIKE-DANES: I was talking about fluid management.
19 I thought then that Dr Curran expanded that to mean
20 generally.

21 THE CHAIRMAN: No, he's just said that generally there were
22 more structured meetings in the medical department and
23 time allowed to go to them.

24 MS ANYADIKE-DANES: I meant aimed at the JHOs. I think he
25 was then saying he wasn't aware of anything for the

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1 JHOs.

2 Perhaps you can clarify the position so far as you
3 can. Do you recall there being lunchtime --

4 THE CHAIRMAN: Let's do this slowly. As a JHO, do you
5 remember anything about lunchtime lectures or meetings?

6 A. No, I don't.

7 THE CHAIRMAN: And that may --

8 A. In surgery, sorry.

9 THE CHAIRMAN: In surgery you don't, right. In medicine?

10 A. In medicine I do recall lunchtime meetings.

11 THE CHAIRMAN: As a JHO? Or is it too vague to
12 differentiate between JHO and SHO?

13 A. It definitely happened as an SHO in medicine. I'm not
14 sure about as a JHO.

15 MS ANYADIKE-DANES: So my follow-up point to you therefore
16 was that you're not aware of anybody who was in
17 a supervisory relationship with you pointing out that
18 there were lectures and seminars that it really would be
19 useful to you to attend; you don't recall anything of
20 that sort?

21 A. Definitely not.

22 THE CHAIRMAN: And just on this point, do you see the
23 heading "Whole hospital training" on the left side of
24 the screen?

25 A. Yes.

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1 THE CHAIRMAN: If you go to the second paragraph, it says:
2 "The lectures on fluid balance were given by an
3 anaesthetist."
4 So the hospital is not there referring to a lecture
5 given by a paediatrician or by a surgeon, but it's
6 referring specifically to a fluid balance lecture given
7 by an anaesthetist; does that help you?
8 A. I don't believe there's any fluid balance lectures that
9 I attended as a surgical JHO from anyone.
10 THE CHAIRMAN: Sorry, in the paragraph above it doesn't say
11 "surgical", it says, "Within the medical division
12 teaching and training programme". Let's understand this
13 properly. This is a letter which refers to teaching of
14 fluid balance within the medical division. So it
15 doesn't say "surgical".
16 A. Sorry, just to clarify, I don't remember any training on
17 fluid balance as a JHO full stop.
18 THE CHAIRMAN: Okay. Can we follow on down then? Do you
19 then remember that after -- if you look to the
20 penultimate paragraph, starting "in 2002", do you
21 remember that after Raychel died there was a talk
22 specifically prepared by Dr Nesbitt on lessons learned
23 in effect?
24 A. I was in Altnagelvin until 2003. I don't remember that
25 lecture. I don't know whether it took place for the

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1 had died; do you remember anything like that?
2 A. I don't remember that lecture. If I was at that
3 lecture, given my contact with Raychel, I would remember
4 that. But the reason for not being at it, I'm not sure.
5 Q. You might have had a good reason for not being there?
6 A. I actually think the transition from JHO to SHO, as
7 I recollect, happened on a Wednesday, and it's the first
8 Wednesday, so it may have been that we transferred from
9 JHO to SHO on 1 August or 8 August. So maybe that was
10 the first lecture for the new SHOs or JHOs, but I don't
11 remember the lecture. If I went to it, I would remember
12 that.
13 Q. Thank you.
14 THE CHAIRMAN: Is Dr Morrow an anaesthetist?
15 A. Yes.
16 THE CHAIRMAN: Thank you.
17 MS ANYADIKE-DANES: Moving from that and speaking generally
18 as to the context in which you operate as a doctor, you
19 would have been aware as a JHO that there are practices
20 and guidance from the GMC --
21 A. Oh yes.
22 Q. -- and the general principles that you might have been
23 expected to apply to your work. For example, I presume
24 you would have been aware that it's important, in terms
25 of case notes, to take clear and accurate case notes and

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1 surgical division or the medical division or the whole
2 hospital, but I don't remember that lecture.
3 THE CHAIRMAN: Thank you.
4 MS ANYADIKE-DANES: Right. And just to round it off, if you
5 would pull up 316-004e-019. If you scroll down and you
6 see:
7 "Wednesday 8 August 2001. Management of fluid
8 balance by Dr Morrow."
9 That's the sort of thing that I was asking you
10 about. Of course it happens after Raychel, but at this
11 stage you're an SHO.
12 A. Yes.
13 Q. 8 August?
14 A. Yes.
15 Q. Do you remember anything like that?
16 A. As a JHO?
17 Q. As an SHO. Do you remember that sort of thing?
18 A. No, I would have been an SHO in medicine. I don't know
19 whether that lecture was for the medical division or the
20 whole hospital.
21 Q. These lectures, as we have understood it, are lectures
22 that were open generally and aimed at JHOs and SHOs.
23 You've said that you don't recall particularly anything
24 very much as a JHO, so I'm now asking you as an SHO
25 particularly as this would have happened after Raychel

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1 to have them timed and dated and signed. You would
2 accept that, wouldn't you, that that's important?
3 A. Yes.
4 Q. And it's important because not only is it recording
5 directions that you might give or interactions with
6 patients and carers, but it's a record for those coming
7 after you so that they understand the care that's being
8 given to a particular patient and maybe even why. It's
9 important in terms of continuity, you would recognise
10 that?
11 A. It is important, yes.
12 Q. One's talking about continuity. You would have
13 understood about the principle of a handover between an
14 outgoing team and an incoming team so that there is
15 continuity of care for a patient, you'd have understood
16 that?
17 A. Are you asking me was there a handover?
18 Q. I'm firstly asking you would you have understood the
19 importance of that.
20 A. I can understand that it would be very helpful, yes.
21 Q. Yes. You would have understood that as a JHO, the
22 principle of it?
23 A. The principle, yes, definitely.
24 Q. And you would have been able to see that that can be
25 an important thing to make sure that people understand

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1 the continuing care to be provided to the patient and
2 anything that the incoming team should be alerted to,
3 you can understand the principle of that?
4 A. Yes, definitely.
5 Q. You presumably, since you've been frank about your
6 paediatric experience, can understand the principle that
7 the GMC underscores about not overreaching yourself, not
8 overreaching your competence?
9 A. Yes.
10 Q. And that that is very important, particularly as you're
11 just starting, that you're careful to make sure that you
12 communicate with your more senior colleagues, you ask
13 questions, and make sure that you don't get out of what
14 should be your comfort zone.
15 A. Yes.
16 Q. And then in terms of interacting with patients and their
17 carers, if they're paediatric patients -- although you
18 might not have done very much of that on your own -- you
19 can understand the importance of keeping them informed
20 who you are, what you're doing and why you're doing it
21 in a way that they can understand? You can see the
22 importance of that?
23 A. Yes.
24 Q. As it happens, all those things, one way or another, are
25 included in the Altnagelvin junior handbook and the GMC

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1 codes of practice -- and I'm sure the Oxford pocket book
2 that you had -- but you wouldn't, for some of those
3 principles, have necessarily needed that for you to see
4 that those things were all important and that you should
5 have them in your mind.
6 A. Yes.
7 Q. I suppose also, because you were starting out, you would
8 understand the importance of establishing a good working
9 relationship with the nurses.
10 A. Yes.
11 Q. Can I just ask you, from your point of view, how
12 important was your interaction with the nurses?
13 A. As a JHO?
14 Q. Yes.
15 A. Vital. The training and most of the stuff you're
16 learning as a JHO, day-to-day stuff, is from the nurses.
17 So your interaction with the nurses, you learn most of
18 your trade from that as a JHO and I made a lot of good
19 friends as a JHO and still keep in contact with them.
20 So vital.
21 Q. These are because nurses, I presume, are in close
22 contact with the patients and the families and they're
23 experienced in a way that you're not?
24 A. All of those things, yes.
25 Q. I should have told you --

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1 THE CHAIRMAN: Sorry. In a sense, but the other point
2 is that when you come in as a JHO, whatever about your
3 undergraduate training, you're at the bottom end of
4 a learning curve and, at that bottom end of the learning
5 curve, the people who you will have a lot of contact
6 with who will help you move along the learning curve are
7 the nurses; is that right?
8 A. Probably more so than the doctors because of the amount
9 of contact, yes, with nurses compared to SHOs.
10 THE CHAIRMAN: Yes.
11 A. I just would add to that: your knowledge in medical
12 school, theoretical knowledge, doesn't prepare you for
13 the learning curve of being a JHO.
14 MS ANYADIKE-DANES: I'm sure that must be true when you're
15 actually dealing directly with the patients. I know
16 that you say that you didn't have it very much to mind,
17 but it may be you can help me with this, whether it was
18 explained to you -- in the Altnagelvin Junior Doctors'
19 Handbook it does refer to the role of the JHO, your
20 pre-registration period, and it refers to the fact that
21 you're assigned -- this is the part that I was referring
22 to earlier -- a supervisor, consultant, but the
23 important thing about that, it says:
24 "With whom you should meet on a regular basis."
25 You have mentioned the fact that you thought there

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1 was somebody in charge of the JHOs, but now that I put
2 it to you in that way, which is how it's put in the
3 handbook, were you conscious of having a relationship
4 like that, that you had a consultant supervisor, if I
5 can put it that way, that you would meet on a regular
6 basis and who would presumably assist you in the early
7 part of your training?
8 A. I suspect I was aware that there was a nominal figure
9 who would be in perhaps a supervisory capacity, but
10 I have no -- I'm pretty sure that my only contact with
11 that person would have been at the end of the six months
12 to sign the form to say you've done your
13 pre-registration surgical six months.
14 Q. So when you say a nominal figure, that doesn't sound as
15 if it's a person with whom you had a close relationship
16 who was acting as a mentor in some way? It wasn't that
17 sort of thing?
18 A. No, there's no mentor. There's no person meeting with
19 you every few weeks or every month or every three months
20 to say, "What have you learnt? You should have acquired
21 these skills? What are you having difficulty with --"
22 Q. If you were learning in that way at all, you were
23 learning from the experienced nurses and from the SHOs,
24 registrars and consultants who you accompanied as you
25 followed them round on ward rounds or followed them in

24

1 their work?
2 A. Yes, there would have been surgical -- the JHO would
3 have been on the surgical ward round, which generally
4 took place once or twice a day sometimes. Sometimes
5 there was training on those ward rounds, yes, questions
6 asked, otherwise, your training would have been from --
7 if you asked the surgical SHO a question or how to do
8 something, they would obviously help you. Lots of times
9 there was no surgical SHO on the ward, so you learned
10 from the nurses.

11 Q. Thank you. Then just finally, you had been asked about
12 what you understood about the possible dangers where
13 a child was suffering prolonged vomiting following
14 surgery and was in receipt of hypotonic fluids. We
15 don't need to pull it up -- it might assist you to see
16 it.

17 You were asked in your second witness statement
18 028/2, page 10. It's the answer to question 9. You
19 say:

20 "[You] had limited experience at that time and [you]
21 would have considered the main risk with vomiting to be
22 dehydration."

23 Then you go on to say that you weren't aware of the
24 risk of hyponatraemia.

25 On the previous page, which we don't need to pull

25

1 with the next 2 years forming the pre-clinical years.
2 He sets out the core topics that he regards as being
3 taught at that time. Then if you look at the bottom
4 paragraph he says:

5 "It was during these years that medical students
6 would learn about the physiological relevance of sodium,
7 its absorption during digestion, its distribution within
8 bodily fluids and its elimination in urine and the vital
9 role played by anti-diuretic hormone and other hormones,
10 their secretion from the hypothalamus, and their effects
11 upon the re-absorption of sodium from the renal tubules
12 would also have been addressed."

13 If you go across, he refers to what happens then
14 in the clinical years, years 3 to 6:

15 "It would have been during this year that the basic
16 physiology and pathophysiology of the syndrome of
17 inappropriate anti-diuretic hormone would be taught, the
18 situations in which this might occur, the consequences
19 of inappropriate retention of salt by the kidneys, and
20 the clinical signs caused by this phenomenon would be
21 covered in detail. Some understanding of the use of
22 IV fluids in clinical settings may have been learned in
23 this year."

24 Does that accord with anything that you remember
25 from your training and education?

27

1 up, when you're dealing with a similar sort of question,
2 you say that:

3 "During the JHO year, a JHO would learn most aspects
4 of the job from the SHO and senior nurses. I don't
5 believe I had any experience [and this is the part I
6 want to emphasise] or awareness of the condition of
7 hyponatraemia or other electrolyte imbalance in
8 a post-op paediatric patient."

9 I don't know whether you have seen a report from the
10 inquiry's expert on the teaching to clinicians of fluid
11 balance and sodium management in Northern Ireland and
12 the Republic of Ireland from 1975 to 2009 to span the
13 period of time we're concerned with in the inquiry. His
14 name is Dr Michael Ledwith; are you aware of that?

15 A. No.

16 Q. He produced a report. In the course of it, he discussed
17 what he thought doctors were being taught at that time.
18 If I take you to it and see whether you are aware of
19 being taught these things. 303-046-519. Then
20 if we pull up alongside it 520. You can see he starts
21 off that:

22 "Until 1996, medical education in Northern Ireland
23 as in the rest of the United Kingdom consisted of two
24 phases."

25 And he talks about the pre-med and then the pre-med

26

1 A. You mean at Queen's University?

2 Q. Yes.

3 A. We certainly did physiology as part of our core studies.
4 As to SIADH, no.

5 Q. You don't recall being taught about that?

6 A. No.

7 Q. Well, can I ask you this: is it possible that you were,
8 but it is just such a long time ago you can't really
9 remember?

10 A. Yes, definitely it's possible.

11 Q. So if you were taught those sorts of things, although
12 you may not have come across a child who had
13 hyponatraemia, the principles involved in a child
14 developing it you might have understood?

15 A. No.

16 Q. You wouldn't have?

17 A. If you asked me, "Did I know what hyponatraemia meant at
18 that stage", yes, I know hyponatraemia: hypo, low;
19 natraemia, sodium. But no, my training in fluid balance
20 in general was very little. So the answer to your
21 question is no.

22 Q. You said you knew what it was.

23 A. Yes.

24 Q. If I had asked you in June 2001, "Do you know what
25 hyponatraemia is?", I think from what you have just said

28

1 the answer to that would have been, yes, I do know what
2 it is.
3 A. Yes.
4 Q. And because you know what it is, you know how it
5 develops, you know why it happens?
6 A. I don't think one leads on to the other. I know
7 hyponatraemia means low sodium.
8 Q. Oh. Would you have appreciated how an individual can
9 reach a stage where they have low sodium?
10 A. Sorry, are you asking me do I know causes of
11 hyponatraemia?
12 Q. Yes.
13 A. No, not at that stage, no.
14 Q. You wouldn't have known that then?
15 A. No. I wouldn't have seen anyone with hyponatraemia
16 except perhaps when I was in medicine and in that case
17 it would have been maybe drug induced.
18 Q. Would you have understood the necessity and the function
19 of sodium in the body, the need to maintain electrolytes
20 at a certain level and the consequences if you don't?
21 A. As a general principle, yes.
22 Q. So you'd have understood that? Would you have
23 understood as a general principle that if something
24 arises that causes the body to retain too much fluid,
25 then that's likely to have a diluting effect on the

29

1 A. -- and therefore get dilutional hyponatraemia,
2 I understand the concept you're telling me, yes.
3 Q. And therefore, if I keep it as an open question, is that
4 a concept which, if described to you in that way, you
5 would have understood in June 2001?
6 A. No.
7 Q. If I had given you that description in June 2001, you
8 would not have appreciated that that would lead to
9 hyponatraemia?
10 A. Hyponatraemia wouldn't have been even on my radar. What
11 you said now, if I understand you -- because I want to
12 answer you correctly -- if a patient retains too much
13 water, they will get a dilutional effect on the sodium
14 and therefore get dilutional hyponatraemia.
15 Q. Yes.
16 A. That concept as you explain it to me is very
17 straightforward, no problem, but if you are asking me --
18 Q. Just as we pause there, would you have understood that
19 concept in June 2001?
20 A. If you had said that to me in June 2001, yes, I would
21 have understood the concept, but you're saying to me
22 today if you said that to me in June 2001.
23 THE CHAIRMAN: Because it must follow that if you retain too
24 much fluid, then the level of sodium in your body will
25 diminish as you retain more and more fluid.

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1 sodium in the body?
2 A. Yes.
3 Q. And that would mean if that has that effect, then the
4 consequences of that might be you end up with the low
5 sodium that you've just described as meaning
6 hyponatraemia? You'd understand that?
7 A. Do you mean if you're giving too much fluid that's got
8 low sodium?
9 Q. Yes.
10 A. Yes.
11 Q. So you'd have understood that in 2001?
12 A. I would have understood that principle.
13 Q. If you had sat back and worked it out?
14 A. Yes.
15 Q. Yes.
16 THE CHAIRMAN: Sorry, I don't know what he's saying "yes" to
17 because there were two questions run together.
18 MS ANYADIKE-DANES: Sorry, I beg your pardon.
19 In 2001, would you have understood that if a patient
20 had a condition which caused the patient to retain fluid
21 that that could result in the sodium being diluted and
22 therefore leading to the condition of hyponatraemia?
23 A. If you're asking me if a patient were to retain too much
24 fluid --
25 Q. Yes.

30

1 A. I understand the concept you're saying of dilutional
2 hyponatraemia as you explained it to me. Yes, that's
3 straightforward.
4 MS ANYADIKE-DANES: You understood that?
5 A. Yes.
6 Q. Let's put it another way. If you have a patient now who
7 is vomiting a lot, would you understand that that vomit
8 is likely to be rich in electrolytes?
9 THE CHAIRMAN: Sorry, would you understand when?
10 MS ANYADIKE-DANES: I beg your pardon, all this
11 is June 2001.
12 A. No.
13 Q. You wouldn't have understood that vomit is rich in
14 electrolytes?
15 A. No. In June 2001, no.
16 Q. So you wouldn't have understood that if you've got
17 a patient who is vomiting excessively, they are likely
18 in that way to be depleting their sodium unless,
19 of course, that sodium is being replenished in some way.
20 You wouldn't have understood that in 2001?
21 A. No, no. Can I expand on that?
22 Q. Yes.
23 A. When you say "June 2001", obviously I'm trying to
24 separate my knowledge since Raychel from my knowledge
25 prior to Raychel.

32

1 Q. Yes.
2 A. But as far as I can honestly recollect, there was no
3 training on fluid balance. The fluid balance training
4 in the surgical directorate would have been either one
5 of the SHOs or one of the nurses telling you someone's
6 going to be on this fluid, Solution No. 18, or someone's
7 going to be on normal saline, one bag every eight hours.
8 This concept you're saying now about vomiting and losing
9 electrolytes -- I mean since 2001 and in my medical
10 training I understand the concept of vomiting and
11 diarrhoea and the electrolyte loss. Back in 2001, if
12 a patient was vomiting, thinking about electrolyte
13 abnormalities or loss of sodium wouldn't even have
14 occurred to me.
15 THE CHAIRMAN: What we have heard a number of witnesses say
16 is that if somebody was vomiting or had vomiting and
17 diarrhoea in particular, the concern was not to let that
18 person become dehydrated.
19 A. Yes.
20 THE CHAIRMAN: The way to avoid dehydration was to give that
21 person a fluid and the fluid which was regarded at that
22 time as the appropriate fluid in Altnagelvin was
23 Solution No. 18.
24 A. Yes. But the concept that I would have understood in
25 2001 is if someone is vomiting or has diarrhoea

33

1 pages 34 and 35 alongside each other, please? If you go
2 on 34 to line 24:
3 "In 2001, I would be aware of some factors that
4 could cause electrolyte imbalance in post-operative
5 patients. Bleeding, infection, vomiting, diarrhoea,
6 fluid administration, hormonal response to surgery,
7 bowel obstruction, medications could all cause
8 electrolyte imbalance."
9 Would you say that your knowledge went as far as
10 that in 2001?
11 A. No, not in 2001. My knowledge personally, no. But
12 I would add to that that, as I've said, the training in
13 fluid balance was minimal, so you would be learning from
14 your SHO. So I guess everyone's training would be
15 a little bit different then.
16 Q. I was going to ask you that. If you happened to be
17 accompanying an SHO or a registrar, for that matter,
18 where there was an incidence of a child who had
19 a particular condition that allowed the SHO or the
20 registrar to explain these things, then you would be
21 fortunate because you would then have that information
22 that maybe another JHO wouldn't have? Would that be
23 a fair way of putting it? So it may be that Dr Devlin
24 is fortunate enough to have had that explained to him at
25 that time because of his interactions with whichever of

35

1 excessively, then the risk to that person is
2 dehydration, and therefore make sure that person is on
3 intravenous fluids, replace the fluids, not to replace
4 electrolytes.
5 THE CHAIRMAN: So you give the anti-emetic to stop the
6 vomiting --
7 A. Yes.
8 THE CHAIRMAN: -- and you give the fluids to prevent
9 dehydration?
10 A. That would have been my understanding, yes.
11 THE CHAIRMAN: The additional issue then of what was
12 contained in the vomit which was expelled from the body,
13 how that was constituted and whether that led to any
14 imbalances within the body, that wasn't really something
15 which crossed your mind?
16 A. Not at all.
17 THE CHAIRMAN: Thank you.
18 MS ANYADIKE-DANES: Can I just put one thing to you because
19 a similar question was asked of Dr Devlin? What we're
20 trying to do is find out what the level of knowledge was
21 amongst the JHOs, apart from anything else because you
22 JHOs seem to have been the first point of contact, so
23 we're trying to see what the level of your knowledge
24 was.
25 It's the transcript for 6 March and can we pull up

34

1 the medical or surgical personnel he was accompanying.
2 But as I understand you to say, you were not aware of
3 that interaction between these conditions and
4 electrolyte imbalance?
5 A. That's fair to say that, yes.
6 Q. So then if a patient was vomiting or had excessive
7 diarrhoea, as the chairman has said, what you would be
8 concerned about was dehydration?
9 A. Yes.
10 Q. Thank you. Then can I ask you, because we're almost
11 into it from there, what you considered the role of
12 a surgical JHO to be? That's what you had been doing
13 from August 2000 to February 2001. And what did you
14 regard your role as?
15 A. The surgical JHO was basically the person who did all
16 the tasks, so in the morning you would do your ward
17 round. You would write the patient's notes as
18 consultant did the ward round -- or the registrar or the
19 SHO, whoever led the ward round. The ward round would
20 generally have lots of tasks, so after the ward round
21 then you would have quite a few blood tests to do,
22 perhaps heart tracings, perhaps organise X-rays. There
23 would have been investigations carried out in the X-ray
24 department the previous day you'd have to go down and
25 chase the results for. There may be discharge letters

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1 to write, there may be new patients coming in. We
2 basically were doing what you were asked to do. A busy
3 role, but --
4 Q. Did you ever have to exert any initiative at all? For
5 example you now know, I take it, that Dr Devlin followed
6 up and administered a pre-prescribed, if I can put it
7 that way, anti-emetic. Dr Gund, the anaesthetist, had
8 said that Raychel should have an anti-emetic if
9 required. And as it happens, the nurses were of the
10 view that it was required, he came and he administered
11 that anti-emetic. I'm not going to get into the full
12 detail of what you did until a little later on, but for
13 these purposes, to explain matters, you came and there
14 wasn't a pre-prescription, if I can put it that way, for
15 the anti-emetic that you administered, so you presumably
16 wrote up a prescription?
17 A. Yes.
18 Q. So quite apart from following on from things that had
19 been initiated in the ward round or that you were
20 specifically directed to do by your senior colleagues,
21 were there therefore, like that example, instances where
22 you had to exercise your own initiative about what to
23 do?
24 A. Yes, to a point, but when I say more senior colleagues,
25 I would consider that would be your SHO, your registrar,

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1 A. Possibly, it depends on the context. Possibly.
2 Q. But the condition of the patient may be such to raise
3 that query in your mind, maybe I should talk to somebody
4 about that?
5 A. Yes.
6 Q. Did you know how to calculate the maintenance fluid
7 needs of a child as at June 2001?
8 A. No.
9 Q. Had you heard of a thing called the Holliday-Segar
10 formula --
11 A. No.
12 Q. -- which is by reference to a child's weight?
13 A. No. I mean, I guess I would have had a vague idea that
14 you would take the first 10 kilos and multiply by 100,
15 or maybe the next 10 kilos and multiply by 50. But to
16 my best knowledge I never wrote up fluids for a child.
17 Q. You were aware of the formula, that there was a formula
18 for doing it?
19 A. I was aware that there was a formula, yes.
20 Q. Although you never had to calculate what it was for
21 a child and therefore prescribe that amount, would
22 you have been in the position to recognise whether
23 a particular rate seemed high to you, based on that kind
24 of formula?
25 A. No.

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1 your consultant, but also the nurses. So if you were
2 asked to do a task, you're not going to second-guess
3 someone more experienced, you're going to do the task,
4 you follow what you're asked to do.
5 Q. We'll come to that in a minute. What I was trying to
6 see if you could help me with is whether you were ever
7 in the position of having to make a decision about what
8 to do about a particular patient, no matter how minor
9 the matter was, were you in the position of having to
10 make decisions?
11 A. You would show initiative at times, yes.
12 Q. And when you were doing that, you were involving
13 yourself in patient care, effectively, you weren't just
14 following straight directions?
15 A. Yes, but it depends on the decision.
16 Q. And you might, for example, be involved in replacing
17 bags of IV fluid. That might be something you might be
18 asked to do.
19 A. To replace the cannula?
20 Q. Yes -- no. To place a catheter or to put up a new bag
21 of fluid when the IV fluid is finished?
22 A. Certainly, yes.
23 Q. And if you were doing something like that, might you be
24 expected to think about whether I should ask somebody
25 whether we need another bag at this stage?

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1 Q. Would it even have crossed your mind to think about
2 whether a rate is too high?
3 A. No. I wouldn't have queried fluids.
4 THE CHAIRMAN: Can I take it that when you say you would
5 haven't queried them, does that mean you wouldn't have
6 queried them unless they were obviously very high or
7 obviously very low?
8 A. Yes, I mean at a -- if I just say about an adult
9 surgical ward, I would have a rough idea to calculate if
10 a person was on 4 litres of fluid in 24 hours or
11 3 litres, so you'd know what millilitres per hour that
12 was. If it was excessively high, that would raise alarm
13 bells in your head.
14 MS ANYADIKE-DANES: For a child, because you weren't
15 familiar with paediatric patients, are you saying you
16 wouldn't be aware of what those parameters might be for
17 a child?
18 A. I think it would depend obviously on the child's
19 weight. Obviously I wouldn't -- adults generally from
20 my knowledge had a set 3 litres of fluid over 24 hours,
21 for instance. So it was easy to have a figure in your
22 head whereby you could say 3,000 divided by 24 equals
23 whatever. In a child, no, you wouldn't have any figure
24 in your head to say that's too high, too low.
25 Q. Thank you. Can I ask you about the support and

40

1 supervision that you received as you were carrying out
2 your task as a surgical SHO? What level of supervision
3 did you receive?
4 A. As a surgical JHO --
5 Q. I didn't mean that. Surgical JHO, thank you, sorry.
6 A. If you clerked in a new patient, then the patients, from
7 recollection, were routinely reviewed by the SHO after
8 you clerked them in. And you would learn from that,
9 obviously. In terms of other formal teaching, it would
10 be on ward rounds. If the consultant had time, he would
11 teach you on some ward rounds, which was very useful.
12 In terms of supervision throughout the remainder of the
13 day you would have had, the surgical SHO would pop in
14 and out of the ward, but more than not they would have
15 been in theatre or clinic. So most supervision
16 otherwise would really be under the wing of the nursing
17 staff.
18 Q. So would it be fair to say that your work, unless you
19 were literally with a more senior colleague at that
20 time, generally wasn't really supervised by a more
21 senior colleague? On the surgical side, I'm talking
22 about.
23 A. Your work generally wasn't supervised by a more senior
24 doctor except for maybe new admissions because they were
25 reviewed, or obviously if you contacted your SHO about

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1 in or out, but more typically they were in the theatre.
2 Did that mean that they weren't very accessible to you?
3 A. You always could bleep your SHO, but if your SHO was
4 in the theatre assisting in an operation, then sometimes
5 you would bleep them and the theatre nurse might answer,
6 and you'd be told, "We'll get back to you when
7 finished", but you could always bleep them of course.
8 They would on the ward sometimes because they would have
9 to review the new admissions, but more often than not
10 they weren't.
11 Q. One of the things that you said you were involved in was
12 ward rounds.
13 A. Yes.
14 Q. If you can just help me with how the daily post-take
15 ward round worked when you were a surgical JHO. If
16 I can put it in this way: some of the evidence that
17 we have had -- and let's see if you can help if this
18 accords with your recollection -- suggests that the JHO
19 might make up the list of all the new admittances and
20 those who had just had surgery the previous day, might
21 make up a list like that ready for a ward round, and
22 might take the notes of the ward round as the consultant
23 or the registrar proceeds through the ward round.
24 Is that how you recall it?
25 A. I don't recollect that a JHO would be the one to tell

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1 something. You could always contact them.
2 Q. Yes, but absent that, then your work wasn't really going
3 to be supervised and the only people who might raise
4 a concern if they were troubled by what you were
5 proposing to do or what you had done would be the
6 nurses?
7 A. Yes.
8 Q. And I think in your witness statement you refer to some
9 of your tasks. Apart from the clerking in, for example,
10 you talked about administering medication intravenously
11 and so forth. That is something you could be doing and
12 you might do that and that wouldn't be necessarily
13 supervised by a more senior colleague, although the
14 nurses were there because they're present on the ward?
15 A. Yes. I wouldn't be supervised by a more senior doctor.
16 THE CHAIRMAN: I take it from the way you're answering these
17 questions, doctor, that at that stage in your career you
18 would have regarded nurses as almost senior colleagues;
19 would that be right?
20 A. Definitely.
21 THE CHAIRMAN: Thank you.
22 MS ANYADIKE-DANES: Apart from the way that you've just
23 answered the chairman that you would have regarded the
24 nurses as your senior colleagues, and I think you'd
25 answered me before by saying sometimes the SHO would pop

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1 the consultant: these are the ten new patients.
2 However --
3 Q. I'm not sure I meant tell them, I mean accumulate to
4 make sure there's a comprehensive list of them. Would
5 that fall to you to do?
6 A. I think we could have done that, yes.
7 Q. Then you say you could have done that, so maybe I'll ask
8 you then: what was a typical post-take ward round on
9 Ward 6 so far as you are concerned?
10 A. On Ward 6?
11 Q. Yes.
12 A. The paediatric ward?
13 Q. Yes.
14 A. Sorry, I don't think I ever did a post-take ward round
15 on Ward 6.
16 Q. Ah, okay. Thank you. Did you know that they had them?
17 A. If I can answer by saying I did urology, it was Ward 7,
18 and then I worked in Ward 9. So typically if you had
19 a post-take ward round in Ward 7, your consultant and
20 you would have -- and the SHO whatever -- done the ward
21 rounds, but you'd have stayed on the ward then to start
22 your jobs. Whereas the consultant and the SHO would
23 then go and see what they called outliers, which would
24 have included Ward 6.
25 Q. In fact, Mr Zafar, who was a surgical SHO, described

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1 precisely something like that. He did, as you probably
2 will recall now from having looked at Raychel's medical
3 notes and records, the post-take ward round in relation
4 to Raychel on 8 June. It appears that he did it by
5 himself and he was asked to go off, there was only, it
6 seems, one post-take patient, surgical patient, on
7 Ward 6, and he was asked to go and carry out that ward
8 round, which he did. The impression he gave was that
9 other colleagues would be doing the rest of the ward
10 round in other locations, if I can put it that way.
11 Is that the sort of thing that you meant?
12 A. Yes. I think the JHO was ward-based, so we would have
13 done the ward round with the consultant, but I don't
14 believe we -- certainly I didn't leave Ward 7 to follow
15 the consultant to Ward 6. If the consultant went to
16 Ward 6, I would have stayed on Ward 7, did the ward
17 round for the hour or whatever it took, and then start
18 jobs.
19 Q. I see.
20 A. In fact, I don't think I ever did a ward round in
21 Ward 6, post-take or any other ward round.
22 Q. Thank you. It may be then that you can't help us very
23 much with this, partly because you have said that your
24 experience with surgical paediatric patients was very
25 restricted before Raychel and then you didn't have any

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1 that surgeons weren't very good at monitoring their
2 children who were on IV fluids. Was there any kind of
3 tension in relation to that, were you ever aware of
4 that?
5 A. Sorry, I'm not sure what you mean, tension.
6 Q. That would be a tension between or potential tension
7 between the nursing staff on Ward 6 and the surgeons and
8 potentially also the paediatricians. But were you ever
9 aware of that feeling that the surgeons weren't very
10 good at monitoring their own patients on Ward 6?
11 A. It's not something that I really thought about. Having
12 not been asked to write fluids up myself, it's not
13 something I've had to think about.
14 Q. Leaving aside the fluids, were you ever aware of the
15 fact that the nurses had a feeling that the surgeons,
16 because they were spending a significant amount of their
17 time in theatre and so forth, weren't readily accessible
18 and weren't very good at monitoring their patients on
19 Ward 6? Were you aware of any of that sort of feeling?
20 A. I could understand if they were, but I wasn't aware that
21 they thought that.
22 Q. You can understand that that might be the case, but you
23 didn't get that sense from them?
24 A. Yes.
25 Q. And although you didn't go to Ward 6 very often, were

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1 after Raychel. Were you aware of how the
2 responsibilities fell for the surgical patients on
3 Ward 6?
4 So if I narrow that down for you. In terms of
5 medication and fluids, so far as you are concerned, was
6 it the surgical team who was responsible for them
7 because the patient would be a surgical patient, or was
8 it the paediatric team who would be responsible for
9 them?
10 A. I would be guessing. I don't think I ever wrote fluids
11 up for a paediatric patient. In terms of medication, my
12 experience of going to the paediatric ward would have
13 been, rarely, to write maybe a discharge letter, so
14 I don't know whose responsibility it is to write up the
15 fluids for the paediatric patients.
16 Q. Do I take it from that that you wouldn't have been aware
17 of there being any different views as to who was
18 responsible for what in relation to the surgical
19 patients on Ward 6 on fluids, you wouldn't have been
20 aware of that?
21 A. No.
22 Q. You probably are aware now that after Raychel's death
23 there was a critical review meeting on 12 June. During
24 that meeting there was a general discussion and part of
25 that discussion was to do with a view that was emerging

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1 you aware of the fact that if you are in Ward 6, which
2 obviously is a paediatric ward, that you had available
3 to you paediatricians to ask questions of if you should
4 have any concerns about what you were going to do
5 in relation to a patient?
6 A. Oh yes, yes.
7 Q. And you wouldn't have had any hesitation in doing that?
8 A. None at all.
9 Q. Have you ever done that?
10 A. I can't remember, but as a JHO you knew most people
11 in the hospital, so if you wanted advice you'd ask the
12 person who'd give you the advice you wanted, so
13 I wouldn't have had any hesitation. I can't recall
14 whether or not I ever asked for paediatric advice, but
15 I would have done so.
16 THE CHAIRMAN: You don't see any reason why you wouldn't
17 have asked a paediatrician for advice if you needed it
18 in relation to a child on Ward 6?
19 A. Definitely not.
20 MS ANYADIKE-DANES: In fact, given your level of experience
21 in paediatric matters, would you have considered that an
22 entirely natural thing to do, to ask for the view of
23 a paediatric colleague?
24 A. Entirely, yes.
25 Q. Thank you. I want to ask you now about the specifics of

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1 your involvement with Raychel and your attendance on
2 her. In your first witness statement for the inquiry,
3 which was a witness statement that you made in 2011, you
4 said at 028/1, page 2:

5 "I have a very limited recollection of specific
6 events on the evening/night of 8 June. I was contacted
7 by a staff nurse on Ward 6, which is a children's ward,
8 and asked to prescribe/administer an anti-emetic for
9 Raychel, who had vomited. I noted she was
10 post-operative following appendicectomy and I would have
11 spoken to the staff nurse prior to seeing Raychel."

12 Staff Nurse Gilchrist, that is the nurse who
13 contacted you?

14 A. Yes, I believe so.

15 Q. Her evidence at 053/1 at page 3:

16 "I contacted the surgical JHO on call, a locum named
17 Dr Michael Curran."

18 Could I pause there and ask why she refers to you as
19 a locum, do you know?

20 A. No. I guess your involvement in the paediatric ward
21 would have been so limited that perhaps they wouldn't
22 have known you as well. If you were one of the adult
23 surgical nurses -- or the medical surgical nurses, you
24 probably know every one of the 12.

25 Q. She goes on to say:

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1 at 3.19 am, it ends in "3106". That was the phone
2 extension for Ward 6. Your bleeper would bring up 3106.

3 Q. So these are unique identifiers, are they?

4 A. They're just phone extensions.

5 Q. So for example, if we look at 3187, which actually
6 occurs about four or five times that evening, that would
7 be a particular extension, would it?

8 A. Yes. I can't recollect which ward, but that was an
9 extension.

10 Q. I only ask you that because if one goes back again to
11 the far left-hand side and one looks at the time when
12 you are likely to be involved with Raychel, if you were
13 to take 3.15, say, and work your way down to 4.49, just
14 before 5 o'clock, and the evidence seems to suggest --
15 although we can't be precise -- that that's when the
16 SHO, Mr Zafar, and the registrar, Mr Bhalla, arrived on
17 the surgical side, if I can put it that way. If we took
18 that as a block, one can see that you're receiving
19 a number of pages in that time frame. And one of them
20 is this "3457" and the "3187" that I just mentioned to
21 you. Do you know at this remove what extensions those
22 are?

23 A. No, not those ones. The one above it, "3680", was
24 casualty, actually. "2005" was an outside line, usually
25 a GP. The "3187", no.

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1 "I explained to him about Raychel's nausea and
2 vomiting and he said he would come to see her. He
3 arrived on the ward at approximately 10 o'clock and
4 administered cyclizine at 10.15 and Raychel's nausea
5 subsided at this time and she fell asleep."

6 Let's just pause there. How would you have been
7 contacted? Would it have been via a bleeper?

8 A. Yes.

9 Q. You have provided a page of your bleeper. It has more
10 significance when we get to the second time that you are
11 contacted because one of the things you do is you use it
12 to try and assist in timing when you were contacted.
13 But I wonder if you can help us by explaining how it
14 works so that we can interpret it? It's to be found at
15 028/2, page 18.

16 Obviously, the date and time. That's fairly
17 obvious. Then the duration, that's the next column,
18 isn't it? And as for the source, what does -- there
19 seem to be two different ones there, "A004" and "A003";
20 what do they tell you?

21 A. I don't know if the source has any relevance. I don't
22 know what that means. The source and the destination,
23 I don't know what that means. But if I just go across
24 to where it says "digits", the last four numbers refer
25 to a particular phone extension. So if I look at 9 June

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1 Q. Or the "4138"?

2 A. No, sorry.

3 Q. Okay. But you do recall that "3106" is Ward 6?

4 A. That's only because it was 3105 for ward 5, 06, 07, 08,
5 09. That's the only reason I remember them.

6 Q. I understand. Thank you. Just as a matter of interest,
7 you have got that which covers essentially the period
8 when you came to see Raychel the second time. Would
9 they have had the records that would have covered the
10 first time you went to see Raychel?

11 A. I didn't get them. I went to switchboard to just get
12 a printout, but they obviously only printed me out from
13 the 9th.

14 Q. Okay. I'm going to ask you a little bit about that
15 later on, but I just wanted to establish what those
16 things meant. Is there anything that records on this
17 type of documentation the bleeps that you issue
18 yourself? These are the ones that you received. Does
19 anything record what you make?

20 A. No, because you're just making the bleep from the phone
21 line.

22 Q. So you're just using a normal phone line?

23 A. Yes. I asked for a copy of my pages for the 9th and
24 a copy of the pages for the surgical SHO, so I had
25 a copy of those two. In terms of me bleeping other

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1 people, you would have to get a copy of the pager number
2 for the other person.

3 Q. So you don't have a device, like a text thing, where you
4 can reach other people, you're just going to use
5 a normal phone and ask them to bleep Mr Zafar or
6 Mr Bhalla, for example?

7 A. Yes.

8 Q. And you would need to look at their corresponding record
9 if you wanted to see exactly when they received that?

10 A. Yes.

11 Q. Thank you. Staff Nurse Gilchrist also says that at the
12 time that she made contact with you, bleeped you, she
13 found Raychel to be nauseated and pale. Her obs were
14 stable, though, and she didn't regard post-operative
15 vomiting as unusual. But that's the description that
16 she had. Can you recall: did you actually speak to her
17 when you arrived on the ward?

18 A. I spoke to -- well, I can recall speaking to a nurse,
19 but I don't know which nurse I spoke to.

20 THE CHAIRMAN: The sequence I got earlier this week was
21 along these lines: a doctor receives a bleep. Does the
22 doctor then typically ring the ward from which the bleep
23 has come to find out what the problem is?

24 A. Yes. Because your bleeper would bring up 3106 and I'd
25 ring 3106.

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1 this, but how confident are you that you did speak to
2 a nurse when you got to Ward 6?

3 A. I believe I did. When you get to Ward 6 obviously the
4 door is locked, you have to get bleeped in by someone.
5 When I went to Ward 6, I would not have known where
6 Raychel was, which room she was in. I would have had to
7 speak to the nurse to get the medication, so I believe
8 I spoke to a nurse, but if you ask me specifics of what
9 was said, I can't recollect at all.

10 THE CHAIRMAN: Okay.

11 MS ANYADIKE-DANES: Is part of that because these are nurses
12 on a paediatric ward, which is a ward that you weren't
13 very familiar with, so they're not nurses that you would
14 be working regularly with?

15 A. I think that's fair. Most of the nurses in the surgical
16 ward I'd know by first name.

17 Q. Just to help you, Staff Nurse Noble's evidence was that
18 she doesn't recall speaking to you at all. She
19 certainly anticipated that you would be giving an
20 anti-emetic. That's why they wanted a doctor to come,
21 she had that discussion with Staff Nurse Gilchrist, but
22 she does not believe that she spoke to you. Staff
23 Nurse Gilchrist equally is of the view that she didn't
24 speak to you, and there seems to be no suggestion that
25 Staff Nurse Bryce spoke to you. So the significance of

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1 THE CHAIRMAN: You'd ring Ward 6 and in effect say, "I'm
2 Dr Curran, why are you bleeping me?"

3 A. Yes.

4 THE CHAIRMAN: At that point are you given a general rather
5 than a detailed explanation of what you might be wanted
6 for and then you go to the ward and you are typically
7 given more detail?

8 A. No, it could happen either way. You could be just told
9 the first time.

10 MS ANYADIKE-DANES: But when you said that you spoke to
11 a nurse, could it have been that that is when you spoke
12 to the nurse when you phoned back to find out what the
13 reason for the bleeping was?

14 A. I definitely spoke to the nurse when I phoned back, but
15 when I went to the ward I would have had to speak to the
16 nurse as well.

17 Q. That's one of the things I want to explore with you as
18 to whether you did necessarily. The difficulty is that
19 the nurses who were on duty then, there were three of
20 them: you may know now one is Staff Nurse Gilchrist,
21 then there's Staff Nurse Noble and Staff Nurse Bryce.
22 None of them appear to remember speaking to you.

23 A. When I went to Ward 6?

24 Q. Yes.

25 THE CHAIRMAN: I know that your memory isn't complete on

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1 this is to try and see what information you had and what
2 your expectations were about what you were to do with
3 Raychel when you arrived, and at the moment we don't
4 have any information from the nurses to say what they
5 would have been telling you at that stage and helping
6 you with. So it would seem from their point of view
7 that they had communicated to you -- this is what Staff
8 Nurse Gilchrist says -- that Raychel was nauseated,
9 she'd been vomiting and that was what they really wanted
10 to have addressed, her vomiting, and that that had been
11 communicated to you. And effectively, what they were
12 expecting you to do was to administer the anti-emetic.
13 And they didn't seem to feel that they personally needed
14 to tell you very much more and you would conduct your
15 own examination and form a view as to what was the
16 appropriate thing to be done with Raychel. That's why
17 I'm pressing you a little on this.

18 A. My recollection, whether it was on the telephone after
19 answering the page or whether it was when I spoke to
20 them on the ward, is that I was simply asked to do
21 a routine task, to administer an anti-emetic. There was
22 nothing uncommon about this. It is something that we
23 did routinely several times on a shift. If you're asked
24 to give an anti-emetic, then you go and give an
25 anti-emetic. If you nurse or someone is worried about

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1 a patient and asking you to come and assess a patient,
2 I certainly differentiate those two things. So
3 I believe I was simply asked to come and administer an
4 anti-emetic and I think if the nursing staff had been
5 able to administer the anti-emetic themselves, I don't
6 think I would have been called to see Raychel.

7 Q. Well, can I put to you directly what Staff Nurse Noble
8 is saying? It's in her transcript of 27 February of
9 this year. If we go to pages 79 and 80, pull those up
10 together. You can see there, starting at line 6,
11 the suggestion that had been put to her was that really
12 she and Staff Nurse Gilchrist were expecting that you
13 would come and prescribe an anti-emetic, and effectively
14 almost as you're saying, that would be the end of that:
15 we want an anti-emetic, we need a doctor, he's going to
16 come and prescribe it:

17 "Yes, but a doctor must see the patient and make his
18 own assessment. I mean, I wouldn't advise a doctor to
19 do anything without making a full assessment of the
20 patient before doing so."

21 Did you understand that that's what you were going
22 to do when you came to see Raychel?

23 A. No. I was coming to give an anti-emetic for someone who
24 was vomiting. This is something we do commonly as
25 a JHO. When you do see someone, you're obviously going

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1 A. Yes.

2 Q. What else did you do?

3 A. The extent of my assessment observation of Raychel now
4 would have been to look at her obs charts for her
5 temperature, for infection, and to palpate her tummy and
6 simply to look at her and see whether she was
7 distressed. Beyond that, my role there, as I seen it,
8 was simply to be asked to come and give an anti-emetic,
9 which seemed appropriate.

10 Q. Well, given the fact that you didn't literally just come
11 and administer an anti-emetic, you did think it was
12 necessary to look at her charts or some of them, you did
13 think it was necessary to examine her abdomen. So
14 you're not literally just coming to do exactly what you
15 think the nurse has asked you to do. You are going to
16 exercise some judgment of your own as to what to do
17 in relation to that patient.

18 A. You're going to make a limited assessment. You'd be
19 certainly negligent not to put a hand on someone's tummy
20 after they have had surgery.

21 Q. Exactly.

22 A. What I'm looking for there is for an obvious
23 post-surgical complication, something which would worry
24 me such as the wound breaking down internally, internal
25 bleeding, if her heart rate was particularly high or she

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1 to take in some information, you're going to look at the
2 patient. When I seen Raychel, Raychel was not vomiting
3 when I seen her. She wasn't retching and didn't look
4 distressed when I'd seen her. I was only with Raychel
5 for maybe 10 minutes in total, at most.

6 THE CHAIRMAN: Sorry, why would it take that long? If all
7 you did was come along and give an anti-emetic, how
8 would it take 10 minutes?

9 A. There are certain things that you do. If someone is
10 vomiting, a surgical patient with an appendicectomy, you
11 would palpate the stomach.

12 THE CHAIRMAN: Would you describe for us what you did when
13 you saw Raychel?

14 A. I would have went and obviously said hello to Raychel,
15 I can't recollect if mum or dad was there when
16 I visited. I would have checked her obs chart for her
17 temperature.

18 THE CHAIRMAN: Did you remember if you got a response? Was
19 she awake to respond to you?

20 A. She responded to me. And whenever -- so I would have
21 been looking really for post-operative infection or,
22 because she was post-appendicectomy, you would feel the
23 tummy to make sure that the wound hadn't broken down or
24 she wasn't sitting there with a rigid abdomen.

25 MS ANYADIKE-DANES: And you did that?

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1 had a fever to suggest infection. That's what I'm
2 primarily looking at.

3 Q. At this stage, you accept that you've been told that
4 this is a post-surgical patient who has been suffering
5 vomiting and is nauseous.

6 A. Yes.

7 Q. So you know that?

8 A. Yes.

9 Q. And you say that you've looked at her charts. Let's see
10 if we can gather together the information that you
11 actually had.

12 MR QUINN: Just before my learned friend goes on to that,
13 when this doctor says that she responded to him -- and
14 I've made a careful note of that -- could we ask
15 what was the response? Because it was 8 o'clock in the
16 evening as we understand it.

17 THE CHAIRMAN: 10 o'clock.

18 MR QUINN: Sorry, 2200 hours. At that stage, Raychel would
19 have been quite far gone, we assume. But I would like
20 to hear anyway what this doctor says about her reaction,
21 what reaction he goes from her, and what response, to be
22 clear about the wording.

23 A. I think all she said to me was "hi", "hello", something
24 like that.

25 MS ANYADIKE-DANES: What was her demeanour?

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1 A. She was lying in bed, she wasn't vomiting, her eyes were
2 open.
3 Q. Did she appear unwell to you?
4 A. She didn't look like she was vomiting or distressed,
5 but ... Did she look unwell? She didn't look
6 particularly unwell.
7 Q. She didn't? Did she look pale at all, which was
8 a description that has been given of her at various
9 times?
10 A. It wasn't something that I thought she looked pale, no,
11 at the time I had seen her. I think I was bleeped
12 perhaps maybe 9.30, roughly, and I think I was in the
13 ward maybe 10.10. So it was maybe 40 minutes after,
14 roughly.
15 Q. Apart from you being told that she was nauseous and
16 vomiting, and you looked at the notes, what were you
17 looking for in those notes?
18 A. When I say I looked at the notes, I mean I looked at the
19 TPR chart, the temperature, pulse, respiration.
20 Q. I should have clarified that with you because there has
21 been some evidence of the fact that not all a patient's
22 notes are kept by the bedside or at the foot of the bed:
23 some of them are kept in the nurses' station and some by
24 the foot of the bed. So far as you're concerned,
25 what was available to you to look at?

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1 the nurses was that Raychel has had an appendicectomy
2 and she's been sick and needs an anti-emetic, not that
3 there was a problem. You can say that the vomiting is
4 a problem, but vomiting post surgery is very common.
5 THE CHAIRMAN: But by this time the surgery was about
6 22 hours previously.
7 A. Yes.
8 MS ANYADIKE-DANES: I was going to ask him that,
9 Mr Chairman.
10 THE CHAIRMAN: Did you know that?
11 A. I had known that the surgery was in the early hours of
12 that day. Maybe not 22 hours, but I knew the surgery
13 wasn't during the 9 to 5 period.
14 MS ANYADIKE-DANES: But if you were thinking that the
15 vomiting might be related to the surgery, should you not
16 have tried to find out when was the surgery, have they
17 given her anything in relation to that vomiting before
18 and how has that worked or why hasn't it worked?
19 Is that not the sort of questions you should have been
20 asking the nurse if she was available to you?
21 A. Sorry, I did speak to the nurse. I spoke to the nurse,
22 whether it be by telephone -- and I also believe
23 I briefly spoke to the nurse when I arrived on the ward
24 to get the medication and get into wherever it was ...
25 Sorry, can you ask your question again?

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1 A. I don't know what was at the bottom of the bed, but
2 I certainly looked at the one that had her temperature on
3 it, which is the TPR chart, temperature, pulse,
4 respiration chart and her drug sheet.
5 Q. Since you've been told that she's been vomiting and you
6 can see that she's on IV fluids, would you have looked
7 at her fluid balance chart?
8 A. No.
9 Q. Do you think you should have looked at her fluid balance
10 chart?
11 A. At the time no, because she was on intravenous fluids,
12 she wasn't actively vomiting and my role as the JHO
13 there, as I understood it, was to give the anti-emetic
14 to make sure she doesn't vomit again.
15 Q. I understand that. But would you not be trying to see
16 what the incidence of vomiting is? And if you had
17 looked at her fluid balance chart, that's where you
18 would expect to see that recorded.
19 A. I felt I had that information from chatting to the
20 nurses, whether it be on the telephone or in person.
21 THE CHAIRMAN: So the information you had from the nurses
22 was in effect that there was a problem about Raychel
23 vomiting, that she was vomiting, which is why you were
24 being asked to come to give the anti-emetic?
25 A. I would just like to clarify that. The information from

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1 Q. Let's start with speaking to the nurse when you're on
2 the ward because on your view you did speak to a nurse.
3 So let's deal with that.
4 A. I wouldn't have had the cyclizine.
5 Q. Exactly. So if you know that this is a post-operative
6 patient who has been vomiting, is it not a relevant
7 thing to find out when she did have her surgery and how
8 long has she been vomiting for; is that not relevant?
9 A. The timing of surgery is obviously relevant and I would
10 have known the surgery was in the early hours of the
11 morning.
12 Q. Would you have known that because you asked that?
13 A. I would have been told that.
14 Q. Were you told that because you asked that?
15 A. Sorry, I don't know whether I was told that on the phone
16 or whether I asked that. But I would have known the
17 information when the surgery was, give or take a couple
18 of hours.
19 Q. So you'd have known it happened sometimes in the early
20 hours of the morning? That was your impression if I can
21 put it that way.
22 A. Yes.
23 Q. If you'd looked, of course, at her notes you could have
24 found out exactly when it was. Did it occur to you that
25 it might be useful to know exactly when it was as

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1 opposed to having an impression about it?
2 A. It didn't seem -- I -- no, is the answer to that
3 question. I knew roughly when the surgery was give or
4 take roughly two hours.
5 Q. Did you know how long she'd been vomiting for?
6 A. How many times she'd vomited?
7 Q. No, firstly the period of time over which she had been
8 vomiting. So in other words, when her first vomit was.
9 A. No.
10 Q. You didn't know that?
11 A. No.
12 Q. Well, since you were thinking that this might be
13 post-operative vomiting, did it not strike you that,
14 well, if I want to test that hypothesis, maybe I'll find
15 out when she first started?
16 A. I understand entirely what you're saying there, but
17 you are reliant on what you're being told. Having given
18 anti-emetics many times, if you are told someone needs
19 an anti-emetic because they're vomiting you don't
20 question that.
21 THE CHAIRMAN: I think, doctor, the question is this: are
22 you dependent on what you're told, or should you not
23 also be checking the records? And how much differently
24 you would have acted had you checked the fluid balance
25 chart we may not know, but the fluid balance chart shows

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1 A. One, yes, I would agree with that. But also, if a nurse
2 phoned me and said something to me that ... If someone
3 phones me and says, "This patient, whoever it may be, is
4 vomiting, I'm concerned", then my reaction to that will
5 be, "I'll come, I'll give the anti-emetic and I'll do an
6 examination", prior to automatically phoning the SHO.
7 I differentiate being asked to assess someone from being
8 asked to give an anti-emetic. But if anyone who
9 I consider more senior to me -- and that involves
10 nurses, SHOs, whatever -- says to me that they're
11 concerned about a patient -- especially a paediatric
12 patient given the obvious lack of experience -- you are
13 not going to go and say, "There's the anti-emetic,
14 things are grand". You're going to go and give the
15 anti-emetic, do a quick examination and phone the
16 surgical SHO and make sure the surgical SHO sees the
17 patient.
18 MS ANYADIKE-DANES: Yes. What I'm inviting you to see or
19 help me with is that, although you are a JHO, you are
20 a doctor nonetheless.
21 A. Mm-hm.
22 Q. And you have been asked by a nurse to come and
23 administer, on your understanding of it, an anti-emetic.
24 But you have thought that it was appropriate to carry
25 out some, however limited, examination of Raychel

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1 that Raychel didn't vomit at all after the operation
2 until about 8 o'clock. And she's then vomiting -- even
3 on the chart, which I know is incomplete in terms of
4 recording vomits, that she had vomited a number of times
5 fairly consistently from 8 o'clock in the morning
6 through the morning, through the afternoon, and now into
7 the evening, and you're being called because she's
8 vomiting again in the evening. Did you know from the --
9 so you don't just go by what -- sorry.
10 The suggestion from the experts, which you'll be
11 asked to comment on, is that you don't just go by what
12 you're told. Sorry, I should say the suggestion from
13 some of the experts is that you don't just go by what
14 you're told. Should you not also have looked at the
15 records which were available at the bed at least, which
16 included the fluid balance chart?
17 A. I would disagree with that. Having been in the
18 situation many times when you're asked to do something.
19 Put it another way, if someone -- if a nurse is
20 concerned about a patient, concerned something is
21 abnormal, they won't phone the JHO, they will phone the
22 SHO.
23 THE CHAIRMAN: So am I to understand from your perspective
24 the fact that she phones you is an indication of the
25 extent of her concern?

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1 because I think, in your view, if you didn't at least
2 put your hand on her stomach, you'd be negligent.
3 A. Yes.
4 Q. So you have to do something, you don't just administer
5 the anti-emetic and walk away to your next task. So you
6 do something. What I'm teasing out with you is what
7 would have been reasonable or appropriate, more, for you
8 to have done. And what I'm inviting you to consider
9 is that when you are being called to see a patient for
10 the reasons to do with vomiting and which you yourself
11 are thinking this could be post-surgical vomiting, then
12 the very least you could do is ask some questions, look
13 at the notes, in relation to the vomiting so that you
14 can be either of best use to that patient or at least
15 know whether you're in a situation where maybe I ought
16 to be telling my SHO about this. Maybe it's not just so
17 straightforward. That's what I'm asking you to
18 consider.
19 A. Yes. I guess from -- sorry, I know from the lack of
20 concern from the nurse, I didn't consider phoning the
21 SHO. The idea of palpating someone's tummy and checking
22 their temperature is something you would do in any
23 patient you've seen who is post abdominal surgery. So
24 that wasn't something I would do with Raychel that
25 I wouldn't have done with something else, that is just

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1 something you'd automatically do.
2 Q. Yes.
3 A. But the surgical complications I would have seen would
4 have been picked up by looking at a temperature chart
5 and feeling an abdomen.
6 Q. Can I put it to you this way? Let's say the nurse
7 hadn't been there, it's as the nurses say, which is that
8 they had had a conversation with you on the telephone,
9 told you about the nausea and the vomiting and the idea
10 that what might sort this out is an anti-emetic, can you
11 come please and attend the patient, and when you arrive
12 you are let in in some way, but there's no nurse to
13 assist you with the history. If that was the situation,
14 what would you have wanted to look at?
15 A. Sorry, you're assuming I didn't speak to the nurse on
16 the phone prior to going to the ward?
17 Q. You have spoken to the nurse on the phone and that's
18 when you're told the child has whatever surgery, late
19 evening early hours of the morning, she's nauseous, been
20 vomiting, and we think that an anti-emetic might be
21 appropriate, but could you come? If that's all that you
22 knew and you were there --
23 THE CHAIRMAN: First of all, let's stop at that point.
24 Is that a realistic scenario of what you might have been
25 told on the phone?

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1 you can see the one that's struck through. You struck
2 that through, didn't you?
3 A. Yes, I wrote the wrong time, I think.
4 Q. Okay. Then you can see you have "Valoid, IV stat" and
5 that's you signing off at 10.15.
6 A. Yes.
7 Q. You can see a little bit above that, the second line,
8 you can see the Zofran, and that's signed by Dr Gund;
9 "if required" is the notation there. So let's just,
10 since you must have seen this document because you wrote
11 in it, would you have wanted to know, "I wonder if she
12 did require that and whether she'd received it"?
13 A. Sorry, um ...
14 THE CHAIRMAN: This document doesn't tell you if Raychel had
15 already received the anti-emetic.
16 A. Sorry, I see.
17 THE CHAIRMAN: It tells you that it's prescribed if
18 required, but it doesn't say that it has been given. So
19 first of all, did you know whether she had received an
20 anti-emetic earlier in the day?
21 A. I honestly can't recollect.
22 THE CHAIRMAN: Would it make a difference to know if she'd
23 already received an anti-emetic because that might
24 suggest that if she'd already had an anti-emetic, which
25 is the standard treatment for a child who is vomiting,

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1 A. I'd put it more succinctly, that I was told that Raychel
2 was a post-operative patient who has had vomiting and
3 needs to be given an anti-emetic.
4 MS ANYADIKE-DANES: Right. Let's say that's what you're
5 told. When you arrive, there isn't a nurse to attend
6 you, to give you any more details about Raychel's
7 condition, if I can put it that way. Would you have
8 looked in her notes in such a situation?
9 A. No, I wouldn't have looked in her notes. If I knew the
10 time she had her surgery approximately and I was going
11 to feel her tummy and check her temperature and I knew
12 she was on intravenous fluids, based on the information
13 I was given I would have felt it was appropriate to give
14 the anti-emetic and see how she responds to it.
15 THE CHAIRMAN: Would you have enquired whether this was the
16 first anti-emetic she had received?
17 A. Would I have enquired? Um ... When I wrote it up,
18 I wrote it up on the drug kardex, so I would have seen
19 presumably that the Zofran had been administered. So if
20 you're asking was I aware that she'd had Zofran, I can't
21 recollect, but it seems it was on the drug kardex, so
22 I can only assume ...
23 MS ANYADIKE-DANES: It's not necessarily immediately above
24 where you would have entered it. We can go to it
25 if we pull up 020-017-034. There you can see "Valoid",

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1 and that hasn't worked and the vomiting has continued,
2 there might be more to this than post-operative nausea
3 and vomiting?
4 A. It would have been relevant to know it.
5 THE CHAIRMAN: Yes.
6 A. But at the same time, it wouldn't have changed what
7 I did.
8 THE CHAIRMAN: And when you say that, do you mean that it
9 would not be unusual to give a second dose of
10 anti-emetic to a patient?
11 A. Yes. I think it's -- as a JHO, I think I've said
12 several times, we have given second doses of
13 anti-emetics, which wasn't unusual. My reference for
14 whether vomiting -- there's no lectures or training on
15 is this amount of vomiting unusual or is this amount of
16 vomiting excessive or is it normal post-operative nausea
17 and vomiting. There's no training to that effect.
18 I suppose you could say, "I may have been falsely
19 reassured because no concerns were raised to me that
20 this was anything other than post-operative nausea and
21 vomiting", but you can only act either in reference to
22 training you have received or experience you've had to
23 date. And if the experience you have had to date
24 is that a second dose of anti-emetic is a reasonable
25 thing to give, then you will give it. If someone else

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1 raises a concern to you who is more experienced and they
2 say, "Hang on, there's something not right here, we
3 shouldn't be giving just an anti-emetic, we should be
4 doing something more", then you'd do something more, but
5 you can only act in reference to what you've learnt.
6 MS ANYADIKE-DANES: I understand that. If you had known
7 that there was a previous anti-emetic administered,
8 would you not have wanted to know when it was and what
9 happened in relation to it? Because even though from
10 your point of view you're still going to go and give the
11 anti-emetic because that's what you think is appropriate
12 and that's what more senior people are telling you, but
13 it might have suggested that maybe I'll just tell my SHO
14 about that, if nothing else as a learning point.
15 A. Sure. I find it difficult because I can't recollect
16 whether I knew or did not know that Raychel had received
17 Zofran prior to it. I may have known that, I just don't
18 recollect that.
19 Q. Dr Devlin was of the view that if he had been coming
20 again, so he'd known about the first one, which might be
21 because he had administered it or somebody had told him
22 and he was coming again at the time that you came, that
23 that might have been relevant for him to know that and
24 it might have, not necessarily conclusively, but it
25 might have persuaded him that perhaps an electrolyte

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1 a factor which you would have had to consider in
2 deciding what to do or who to call, if anybody?
3 A. Coffee-ground vomiting by definition means there's
4 bleeding somewhere in the upper gastrointestinal tract.
5 It's certainly something I would have been very scared
6 of as a JHO. If in Raychel's case, if there was
7 coffee-ground vomiting, it would have been automatic
8 that I would have asked the SHO to see her.
9 THE CHAIRMAN: The problem is, doctor, the fact is that
10 coffee-ground vomiting is on the fluid balance sheet.
11 A. I never looked at the fluid balance sheet.
12 THE CHAIRMAN: That's the point. The point is whether you
13 should have looked at the fluid balance sheet.
14 At the end of Raychel's bed, as we understand it,
15 there's very limited information. There's the
16 observation chart, which you refer to as the TPR,
17 there's the kardex and, as we understand it, the only
18 other document there is the fluid balance sheet.
19 A. That may have been there.
20 THE CHAIRMAN: I have to say, doctor, I'm working on the
21 basis that it was there because I've been repeatedly
22 told it's there and that's where the entries about the
23 vomiting are. In fact, it was that which had led to you
24 being called.
25 A. Sir, I totally accept what you're saying. I didn't look

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1 test would be appropriate or at least to have discussed
2 that with somebody.
3 A. If I had known Zofran was given, I don't think it would
4 have changed what I did. And the certain things that
5 would have maybe made me contact the SHO ... But
6 I wouldn't have considered doing a blood test.
7 Q. Would it have predisposed you to contacting your SHO?
8 A. The fact that she had a second anti-emetic?
9 Q. Yes.
10 A. No.
11 THE CHAIRMAN: The type of vomiting had changed. And as we
12 understand it, it was now coffee-ground vomiting, which
13 it had not been earlier on in the day. Our
14 understanding is that that indicates an increase in the
15 concern which one might have about vomiting; do you
16 agree with that?
17 A. Yes.
18 THE CHAIRMAN: Right. So what had changed since Dr Devlin
19 had been there was that the anti-emetic had been given,
20 but had not brought an end to the vomiting. You say
21 that of itself is not necessarily unusual. She had
22 vomited a number of times. You were being called back
23 and the nature of the vomiting had changed. If you'd
24 known that the nature of the vomiting has changed, which
25 would be apparent from the fluid balance sheet, is that

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1 at the fluid balance chart, but the reason I didn't look
2 at the fluid balance chart is because Raychel was on
3 intravenous fluids. I don't write up intravenous fluids
4 as a JHO for a patient. She was on fluids. My concern
5 was to prevent dehydration by giving her the
6 anti-emetic.
7 THE CHAIRMAN: Sorry, doctor, the fluid balance chart
8 doesn't just tell you about the IV fluid, it also tells
9 you about the amount of vomiting. It gives some hint,
10 which is a bit vague, about the volume of vomits, but it
11 also specifically in Raychel's case would have told you
12 about the type of vomiting, and I now understand from
13 what you're saying that, had you known it was
14 coffee-ground vomiting, you'd have certainly gone to the
15 SHO.
16 A. Yes.
17 MS ANYADIKE-DANES: Just to finish that off, since we've
18 been talking about it so much, it's 020-018-037 --
19 THE CHAIRMAN: Can I take it from these answers, doctor,
20 that you were not told by a nurse that it was
21 coffee-ground vomiting?
22 A. I was definitely not told it was coffee-ground vomiting.
23 THE CHAIRMAN: Thank you.
24 MS ANYADIKE-DANES: Here it is. Had you looked at it or had
25 somebody suggested that you did look at it, this is what

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1 was available for you to see. It gives you the period
2 of time over which she has been vomiting, the vomits
3 that the chairman has just been pointing out to you, and
4 some indication of the volume. You can see "large
5 vomit", "vomited plus plus", and so on. Then you can
6 see -- well, if we go to the relevant time for you,
7 obviously you came at 10 o'clock or there or
8 thereabouts. The 9 o'clock one, if you see that time,
9 you can see "vomiting coffee grounds plus plus" and
10 that's signed by Staff Nurse Gilchrist, who is the staff
11 nurse who contacted you. So that's what had happened
12 just approximate to when you were being contacted about
13 the anti-emetic. In fact, you can also see, if you look
14 at her outputs, you have got the vomit, but you can see
15 that according to this she's only got one recorded
16 urine. So what I was trying to --

17 THE CHAIRMAN: I think, on the evidence we've been given,
18 it's not unusual for a chart in Altnagelvin to show only
19 one recorded passage of urine. The Altnagelvin records
20 at those times just didn't tell you. They told you the
21 first time a child had passed urine and not afterwards.

22 MS ANYADIKE-DANES: I beg your pardon then, Mr Chairman.

23 So you'd have appreciated from that that she passed
24 urine at 10 o'clock and then you would have no knowledge
25 of what she passed or didn't pass from then on, as

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1 a red flag. But I would put it to you in a context of
2 being a JHO, being asked to do something that was
3 routine with nothing else voiced to you other than
4 a person needs an anti-emetic. I had that call so many
5 times. You come, you give the anti-emetic. Certain
6 things prompt you to seek further senior help. In
7 Raychel's case, I thought I was simply treating
8 post-operative nausea and vomiting.

9 THE CHAIRMAN: You're emphasising the importance of the
10 vomiting having changed to coffee-ground vomiting;
11 right?

12 A. Yes.

13 THE CHAIRMAN: If you'd been told that by the nurse -- and
14 I know that your estimate is it took you between 30 and
15 40 minutes to be available to go from wherever you were
16 to Ward 6 -- would you have said to the nurse on the
17 phone, "Get an SHO"?

18 A. I would have went to Ward 6 straightaway and I would
19 have automatically phoned the SHO.

20 THE CHAIRMAN: If you'd known it was coffee-ground vomiting,
21 you'd have given Raychel more priority than you did?

22 A. Yes. I would have given her the anti-emetic to stop it,
23 I would have phoned the SHO and said, "Look, this child
24 is unwell".

25 MS ANYADIKE-DANES: No, sorry. I took the chairman to be

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1 I understand from the Altnagelvin records. But in any
2 event, you would have been able to see this pattern,
3 leaving aside everything that comes after 9 o'clock,
4 this pattern of her vomiting. And if you had gone to
5 the next page in the kardex where you signed off, you'd
6 have seen that indeed that anti-emetic was required and
7 it was administered and you'd see that it was
8 administered by Dr Devlin and what time it was
9 administered. Sorry, you wouldn't have seen the time,
10 that's exactly the problem. He didn't indicate the
11 time. So you wouldn't have known that, so you would
12 have had to ask about that. But you'd have seen that it
13 had been administered. And what I'm inviting you to
14 consider is whether it was appropriate for you to come
15 and effectively just administer the anti-emetic or
16 whether you should have taken the opportunity to
17 interrogate a little further as to what was happening,
18 not necessarily so that you yourself could make
19 a diagnosis, but so that you would be armed with
20 information to give your SHO or any other more senior
21 colleague. That's what I'm inviting you to consider,
22 whether you didn't think that you missed an opportunity.
23 A. Retrospectively, looking back, yes, I could have had
24 more information. Obviously, from looking at the fluid
25 balance chart, coffee-ground vomiting would have been

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1 asking you a slightly different question. When he said
2 more priority, would that have meant you would have gone
3 to see her sooner?

4 A. Yes.

5 THE CHAIRMAN: He did say that.

6 MS ANYADIKE-DANES: And just so that we have it, it seems
7 what you're saying is that the responsibility for
8 letting you know whether there were any of these
9 additional features, if I can put it that way, to
10 Raychel's condition, the length of time she'd been
11 vomiting, the nature and volume of the vomit, whether
12 she persisted after a first anti-emetic and so on, the
13 responsibility for conveying that information to you
14 is that of the nurses. That would seem to be how you're
15 putting it, as opposed to you finding out what there
16 might be available to know about her condition.

17 MR STITT: Can I just intervene? I didn't understand that
18 to be the import of the answer because it's predicated
19 on that being the previous -- pulling it together, the
20 sum of the previous answers. The witness has
21 said: look, I didn't look at the fluid balance chart and
22 if I had done and I had seen what is written there, that
23 would have prompted me. And if I had been told by the
24 nurses, then I would have come quicker and I would have
25 taken different steps. But I didn't see the answers as

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1 saying it was the responsibility of the nurses solely to
2 prompt such further action.

3 MS ANYADIKE-DANES: I'm sorry, Mr Chairman. I was actually
4 drawing together not just those last two previous
5 answers, but a number of answers that this witness has
6 given about what further information he might have
7 wanted. I understood him to be saying that if there was
8 anything other than just, as far as we're concerned,
9 administering the anti-emetic, that he would be
10 expecting those additional features of the sort I just
11 described to be information furnished to you by the
12 nurses. That's why I put it to you as a question. Who
13 has the responsibility to find out those sorts of
14 details?

15 A. I think if there's a red flag symptom such as coffee
16 grounds, I think the person who knows that information
17 should have the responsibility to pass that information
18 on.

19 THE CHAIRMAN: And your point is on that that when you were
20 called, when you responded to the bleep, the level of
21 concern or the extent of your intervention did not
22 incorporate anything to do with coffee-ground vomiting?
23 Had it done so --

24 A. I wasn't aware of coffee-ground vomiting.

25 THE CHAIRMAN: Okay.

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1 The other point I want to make is that he says three
2 lines further down that:

3 "She was not actively vomiting or distressed when
4 I assessed her."

5 An assessment means that he did assess her.

6 THE CHAIRMAN: Yes, but the doctor has explained what the
7 extent of his assessment was. He's specifically not
8 saying it was a full assessment; he's saying it was
9 a very, very limited assessment. So I understand what
10 that means now.

11 MR QUINN: With respect, sir, in the next couple of weeks
12 there's going to be a lot of information, a lot of
13 evidence given in relation to what is at the bedside and
14 what is at the nursing station because this is a very
15 important point as to what information a doctor can
16 glean from the evidence that is presented to him at the
17 bedside, rather than having to go back to the nurses'
18 station or enquire from a nurse -- or as this doctor is
19 saying didn't get information that should have been
20 given by a nurse to him.

21 THE CHAIRMAN: Okay.

22 MR QUINN: In my respectful submission, at this stage it
23 must be put to him that he did have the information
24 at the bedside.

25 THE CHAIRMAN: Let me ask you this way, doctor: the evidence

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1 MR QUINN: Mr Chairman, if I could just come in here.
2 Perhaps we could have up WS028/1, page 2, please.

3 THE CHAIRMAN: That's Dr Curran's own statement.

4 MR QUINN: Yes, the handwritten version of the first
5 statement. I just want to read the bit that I want to
6 ask about and highlight here. It's about three-quarters
7 of the way down the second-hand written paragraph,
8 question 1, second paragraph:

9 "I noted her observations that are recorded on her
10 chart."

11 The questions I want to ask is that all week we've
12 been told that certain documents are kept by the bed and
13 certain documents are kept at the nursing station. And,
14 Mr Chairman, you've helpfully said that so far as you're
15 concerned -- and certainly from my point of view I was
16 taking it that there was limited documentation at the
17 bed, but that documentation definitely included the
18 fluid balance sheet.

19 THE CHAIRMAN: Yes.

20 MR QUINN: If one looks at the scant amount of information
21 that there is by the bedside, that is that we have three
22 bits of information, three sheets, how could you miss
23 looking at the fluid balance sheet? There's no other
24 information to look at. That's the point I want to make
25 and I want the witness asked that directly.

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1 I've heard so far has indicated that the fluid balance
2 chart was at the bedside, at Raychel's bedside; do you
3 challenge that or not?

4 A. No.

5 THE CHAIRMAN: Then if it was at her bedside and it's one
6 of, I think, literally about three or four pages because
7 the fluid balance sheet is one page, the kardex goes
8 into two pages, maybe it has flip sides, and what you
9 call the TPR, that's another page, maybe running into
10 two; why would you not look at the fluid balance chart?

11 A. I think the honest answer to that is that it depends on
12 what you're doing when you come to see Raychel. If
13 you're coming to do a full assessment, you will look at
14 her notes, you will look at her fluid balance chart. If
15 you're coming to administer an anti-emetic to relieve
16 vomiting, which you believe is what you've been asked to
17 do, then the information I'm most interested in is
18 simply her abdomen and her temperature. I would have
19 seen many patients in a scenario where they've been post
20 surgery and I would not necessarily have looked at fluid
21 balance charts; I would have looked at temperature and a
22 limited examination.

23 THE CHAIRMAN: Doctor, we have to take a break for a few
24 minutes for the stenographer. We'll come back at 12.10
25 and we'll resume your evidence and progress on with it

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1 then. Thank you.
2 (12.03 pm)
3 (A short break)
4 (12.13 pm)
5 (Delay in proceedings)
6 (12.18 pm)
7 MS ANYADIKE-DANES: I want to move on from the three charts
8 or documents that were available to you at the bedside
9 and to consider something else.
10 Before we got into that territory, I put to you
11 Dr Devlin's view that, had he seen Raychel twice -- so
12 he'd had the benefit of administering the anti-emetic
13 the first time round, come again, then at that stage,
14 leaving aside what contact he might have wanted to make
15 with his senior colleagues -- he might himself have been
16 thinking about electrolyte profiles.
17 I can't remember if you specifically answered
18 whether, if that were you, you'd seen her first,
19 administered the first anti-emetic, come and given the
20 second one, whether you would have had that view also?
21 A. No, I don't believe I would have.
22 Q. I thought that was your answer, but I wanted to give you
23 the opportunity to say that.
24 THE CHAIRMAN: I just want to develop that a little.
25 Dr Devlin wasn't saying yesterday that he would

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1 anti-emetic at 6 o'clock, so you would know with the
2 second anti-emetic.
3 A. Yes. But also I would have had the advantage of knowing
4 what Raychel, say, looked like at 6 o'clock and what
5 Raychel looked like at 10.15. So if I had seen
6 a patient twice, yes, that may have prompted me to act
7 differently.
8 THE CHAIRMAN: I guess the problem is it's hard to devise
9 a system to deliver that because doctors need to go off
10 duty.
11 A. Yes. Dr Devlin would have finished and I would have
12 come on.
13 THE CHAIRMAN: Okay.
14 MS ANYADIKE-DANES: Firstly, just to give you an opportunity
15 to say it, what difference do you think it might have
16 made?
17 A. I think if I had seen the same patient twice and had
18 cast eyes on the same patient twice, then as a general
19 rule it probably would have made me at least say first
20 to the nursing staff, "Look, is this quite right?", and
21 then possibly then the SHO -- I don't think it would
22 have prompted blood tests, but I think it would have
23 prompted certainly -- at least a chat with the nurse, if
24 not the nurse and the SHO.
25 Q. In fairness to you, Dr Devlin wished very much not only

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1 definitely have called for a blood test, but I think the
2 real point he was making was the advantage, if a child
3 was seen a number of times, that the same doctor sees
4 her more than once. So if he was there at 6 o'clock and
5 had he been on duty and he was called at 10 o'clock, he
6 would have the knowledge of what he'd seen and observed
7 and had heard at 6 o'clock, which better informs a view
8 which he forms at 10 o'clock.
9 And the reason I'm interested in your take on this
10 is because it's one of the points that some of the
11 experts have flagged up to me which is when Raychel is
12 seen through the day, but always by different doctors,
13 it makes it more difficult to have continuity of care.
14 It's one thing to say, "Look, the GMC and the
15 Altnagelvin Junior Doctors' Handbook says the notes are
16 supposed to be good and you do your best to make notes
17 as you go along", but that is not as good as being the
18 doctor who has seen the patient twice or three times.
19 As a general point, would you agree with that?
20 A. Yes. I would agree that if I had seen Raychel twice
21 with vomiting, that the second time I would have acted
22 differently. But that's probably because I'll be seeing
23 the same patient twice with the same problem and also
24 because I would have --
25 THE CHAIRMAN: You would have known that you had given the

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1 that he had made a note of his examination for you to
2 see, although I'm not sure that if he had done, given
3 the records that you said you looked at, that you'd have
4 actually seen it, but in any event he wished he had made
5 that note and certainly that he had timed when he
6 administered the anti-emetic and also that he had
7 discussed Raychel with you. Is that something that
8 would have been unusual to happen? I don't mean the two
9 of you because you knew each other, but two JHOs in your
10 position to discuss something like that? Would that
11 have been unusual?
12 A. Yes, the only time you would really have handed over a
13 patient would maybe if a patient had just come in and
14 needed clerked in or if someone was really unwell, but
15 generally if they were really unwell, they would have
16 been seen by the SHO, who would have handed it on to the
17 SHO. So generally there was no handover.
18 THE CHAIRMAN: I know that Dr Devlin said yesterday that he
19 wished in hindsight that he had spoken to Dr Curran, but
20 I did not understand that to be him saying that that
21 would be in any way as a sort of handover.
22 MS ANYADIKE-DANES: No, no, I didn't mean it as a handover.
23 I was simply asking, in the circumstances of that case,
24 whether that sort of thing is something you might expect
25 to happen, if I can rephrase it in that way.

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1 A. No.
2 Q. One can see why he regrets it, but it's not an standard
3 that you would necessarily have expected him to have
4 met.
5 MR STITT: Just a small point of clarification.
6 I understood the question to be implying that this
7 conversation was contemporaneous with the events which
8 were occurring. I may be mistaken on this, but was the
9 conversation as recounted by Dr Devlin not after the
10 event when the two of them, as friends, were talking
11 about this distressing result?
12 MS ANYADIKE-DANES: I don't think so. The reference
13 I have --
14 THE CHAIRMAN: No, he said that he wished -- Dr Devlin said
15 yesterday words to the effect that, with hindsight, he
16 wished he'd spoken to Dr Curran, but he hadn't spoken to
17 Dr Curran on 8 June. That's the point.
18 MR STITT: But there was discussion between the two of them
19 at some stage at a later date --
20 THE CHAIRMAN: That was after the event.
21 MR STITT: Yes.
22 THE CHAIRMAN: That's your point: it was after the event.
23 MR STITT: Yes [OVERSPEAKING].
24 MS ANYADIKE-DANES: You've been provided with the report of
25 Mr Orr, who was an expert surgeon retained by the Trust.

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1 A. To take the blood test?
2 Q. No, you wouldn't have undertaken a review yourself?
3 A. Oh, I would have went and seen Raychel, but it would
4 have prompted me to phone the SHO. I put that in
5 a simple context. As a JHO, you have limited experience
6 and, of the paediatric ward, even more limited
7 experience. If the nurses had a concern, it would be
8 unheard of to ignore that concern.
9 THE CHAIRMAN: Let me take it one step further, doctor. You
10 regard coffee-ground vomiting as a red flag?
11 A. Yes.
12 THE CHAIRMAN: It's an indication that there is perhaps
13 something seriously wrong?
14 A. It indicates severe vomiting.
15 THE CHAIRMAN: Right. In that event, are you surprised that
16 it was you who was called and that there was no apparent
17 effort at that point by a nurse to contact an SHO?
18 A. I am surprised about that simply because of the red flag
19 of coffee-ground vomiting. Can you ask that question
20 again, sir?
21 THE CHAIRMAN: Assuming that a nurse has the same concern
22 that you have that not only is Raychel vomiting, but
23 it's coffee-ground vomiting and that means the vomiting
24 is severe rather than just prolonged -- "just prolonged"
25 isn't meant to demean it. In that scenario, are you

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1 He says that in the light of Raychel's continuing
2 vomiting, her urea and electrolyte results should have
3 been checked during the afternoon. Well, you weren't
4 available in the afternoon to do that:
5 "If the surgical team had been asked to review
6 Raychel because of her vomiting, they should have not
7 only requested a biochemistry analysis, but reviewed her
8 IV fluids with a view to replacement of the losses."
9 And where he says that -- I don't think we need to
10 pull it up -- is at 320/1, page 11. He does use the
11 expression:
12 "If the surgical team had been asked to review
13 Raychel because of her vomiting."
14 Do you make a distinction between what you were
15 being asked to do and that description of "if the
16 surgical team had been asked to review Raychel"?
17 A. I would honestly make a clear distinction between those
18 two things, one being asked to assess and the other
19 being asked to administer.
20 Q. So if you had been asked to review Raychel because of
21 her vomiting, can I ask you what your response to that
22 would have been?
23 A. If I'd been asked to review Raychel because of abnormal
24 vomiting, I would have phoned my SHO.
25 Q. Yes. So you wouldn't have undertaken that yourself?

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1 surprised that the nurses only contacted you as a JHO
2 and did not seek at that time to contact an SHO?
3 A. Yes. On an adult surgical ward, if someone had
4 coffee-ground vomiting, I would expect the nurse would
5 contact the senior house officer.
6 THE CHAIRMAN: Thank you.
7 MS ANYADIKE-DANES: And if the nurse was contacting you
8 because the first thing they wanted to have done was an
9 anti-emetic to be administered, would you have expected
10 them to not only ask you to do that because you're
11 somebody who can readily do that, but then ask you to
12 contact your SHO in view of the coffee-ground vomiting?
13 Would you have expected something like that to have
14 happened?
15 A. Either that or to page us both.
16 Q. But in any event, by whichever route, to have involved
17 the SHO?
18 A. If coffee-ground vomiting -- yes.
19 Q. Am I understanding you to say that you would not expect
20 a nurse to have relied on your diagnosis or analysis of
21 Raychel in relation to coffee-ground vomiting when
22 you are just a JHO?
23 A. Yes, but if I take it one stage further, if someone is
24 concerned that a patient is seriously unwell, then they
25 don't generally ring a JHO.

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1 THE CHAIRMAN: Because you do what Dr Devlin described as
2 almost administrative tasks? You come along, you --
3 A. I don't want to demean the job of JHO, but you're
4 basically asked or instructed to do things --
5 THE CHAIRMAN: He was putting it in context as an indication
6 of how far up the medical ladder you were.
7 A. You're basically being tasked with doing jobs. That is
8 what a JHO's role is. You're asked to do something, you
9 do it. If you had concerns yourself, obviously you're
10 going to raise them, but something has to alert you to
11 the concerns.
12 MR QUINN: Mr Chairman, the word "concern" has been a word
13 that has prompted my interruption on half a dozen
14 occasions in the last week. Perhaps the witness could
15 be asked a series of questions. If he sees
16 coffee-ground vomiting, does that give him cause for
17 concern?
18 THE CHAIRMAN: I think the answer's yes.
19 MR QUINN: I'm just establishing the ground.
20 THE CHAIRMAN: And this will lead into, later on, about the
21 inquest because he says coffee-ground vomiting is severe
22 vomiting.
23 MR QUINN: Exactly. That's the point. And secondly, if one
24 observed coffee-ground vomiting, could one then conclude
25 that they had no concerns, as has been the view

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1 your SHO. But I need to put to you that some of the
2 inquiry's experts have formed the view that it isn't
3 just as straightforward as that and that the junior
4 doctors -- yourself and Dr Devlin for that matter -- the
5 do have a role to play in identifying the significance
6 or otherwise of Raychel's condition and it's not simply
7 a matter of administering something that the nurses have
8 indicated they wish to have done.
9 For example, Simon Haynes says, in his view, from
10 any point in time from late afternoon onwards, the
11 correct course of action was to take a blood sample for
12 electrolyte assay.
13 In fact, the first point in time for you would have
14 been when you attended at 10 o'clock. And so from his
15 point of view, if it had not already been done, then
16 that is something that you should have known to request.
17 A. I would disagree with that simply because I know how
18 things worked in Altnagelvin at the time as a JHO.
19 There was no protocol to say if someone was vomiting for
20 X amount of hours that there should be an EP,
21 electrolyte profile. If someone was on IV fluids for
22 a certain length of time, there's no protocol to say
23 they should have an electrolyte profile.
24 Q. In fact, some of the other experts say much the same
25 sort of thing, so I want to approach it with you in this

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1 expressed by all the nurses in this case?
2 THE CHAIRMAN: There is an issue about the extent of the
3 concerns which the nurses held and they have said that
4 they were not particularly concerned about Raychel
5 because it's not unusual for children to have
6 post-operative nausea and vomiting. Is it your
7 evidence, doctor, that while you would agree with them,
8 up to a point, once the vomiting becomes coffee-ground
9 vomiting, which you described as severe, that must raise
10 concerns?
11 A. Yes, and I think that applies to both adult and
12 paediatric patients. But in terms of paediatric
13 patients, I had limited experience. In an adult ward,
14 it would certainly be a red flag.
15 THE CHAIRMAN: And it is regarded as nurses as a red flag on
16 an adult ward?
17 A. On an adult ward? From my experience, yes.
18 THE CHAIRMAN: Thank you.
19 MS ANYADIKE-DANES: I appreciate that you have said that you
20 would have expected the nurses to have drawn your
21 attention to the coffee-ground vomiting because that's
22 a significant feature of her condition and that you
23 would have expected them to have appreciated that and
24 drawn your attention to it so that you can either pass
25 that on to your SHO or they would be directly contacting

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1 way. What you've now characterised is "Well, this is
2 the environment in Altnagelvin". It may be different in
3 other hospitals, but in Altnagelvin, the JHO's role was
4 actually very limited and people appreciated it was
5 limited, particularly, I think your evidence has been,
6 that the nurses would have recognised that our
7 knowledge, experience and therefore role is rather
8 limited. Would that be a fair way of characterising it?
9 A. Yes.
10 Q. So then if you are being called because you are the
11 people who can usually most quickly attend to a bleep,
12 does it not then become really quite important that
13 you have ready access to your senior colleagues because
14 what you can do, even should you be alive to the fact
15 that there might be a problem, is actually very limited?
16 A. Sorry?
17 Q. Doesn't it therefore mean that, for you as JHOs, the
18 system needs to mean that you can have ready access to
19 your senior colleagues because what you can do is very
20 limited?
21 A. Yes.
22 Q. Yes. And if when we're talking about your senior
23 colleagues, if we're talking about your senior surgical
24 colleagues, isn't the problem that they are very often
25 tied up in surgery?

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1 A. Yes.
2 Q. So even if you can make contact with them, it can be
3 quite unpredictable when they will be free of those
4 duties to come and assist you.
5 A. That's true.
6 Q. And when the chairman was saying that it's not quite
7 clear what you do about the continuity of care issue, do
8 you also not have, so far as you can see now, a problem
9 really in the JHOs being essentially -- I'm talking now
10 about the surgical JHOs attending paediatric patients --
11 being the first on call and yet their role being
12 limited, but their access to their senior colleagues who
13 can assist being unpredictable, maybe uncertain?
14 Is that not a problem for you?
15 A. It was. Yes, it was.
16 Q. Was it recognised as a problem?
17 A. I'm not sure. If you tried to phone a surgical SHO and
18 you couldn't get him or they were in theatre, then you
19 had to wait until they were available.
20 THE CHAIRMAN: Would you have gone up the line to
21 the registrar?
22 A. If there was an urgent problem, yes. But generally
23 speaking you phoned the SHO. It was a hierarchy
24 scenario. To be honest, most times you could get the
25 surgical SHO. It was just if they were scrubbed or in

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1 generally just phone the registrar though, generally if
2 you get the SHO and the SHO cannot attend, then the SHO
3 would get the registrar to attend.
4 MS ANYADIKE-DANES: So you wouldn't be the one who would be
5 going higher up the chain; you'd be expecting your SHO
6 to do that?
7 A. Generally they would do that, yes.
8 Q. If you couldn't reach your SHO, what's your course of
9 action then?
10 A. I guess you would phone the registrar if that were the
11 case.
12 Q. And have you done that before?
13 A. I don't think I ever phoned the registrar.
14 Q. Would you feel a little reluctant to do that and prefer
15 to contact your SHO?
16 A. I think it's fair to say that in terms of, I suppose,
17 the hierarchy, your SHO is more friendly, I suppose,
18 than phoning your registrar. I would have done so if
19 I couldn't get my SHO.
20 THE CHAIRMAN: Yes. It depends how urgent you think the
21 problem is.
22 A. Oh, yes.
23 MS ANYADIKE-DANES: Then it becomes a judgment call as to
24 whether you think this matter can wait until you believe
25 your SHO will get free or whether you gird yourself up

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1 theatre they wouldn't be able to attend for a while.
2 MS ANYADIKE-DANES: That's exactly the point. Not being
3 able to attend for a while is what I count as ready
4 access. You have readily accessed them in the sense
5 that you have made contact with them, but in terms of
6 them being able to respond and assist you, that might be
7 really unpredictable. It depends how long they're tied
8 up with whatever it is that they're doing.
9 A. Yes.
10 THE CHAIRMAN: It has to be unpredictable. But for
11 instance, the night before, we know that Mr Makar did
12 the surgery and there's an issue about whether he
13 contacted Mr Zawislak or what he contacted him for, but
14 Mr Zawislak was the second on call. So there was
15 a first on call and if you can't get the first on call,
16 then there's a second on call, isn't there?
17 A. Do you mean SHO and registrar?
18 THE CHAIRMAN: Yes.
19 A. There's always a registrar in the hospital.
20 THE CHAIRMAN: Yes. That's the point of having a first
21 on-call and a second on-call system. If the first
22 on-call is in surgery, for instance, the second on-call
23 knows that they might get a bleep to do something or
24 intervene in some way.
25 A. I think though it wouldn't be a case that you would

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1 and contact the registrar.
2 A. Yes.
3 THE CHAIRMAN: Okay, I've got the point.
4 MS ANYADIKE-DANES: So then I want now to move to the next
5 period of contact with Raychel, which is after she's had
6 the seizure. Just before then there are two points
7 I should deal with. One is that you actually intervened
8 and wrote a prescription for an anti-emetic.
9 A. Yes.
10 Q. Dr Devlin didn't have to do that because there was
11 already a pre-prescription, if I can put it that way.
12 But you wrote one up. Should you have timed that,
13 should you have inserted it into her notes that you had
14 done that?
15 A. With today's standards, yes. In 2000/2001, if you were
16 called to give an anti-emetic or to do a routine,
17 what was perceived to be, sorry, a routine injection,
18 you would not write that in the notes.
19 Q. And why would that be?
20 A. It was such a common thing you were asked to do, the
21 only entry would literally have been in the drug kardex,
22 drug sheet.
23 Q. But that would require somebody coming afterwards, in
24 order to understand what had happened with her care, to
25 look at the drugs kardex sheet --

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1 A. Yes.
2 Q. -- as opposed to looking at her notes and seeing
3 a chronological narrative of those who had treated
4 Raychel?
5 A. It was the standard practice at the time. I can totally
6 understand what you're saying and it shouldn't happen,
7 but that was standard practice at the time.
8 Q. When you say "it shouldn't happen", do you recognise
9 that it might have been -- or it was, as you're telling
10 us -- the common practice, but it perhaps was not the
11 best practice?
12 A. Well, I work as a general practitioner now and based on
13 today's standards I wouldn't have patient contact
14 without keeping a note on the day. I realise the
15 importance of it. But you do what is common practice of
16 the day and, in 2001, when you gave an anti-emetic --
17 and I assure you I gave anti-emetics dozens of times --
18 you did not write a note unless there was something
19 other than giving an anti-emetic.
20 Q. Well, you'd actually examined her?
21 A. Yes.
22 Q. And you'd palpated her abdomen and you had reached
23 a view. In your witness statement, you said the result
24 of examining her was to reach the view that this was
25 post-operative nausea and vomiting.

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1 practice at the time. Yes, looking back on it, it is
2 poor practice, but it seemed standard practice then when
3 I was a JHO.
4 Q. Finally on that point, although you didn't obviously
5 have a senior colleague with you at the time, but in the
6 time when you had been a JHO, your senior colleagues
7 would have looked over the notes, any notes that you
8 would have made or entries you'd have made, and nobody
9 had ever drawn the practice that you've just described
10 to us to your attention as falling below the standard?
11 A. No one ever said that.
12 Q. Can you clarify whether you recall, now that you've been
13 questioned about that evening, and maybe it's slightly
14 clearer in your mind, whether you did actually meet
15 either of Raychel's parents?
16 A. I honestly don't know if I spoke to mum or dad.
17 Q. If you had spoken to them, would you have recorded that?
18 A. If I'd spoken to them, would I have recorded that?
19 Q. Yes.
20 A. No, I honestly don't think I would have.
21 Q. Thank you. If we come now to the seizure.
22 MR QUINN: Mr Chairman, may I just add to the transcript
23 that Mr Ferguson does recall this doctor. He was at the
24 telephone at the time the doctor arrived and when he
25 came back, the doctor was just getting up off the bed

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1 A. Yes.
2 Q. Should you not have inserted that in your note?
3 A. By today's standards, yes, but in those days that did
4 not happen. Most injections for anti-emetics were
5 either given for patients with viral gastroenteritis or
6 post-operative patients. The usual diagnosis was,
7 hopefully, normal post-operative nausea and vomiting.
8 If it was something that was felt to be routine in those
9 days you did not make a note in the patient's clinical
10 notes.
11 Q. So from your point of view, putting it in the kardex
12 with the time and signing it off, that was an adequate
13 record of your interaction with Raychel, if I can put it
14 that way, at 10.15 or 10.00?
15 THE CHAIRMAN: By the standards of 2001.
16 A. Yes.
17 MS ANYADIKE-DANES: I have to put to you that the inquiry's
18 expert disagrees with that. In fact, not just the
19 inquiry's expert, but Mr Orr also disagrees with that
20 and considers the note taking to have been evidence of
21 poor practice.
22 A. All I can say is that, in 2001, I worked as a JHO.
23 I came across this [inaudible] giving injections many
24 times and I would suggest that the other 11 JHOs would
25 also not have wrote a note. It was the standard

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1 and leaving. They didn't really pass anything other
2 than a nod, I think it was. I just want to say that
3 Mr Ferguson recalls that he and the doctor passed each
4 other as he came back into the room after making a phone
5 call to his wife and therefore he will say the doctor
6 was probably in the room with Raychel for five minutes
7 or thereabouts.
8 THE CHAIRMAN: Okay.
9 MR QUINN: I just want to be complete on that point.
10 THE CHAIRMAN: Yes. Okay. I'm not sure if the doctor can
11 help on that. I think we can agree the estimate of time
12 is particularly difficult.
13 MR QUINN: Yes. Just before we come off that subject,
14 because I knew my learned friend was finishing off the
15 topic, and I did not want to leave it incomplete.
16 MS ANYADIKE-DANES: I think in fairness to Dr Curran, he did
17 say five to ten minutes, so it could have been five
18 minutes.
19 A. It could have been, yes.
20 Q. So if we now come to the seizure, the first you hear of
21 that is when you're bleeped by Dr Johnston; is that
22 correct?
23 A. Yes.
24 Q. And now that we understand how the bleeping system
25 works, your bleep would have gone off and you showed us

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1 on your record that it went off at three --
2 A. 3.19.
3 Q. 3.19, I think, to be precise. That would have then
4 caused you to phone in to find out why you were being
5 bleeped.
6 A. Yes.
7 Q. Can you recall what you were told?
8 A. I recall being told that he -- sorry, I recall him
9 telling me that Raychel had had a seizure, that he was
10 dealing with a seizure and he asked me to come and do
11 blood tests, assist, and do an ECG, a heart tracing.
12 Q. Let me put up what he says because this I think is quite
13 important. This is his first statement, which he makes
14 for the Trust, and it's dated 21 December 2001. So
15 pretty close to events. It's 012-013-114.
16 He says in the middle:
17 "At 0315 [so very close to what you say], I made
18 a note on the chart while I bleeped the on-call surgical
19 pre-registration house officer, Dr Curran. I explained
20 to Dr Curran that the patient had no history of epilepsy
21 and was afebrile. I advised him to contact him surgical
22 registrar and senior house officer urgently."
23 Do you recall it being suggested to you that you
24 should contact your senior registrar and SHO urgently?
25 A. I certainly recall him telling me to bleep the SHO;

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1 of minutes before you answer the bleep. I can't recall
2 whether I answered in 30 seconds, 2 minutes, I don't
3 know, but then you phone 3106 and you speak to whoever
4 bleeped you.
5 Q. When you were doing that, could you not have also
6 bleeped, effectively, Mr Zafar or the SHO or ask
7 somebody else to bleep him to get in contact with Ward 6
8 urgently; could you have done that?
9 A. Sorry, after I had spoken to Dr Johnston?
10 Q. Yes, when you have spoken to Dr Johnston and you know
11 now Dr Johnston wants you to reach your senior
12 colleague, so before you dash off and do the bloods for
13 him, could you at the same time, if you didn't want to
14 spend the time literally bleeping him yourself, ask
15 somebody else to bleep Dr Zafar and ask him to get in
16 contact with Ward 6? Could you have done that?
17 A. I could have done that, it wouldn't have been common to
18 ask someone else to bleep someone for you. I could have
19 done that, but what I understood from the conversation
20 was: get up here urgently and assist and to do the
21 bloods. So I did the bloods and then phoned Mr Zafar.
22 I could have bleeped Mr Zafar from whichever ward I was
23 on, but again you do not know how long it takes someone
24 to answer your page. And if someone says to you that
25 a child's had a seizure, I don't want to sit for five

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1 I cannot recall bleeping -- being told to bleep the
2 registrar, but I certainly recall him telling me to
3 bleep the SHO.
4 Q. Urgently?
5 A. I can't remember whether he said come and do the bloods
6 urgently or bleep the SHO urgently, but I responded and
7 went to the ward straight away.
8 Q. In any event, he wanted you to bleep your SHO.
9 A. Yes.
10 Q. And did you do that?
11 A. I went to the ward immediately and did the bloods
12 immediately and then I phoned Mr Zafar.
13 Q. I take it you don't recall where you were when you
14 received that bleep.
15 A. No.
16 Q. When you do receive a bleep, do you then have to go
17 somewhere to phone in to find out --
18 A. Yes.
19 Q. You go to a station, is that right?
20 A. Yes. You get two types of bleeps. One is the standard
21 bleep, beep beep, it gives you the 3106. The other
22 bleep is the emergency bleep where the pager speaks to
23 you and says "cardiac arrest" or whatever. So this was
24 a standard bleep. Standard bleep, you're going to
25 finish whatever job you're doing and it may be a couple

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1 minutes waiting for someone to answer either. So
2 I thought the priority was to do the bloods. That's why
3 I went first.
4 Q. That was why I was suggesting to you that you have
5 somebody else do that, which I think you have said you
6 could have had somebody else do that.
7 A. I could have had, had there been someone else there.
8 I don't know which ward I was on.
9 Q. Okay. In terms of the concern that he has to involve
10 more senior surgical colleagues, in his inquiry witness
11 statement Dr Johnston says -- there's a series and
12 perhaps I can start with this one. His inquiry witness
13 statement is 029/2, page 9. We don't have to pull these
14 up. There's a series of these and I want you to
15 consider them because they all seem to reflect a sense
16 of urgency about them. You have now arrived at the
17 point he's discussing this in his witness statement:
18 "I discussed with Dr Curran --
19 THE CHAIRMAN: Where on the page are you?
20 MS ANYADIKE-DANES: I've given a new page reference:
21 "I discussed with Dr Curran that there was a likely
22 serious cause for the fit, most likely an electrolyte
23 abnormality, so urgent electrolyte profile, calcium,
24 magnesium and full blood picture should be sent to the
25 laboratory. In view of this, I requested that he call

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1 his registrar and SHO to see the patient urgently."
2 So he's had that discussion about what he wants you
3 to do and why he wants you to do it, but he refers again
4 that he wants you to get in contact with your registrar
5 and SHO to see the patient urgently; do you recall that?
6 A. I recall SHO, I do not recall registrar.
7 Q. Did you appreciate why he wanted you to get in touch
8 with a more senior surgical colleague?
9 A. I appreciated that Raychel had a seizure, which is
10 urgent, and I appreciated that getting a senior
11 colleague, an SHO, was the right thing to do. But
12 I thought that his intention and my intention was that
13 the bloods was the urgent thing to get away. I'm not
14 sure I understand your question. If you're saying
15 should I have phoned the surgical SHO and waited on the
16 bleep for the surgical SHO and then did the bloods or
17 did the bloods and then phoned the surgical SHO. He did
18 ask me to phone the surgical SHO. He asked me on the
19 phone when he bleeped me and when I went to the ward and
20 talked through what we did. But when I was sending the
21 canister to the lab, he said to me again, "Have you
22 phoned your SHO?", and it's at that point I said, "I'm
23 doing it now".
24 Q. The question was slightly different, which is whether
25 you appreciated why he wanted you to involve your more

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1 immediately to the ward, immediately take the blood
2 samples and, having done that, then contact the senior
3 surgical colleague?
4 A. Yes.
5 MS ANYADIKE-DANES: So then you made contact with Mr Zafar.
6 A. Yes.
7 Q. And Mr Zafar was in A&E; is that right?
8 A. Yes.
9 Q. What did you explain to Mr Zafar?
10 A. I told him that one of the surgical patients on Ward 6
11 had had a seizure, that the paediatric SHO had attended,
12 that we had taken bloods, and I asked him to come as
13 urgent.
14 Q. You asked him to come urgently?
15 A. Yes.
16 Q. Did you convey anything to him if you had -- I'm not
17 sure whether you had conceded whether you appreciated or
18 not. Did you convey anything to him about why
19 Dr Johnston wanted more senior surgical involvement
20 because he was concerned that there was a serious
21 post-operative surgical cause for her fit. Did you
22 convey any of that?
23 A. I think the fact when I asked him to come as urgent and
24 said, "We have a child who has had a seizure", I think I
25 conveyed the message that he needs to come urgently.

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1 senior colleagues. Did you understand the surgical
2 concern, if I can put it that way?
3 A. I understood that he wanted a more senior colleague
4 involved because I was a JHO and because Raychel was
5 a surgical patient.
6 Q. Yes. What in fact he said is at 029/2, page 7:
7 "I was concerned that Raychel had a serious
8 post-operative surgical cause for her fit and
9 deterioration. I wanted more senior surgical doctors
10 from her team to assess and manage her condition."
11 So it wasn't perhaps just a matter of going up the
12 chain to more senior paediatric involvement; he actually
13 thought that something surgical might be going on and
14 therefore he wanted senior surgical involvement. Did
15 you understand that from your discussion with him?
16 A. No. Sorry, I don't know if Dr Johnston felt there was
17 a serious surgical cause.
18 Q. That's what he's saying.
19 THE CHAIRMAN: That's what he's saying in the statement.
20 But you understood the urgency was -- in fact there were
21 two urgents. The first urgent was to take the blood
22 samples and the second urgent was to get somebody up the
23 line.
24 A. More senior.
25 THE CHAIRMAN: So your response to that was to go

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1 Q. And what did he say to you?
2 A. He said he was with someone in casualty, but he would be
3 up as soon as he could, which I interpreted to mean
4 he was coming.
5 Q. When you said you interpreted it to mean he was coming,
6 I can see why you would, is there a period of time that
7 would have elapsed when you would have had another go to
8 see if you could reach him or reach somebody else?
9 A. I didn't contact him again.
10 Q. That's what I'm asking you. How much longer, given that
11 all this is urgent, would you have to wait before you
12 formed the view that whatever it was he was doing
13 obviously has got him tied up and he can't free himself
14 and I need to go somewhere else because Dr Johnston has
15 told me he wants senior surgical involvement?
16 A. As a JHO in that scenario, where a child has just had
17 a seizure, you are fairly scared, you are in that
18 environment, you sought your senior assistance and asked
19 them to come urgently. You are waiting for them to
20 come. I don't think there's a time frame that I would
21 say give him 15 minutes and ring him again, has he
22 forgotten or has he rung the registrar to come in his
23 absence or something. There wasn't a time frame where
24 I was saying I need to ring him again, if that's what
25 you were asking.

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1 Q. That is what I was asking, but would it occur to you to
2 contact him again -- or not necessarily him -- to ask
3 him: if you are tied up, Mr Zafar, is there anything
4 I should be doing, should I contact Mr Bhalla?
5 A. Well, as a JHO I would have expected -- my expectation
6 would have been that he would have sent Mr Bhalla if he
7 couldn't attend, knowing that one of the surgical
8 patients has had a seizure.
9 Q. But you're actually there and you're able to see what is
10 unfolding and the concern that Dr Johnston has.
11 Mr Zafar only gets it from what you have told him on the
12 phone. So given that Dr Johnston is urging upon you to
13 get senior surgical input into Raychel's case, if for
14 some reason the SHO has not been able to respond and
15 you have no idea why that is, do you not at some point
16 have to take it upon yourself to see if you can contact
17 the registrar, or to ask Mr Zafar: what should I do, is
18 there anything I should do?
19 A. At that point in time, I was simply waiting for
20 Mr Zafar, hoping he was turning up. No, I wouldn't have
21 thought at that point to ring the registrar.
22 Q. So the reality of it is that, so far as we can tell,
23 although none of these times are entirely precise, but
24 so far as we can tell Mr Zafar doesn't actually arrive
25 until 5 am, which is much longer, I presume, than you

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1 you have said you were shown the witness statements.
2 But it seems, as one goes through them, that Mr Johnston
3 is really wanting some more senior surgical input to
4 help him.
5 A. Sorry, Dr Johnston asked me on the telephone when I got
6 the initial bleep and then once, as I finished and sent
7 the bloods in the canister. There was two occasions
8 I can remember and the second occasion is when I bleeped
9 Mr Zafar. Can I add a point to that?
10 Q. Of course.
11 A. As a surgical JHO, you don't ... At the point where
12 Raychel had a seizure, my feeling on the subject and the
13 matter was that the paediatric team were the team that
14 was required to manage her. If I was on, for instance,
15 covering another ward, an adult ward such as an
16 orthopaedic ward, and an elderly patient having had
17 a hip operation went in and developed, say, a fast or
18 irregular heart rate, it wasn't the orthopaedic SHO that
19 I would ring, it was the medical SHO that I would ring
20 as a surgical JHO. So similarly, I may ring the
21 orthopaedic SHO to say I've made the referral, but when
22 Raychel had a seizure the treatment is best managed, in
23 my opinion, even at that stage, by the paediatric team.
24 Q. Yes. I understand that you're saying that. The
25 difficulty is that Dr Johnston, who is a paediatrician,

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1 thought it would be.
2 A. Far longer, yes.
3 Q. Exactly. But in all that time, you haven't contacted
4 him again, nor have you contacted anybody else on the
5 surgical team.
6 A. I think if you contact someone and you say, "Come
7 urgently, a child's had a fit", and a child -- then the
8 onus is on the more senior person to make a decision.
9 THE CHAIRMAN: I've got the point.
10 MS ANYADIKE-DANES: Thank you.
11 Just finally, in fairness to Mr Johnston, what he
12 says on this matter at 029/2, page 10:
13 "I wanted senior surgical input as soon as possible.
14 I felt that both the registrar and SHO should come to
15 see Raychel urgently. I had been informed that they had
16 been contacted."
17 But I think your recollection is that you'd actually
18 only contacted Mr Zafar.
19 A. Yes.
20 Q. He believed that you had contacted both for some reason,
21 but anyway:
22 "I had been informed that they had been contacted,
23 but yet they had still not come to Ward 6."
24 I'm not going to take you through all the references
25 in his witness statements, they're there and I think

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1 is saying that he is concerned that the electrolyte
2 imbalance, which is one of the things he suspects is the
3 problem here, actually has at its cause a surgical
4 issue, and that is why he wants senior surgical help,
5 not to put too fine a point on it. So, yes, I take what
6 you're saying, but he is the person who wants help.
7 He's the person at that stage who was treating Raychel.
8 THE CHAIRMAN: Okay.
9 MS ANYADIKE-DANES: Anyway, I think we have your answer on
10 that.
11 Just to clarify, because Dr Johnston will give
12 evidence, in his witness statement at 029/2, page 11,
13 which we should bring up, in his view it was confirmed
14 with you that your registrar had been contacted. So if
15 you see at (b):
16 "Did you ascertain whether the surgical registrar
17 had been contacted? Yes, I confirmed this with
18 Dr Curran."
19 A. I believe I only contacted the SHO, Mr Zafar.
20 Q. Do you have a clear recollection of that or could
21 Dr Johnston be correct?
22 A. Um ... It's possible, but I only recollect contacting
23 and speaking to Mr Zafar.
24 Q. If we just go to what was actually happening. I wonder
25 if you might help with this. There seemed to be

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1 a period of time over which Dr Johnston was very
2 concerned that he hadn't received back the electrolyte
3 results that he wanted; are you aware of that?
4 A. Yes, yes.
5 Q. Can I ask you, did you physically take the bloods?
6 A. Yes.
7 Q. So you take the bloods and I think you refer to putting
8 them in a canister.
9 A. Yes.
10 Q. Then where do you take them to?
11 A. There is a chute system in Altnagelvin, so you have kind
12 of a chute system in each ward, which goes to the
13 biochemistry, the haematology lab, and you put the
14 bloods inside a canister, which goes in the chute system
15 to whatever code you put in, which is the destination
16 code for the lab.
17 Q. And they could go to biochemistry or they could go to
18 haematology.
19 A. Yes, you can send them to either, but sometimes the
20 chute system would send them in the wrong place.
21 Q. What actually determines where they end up, if I can put
22 it that way?
23 A. The code, you type a four digit code.
24 Q. You put a code on the canister?
25 A. On the machine that the canister goes into.

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1 A. Yes.
2 Q. Because if we are looking here at this bottom part of
3 his witness statement, you can see that when Dr Johnston
4 telephones the biochemistry lab, they say they haven't
5 received the sample. So he contacts you to confirm that
6 you had actually sent it; do you recall that?
7 A. All this is taking place now when we're both on the
8 ward. When he says "contacted me", I was standing
9 beside him.
10 Q. I understand that, but he has asked you, effectively:
11 are you sure that you sent it to the biochemistry lab?
12 A. He may well have said that to me, yes.
13 Q. Are you aware of the fact that he telephoned the
14 biochemistry lab again to ask them to look for the
15 sample?
16 A. Yes.
17 Q. And it turned out that the sample was actually in the
18 haematology lab.
19 A. That --
20 Q. Were you aware of that?
21 A. That was something that commonly happened at night.
22 Q. I appreciate that, but were you aware that that's what
23 had happened on 9 June?
24 A. I can't recollect if I was aware that I was told that it
25 went to the haematology lab, but ... I sent them to the

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1 Q. Is it automatic in relation to that code if it's working
2 properly where the canister ends up?
3 A. Yes.
4 Q. So there's no human involvement with that?
5 A. No.
6 Q. Are you aware that, by 3.30 or thereabouts -- as I say
7 these times are rather difficult to be precise about --
8 that the full blood picture had become available, but
9 not the electrolytes to Dr Johnston, and it's the
10 electrolytes that he was interested in?
11 A. I think it'd be a little bit later than that, but the
12 full blood count definitely became available first.
13 Q. You knew by that time that what Dr Johnston was really
14 interested in was the electrolytes?
15 A. Oh, yes.
16 Q. Were you aware of the fact that Dr Johnston phoned the
17 biochemistry lab to see where they were, the results?
18 A. Yes, but in the middle of the night when you send off
19 blood samples to haematology or biochemistry, you
20 automatically phone them to tell them they're coming, to
21 wake them up if they're sleeping, and ask them to do
22 them urgently. I had spoken to biochemistry and
23 haematology when I sent the bloods.
24 Q. And that's where they would have to get to if you were
25 going to get the electrolyte results, biochemistry?

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1 labs where they were supposed to go to. I phoned the
2 biochemistry and haematology and said: expect these and
3 do them urgently. When the result didn't become
4 available, I think we both phoned for the result at
5 different times and he may well have been told by the
6 biochemist that the canister meant for biochemistry had
7 gone to haematology, but the labs are next to each
8 other.
9 Q. But all this is adding delay.
10 A. Yes.
11 Q. You're not in a position to evaluate how significant
12 that delay is, but at this stage, any delay might be
13 significant.
14 A. Yes, but all you can do as a doctor -- it doesn't
15 matter, SHO, JHO -- is phone the lab and tell them where
16 is it, what's the answer.
17 Q. Yes. And the significance of all of that is, until
18 Dr Johnston gets those results, he doesn't feel that he
19 is able to institute any change in her fluid management
20 or her regime at all because he doesn't know what
21 actually her electrolytes are, has she got too much
22 sodium or too little sodium? And obviously, he doesn't
23 want to make an error. So that's the significance of
24 getting those back.
25 A. Yes.

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1 Q. While all that is happening and you're waiting for those
2 results to come back, Dr Johnston is doing other things
3 like doing an ECG to rule out a cardiac cause and so
4 forth. Are you aware of that kind of activity?
5 A. I was with Dr Johnston all the time, yes.
6 Q. So you saw all that?
7 A. Yes.
8 Q. Were you aware that, at a certain point, Dr Johnston
9 goes to seek out his own registrar?
10 A. Yes.
11 Q. Did he tell you he was going to do that?
12 A. I believe he did.
13 Q. Did he tell you why?
14 A. It was my understanding when Raychel had a seizure that
15 that became a paediatric problem and that was why he
16 went to get his registrar. That's what I understood.
17 Q. It wasn't only a problem. At that stage he had
18 stabilised her, but he was sufficiently concerned about
19 her that he was going up the line to his registrar.
20 A. Yes.
21 Q. Yes. So you appreciated that --
22 A. Yes.
23 Q. -- even though she had been stabilised, she was still of
24 great concern?
25 A. Definitely.

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1 had a seizure. I would have been scared myself and
2 I wanted someone more senior there immediately. But
3 I didn't mind whether that was a surgical SHO,
4 consultant, paediatric registrar, whoever. But in that
5 scenario, I would have been out of my depth. It didn't
6 matter to me who was managing the situation, but it
7 wasn't appropriate for a JHO. So no, it didn't affect
8 my -- I didn't feel it was less urgent for me to get
9 a surgical senior colleague just because he was getting
10 a paediatric senior colleague.
11 Q. That was the point I was putting to you.
12 A. No.
13 Q. No, you didn't. But still you didn't do anything
14 because, so far as you're concerned, you'd done what you
15 could, you had let Mr Zafar know and you were --
16 A. I was hoping he was going to turn up any minute.
17 Q. You thought, at any point, he's going to turn up or, if
18 he isn't going to turn up, he's made the arrangement for
19 somebody else to turn up?
20 A. Yes.
21 Q. That was your belief?
22 A. Yes. But I also believed at that point as well that the
23 paediatric registrar was going to be on the way because
24 the paediatric -- I think it's called the Special Care
25 Baby Unit -- wasn't that far away. So I expected the

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1 Q. Yes. And at the time when he goes to see his registrar,
2 that's about 4 o'clock at that stage.
3 A. 4.00 or 4.05, yes.
4 Q. Yes. And there's still no sign of any more senior
5 surgical colleague.
6 A. No.
7 Q. And when he went off to go and get his -- he being
8 an SHO -- more senior colleague, were you not feeling
9 there as the sole doctor at that time that you would
10 really like your senior colleague with you?
11 A. Definitely.
12 Q. And is there another surgical SHO other than Mr Zafar or
13 is he the only --
14 A. On call? No, just him.
15 Q. There would just be him?
16 A. But at that point in time -- I'll extend that and say
17 I was looking for the paediatric team rather than just
18 the surgical team to continue to manage the problem.
19 Q. Does that mean that although you knew that Dr Johnston
20 had wanted more senior surgical involvement, from your
21 point of view, if he was going off to go and get
22 a registrar, did that affect how significant or
23 important you thought it was for you to go and get your
24 surgical SHO?
25 A. No. I was a JHO in a situation with a young girl who

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1 paediatric registrar and paediatric SHO to be back
2 imminently as well.
3 Q. All the time that Dr Johnston's away, you don't leave
4 Raychel, do you?
5 A. No.
6 Q. Yes. So do you then see Raychel have her further
7 fitting?
8 A. No. I didn't -- sorry, after what time?
9 Q. Well, what prompts the nurses to bleep Dr Johnston when
10 he is away seeking out Dr Trainor is a deterioration in
11 Raychel's condition. Dr Johnston stabilises Raychel by
12 giving her two sets of medication to address the
13 seizures. Once she is stable, he goes off to discuss
14 her case with Dr Trainor, leaving you. But while he's
15 away and Staff Nurse Noble returns to find that Raychel
16 has fitted. And it is that deterioration in Raychel's
17 condition that causes them to contact or bleep
18 Dr Johnston, which results in him staying and doing
19 Dr Trainor's duties, if I can put it that way, and
20 Dr Trainor dashing back to Ward 6. So the point that
21 I was putting to you is this: did you see that
22 deterioration in Raychel's condition?
23 A. I didn't see Raychel deteriorate; I just didn't see
24 Raychel improve. After someone has had a seizure, even
25 in my limited experience there's a time after you have

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1 a seizure whereby you're flat and unresponsive before
2 you come round, but Raychel wasn't coming round.
3 Q. Maybe I can ask you to describe then -- after she'd had
4 the seizure and had received the two medications that
5 Dr Johnston administered to her, can you describe what
6 she was like, what was her condition?
7 A. When I would have got to the ward, Raychel wasn't
8 fitting at that point. Raychel was lying in bed pretty
9 flaccid, not moving, she had high flow oxygen on her,
10 she wasn't responding. But after someone has a seizure,
11 it is common to have a period where they do not respond;
12 that is called the post-ictal phase. Then you expect
13 the patient to improve after that, to come round.
14 Raychel didn't.
15 Q. Staff Nurse Noble describes Raychel as having
16 intermittent tonic episodes with her pulse rate
17 fluctuating. Was that happening in your presence while
18 Dr Johnston was away?
19 A. I didn't see Raychel having -- tonic episodes means that
20 the patient would go rigid, rather than clonic, where
21 they would shake.
22 Q. Intermittent tonic episodes, to be fair to her, is how
23 she described it.
24 A. I didn't see Raychel have an episode where she went
25 rigid.

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1 that none of your seniors had got there?
2 THE CHAIRMAN: I've got the point about the senior surgical
3 team.
4 MS ANYADIKE-DANES: Then Dr Trainor does arrive and she has
5 certain tasks that you assist in performing; isn't that
6 right?
7 A. Yes.
8 Q. Specifically, she wants to know from you where the blood
9 was taken, whether it was taken from the same arm that
10 the drip was running in.
11 A. Yes.
12 Q. Did you understand the significance of that?
13 A. Yes.
14 Q. Which is?
15 A. Well, if you take blood from an arm on which a drip is
16 running into, you will most likely get a low sodium,
17 which is just an error, it's an artefact.
18 Q. So you knew that?
19 A. Yes.
20 Q. And you were sure you hadn't done that?
21 A. Yes.
22 Q. And that's the information you gave her?
23 A. Yes.
24 Q. Did she not want a second round of bloods taken and
25 tested?

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1 Q. Were you aware that her heart rate was fluctuating
2 between 78 and 140?
3 A. I was aware she had a fast heart rate. I did a heart
4 tracing on her.
5 Q. So you knew that?
6 A. Yes.
7 Q. Mr Ferguson arrives at 4 o'clock and he describes
8 Raychel as being surrounded by people and that she is
9 shaking and trembling in the bed, which might be his
10 description for some sort of activity; did you see that?
11 A. No.
12 Q. In fact, did you see anything that made her appear very
13 much different to you than just before Dr Johnston had
14 gone off to find Dr Trainor?
15 A. During that period?
16 Q. Yes.
17 A. No.
18 Q. She seemed much the same?
19 A. She hadn't improved, but she seemed the same.
20 Q. So do you know what prompted Staff Nurse Gilchrist to
21 bleep the doctors? Do you know what prompted that?
22 A. I fully expected it was her experience in seeing
23 seizures in the past and realising that this wasn't
24 normal, that she wasn't improving.
25 Q. And when that happened, were you still not concerned

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1 A. Yes.
2 Q. And did you do that?
3 A. Yes.
4 Q. And you took those up to where Dr Johnston was, which is
5 where they could be tested quickly; is that right?
6 A. She wanted, I think, two sets of bloods. One was
7 a blood gas, which was processed in the Special Care
8 Baby Unit where Dr Johnston was. There was also
9 a repeat electrolyte profile, but I can't recall whether
10 that was processed through the main lab again or whether
11 that was done in the Special Care Baby Unit.
12 Q. In any event, you did that and you -- it seems at about
13 4.30 -- get to the neonatal intensive care unit to give
14 that arterial blood sample and get it tested.
15 A. Yes.
16 Q. When you get back to the ward, it is about 4.40.
17 A. Yes. That sounds about right.
18 Q. Do you know at that stage that Dr Trainor has telephoned
19 for Dr McCord to come in when you get back?
20 A. I was there when Dr McCord turned up, but I don't know
21 when I was told the phone call was made.
22 Q. And are you there at about 5 o'clock when it seems that
23 Mr Bhalla and Mr Zafar arrive, roughly thereabouts?
24 A. I can't be exact, but yes, it was roughly about then,
25 yes.

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1 Q. When Mr Bhalla arrived, did you know precisely how
2 he had got to be there, who contacted him?
3 A. No.
4 Q. At any time when you were in the ward or in the
5 treatment room, actually by that time, were you aware of
6 what had happened to Raychel's IV fluids?
7 A. No. You mean when they were swapped or changed?
8 Q. Yes, exactly.
9 A. No. I can't recollect whether that was prior to me
10 taking the second sample or when I was away.
11 Q. Do you know who did it? Who gave the instruction that
12 that should happen?
13 A. I expect it was Dr Trainor, but I don't know.
14 Q. Thank you. And when Mr Bhalla and Mr Zafar came, that
15 must have been a moment of relief to you that your
16 senior colleagues were at least there. Did you brief
17 them at all as to what had happened or did you allow
18 them just to observe for themselves?
19 A. I think they turned up when Raychel was in the treatment
20 room. Yes, I spoke to them when they came in, but
21 they ... I think one of them may have examined
22 Raychel's abdomen. But that was it. Dr McCord,
23 I think, was there then, I think the anaesthetist was
24 there at that point. I think they had limited
25 involvement.

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1 months of doing surgery. But I had never seen
2 a scenario like this. In answer to your question, yes,
3 I would have expected that he would have been informed
4 of what had happened.
5 Q. You know ultimately what happened is that Raychel is
6 transferred to the Children's Hospital and it's not
7 possible to help her and that she dies on Sunday the
8 10th. When did you first find out that Raychel had
9 died?
10 A. I remember leaving the hospital very numb that morning,
11 but I knew that this was something big. I think I found
12 out on the Monday.
13 Q. Can you recall who you found out from, or the
14 circumstances in which you found out?
15 A. No, I can't recall who told me, but I would have went
16 looking.
17 Q. Because you knew she'd gone to the Royal?
18 A. Yes, Raychel went down to the -- to have a CT scan done,
19 yes. I would have went down as well. I didn't do
20 anything the rest of that morning. So I don't know on
21 Monday who I found out from, no.
22 Q. Sorry?
23 A. I don't know who told me on Monday that Raychel had
24 passed away.
25 Q. I thought you said you might have gone to try and find

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1 Q. At some point the consultants from the other two
2 disciplines are there, Dr McCord who's a consultant
3 paediatrician, and Dr Nesbitt, who's a consultant
4 anaesthetist. Was it your expectation that a consultant
5 surgeon would arrive?
6 A. I was happy that the surgical SHO and registrar had
7 arrived. I ... No, it wasn't my expectation, is the
8 answer to your question.
9 Q. You presumably appreciated that Raychel was actually
10 Mr Gilliland's patient. He was her consultant.
11 A. I wouldn't have necessarily known it was Mr Gilliland,
12 but obviously I knew Raychel was a surgical patient.
13 Q. And that she would have had a consultant?
14 A. Yes.
15 Q. But are you saying you didn't appreciate that at that
16 time it was Mr Gilliland?
17 A. I can't recall if I knew it was Mr Gilliland.
18 Q. At some point as Raychel deteriorates -- and by this
19 time, at 5 o'clock, her pupils are fixed and dilated --
20 would you have thought that her own surgical consultant
21 would be contacted to let him know what had happened to
22 his patient?
23 A. I would have expected -- yes, I would have expected that
24 he would have been informed. I had never seen
25 a surgical consultant in hospital at night in my six

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1 out.
2 A. Yes. But when something like that happens in
3 a hospital, most staff are talking about it, so I don't
4 know who actually told me.
5 Q. I understand that. When you found out on what you think
6 is the Monday what had happened, did you expect that
7 somebody would come and talk to you about it?
8 A. Definitely, yes. Yes. I knew there would have been
9 some sort of investigation process because of what had
10 happened.
11 Q. And that's one of the reasons you went to get that
12 printout?
13 A. There was some sort of informal meeting the following
14 week, in which I was told there would be an
15 investigation -- a review or whatever it was termed
16 at the time -- so yes, that's when I went to get bleep
17 times.
18 Q. Let me roll that back a little bit for you. You,
19 I think, were quite definite that you would have
20 expected to have been contacted about it since you were
21 involved and there, literally, at the last stages. Did
22 you expect her consultant, whoever that was, to come and
23 talk to you about what happened to his patient?
24 A. I expected either the consultant or the clinical
25 director or ... I wasn't aware of the hierarchy, but

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1 someone from the hierarchy in the hospital to chat to
2 all staff involved about the case.
3 Q. Did you and Dr Curran [sic] -- we know that you did talk
4 about it. Did you talk about it at this stage about
5 what your expectations as to what would happen?
6 A. To who, sorry?
7 Q. Dr Curran -- Dr Devlin, I beg your pardon.
8 A. Yes, I spoke -- sorry, I spoke to Dr Devlin probably the
9 Saturday or Sunday, I would think, that weekend.
10 Q. And then you said some sort of informal meeting. In
11 fact, there was a critical incident review on 12 June.
12 Do you make a distinction between that, which was very
13 shortly after Raychel's death, and the meeting which you
14 thought was going to happen the following week, or are
15 they much the same sort of thing for you?
16 A. I can't recollect being at a clinical incident meeting.
17 Q. No, you weren't at one. I'm asking you whether it was
18 at that meeting that you think you subsequently learnt
19 that all those involved might have to explain the nature
20 of their level of involvement with Raychel; do you think
21 it was coming out of that meeting?
22 A. It could have been feedback from that meeting, yes.
23 Could have been.
24 Q. Did Mr Gilliland at any time come to talk to you about
25 what happened?

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1 A. Yes, I wasn't aware of that.
2 Q. You weren't aware of that?
3 A. No.
4 Q. Did you know that Mr Zafar, for example, had attended
5 the critical incident meeting?
6 A. No.
7 Q. Or Mr Makar?
8 A. I don't think I was -- I mean, if I was invited or asked
9 to attend, I would have attended, so I don't know who
10 did or did not attend.
11 Q. Okay. If I take you to what appears to be the outcome
12 of that. Apart from the fact that you weren't really
13 very clear on what was happening or what the level of
14 surgical involvement in that critical incident review
15 meeting was, and you say that this is a death which
16 obviously would be the subject of discussion and
17 comment, were there any discussions as to what was
18 happening in that meeting? For example, views expressed
19 like I have put to you earlier about the availability of
20 surgical teams, the need to carry out electrolyte
21 testing and so forth. Did any of that find its way out
22 of the meeting into discussion amongst the doctors?
23 A. No, not amongst the JHOs.
24 Q. Not amongst the JHOs. Were you aware that procedures
25 changed shortly after Raychel's death?

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1 A. Not to the best of my recollection.
2 Q. Did that surprise you?
3 A. Yes, a little bit, I suppose, yes.
4 Q. We had asked Mr Gilliland whether he went about trying
5 to establish who was in the surgical team who was
6 treating Raychel, and the answer was, no, he didn't. He
7 confirms that he didn't speak with you and had no
8 specific discussions with you. Did anybody speak to the
9 members of the surgical team who had actually been
10 involved with Raychel that you are aware of?
11 A. Do you mean speak to me or --
12 Q. No, speak to all of you. There's Dr Devlin, yourself,
13 Mr Zafar, Mr Makar, Mr Bhalla. They're all part of the
14 surgical team who had some sort of involvement in
15 Raychel's care. Were you aware of anybody trying to get
16 together what the surgical team's knowledge was about
17 what had happened?
18 A. To the best of my recollection, I don't think anyone
19 spoke to me to get -- spoke to me about what happened or
20 my involvement.
21 Q. And therefore, you're not aware of there being any
22 meeting called where all those surgeons who'd been
23 involved with Raychel gathered together and tried to
24 understand what had happened or give some account of
25 their involvement from the surgical perspective?

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1 A. I was aware that there was changes to be made following
2 Raychel's death. Yes, I was aware that following that
3 critical incident there were changes to be made.
4 Q. 095-011-059g. This is the action points coming out of
5 that meeting. What I want to ask you about is was any
6 of this information communicated to you and the other
7 JHOs to indicate a change in how things were to be done?
8 You can see, for example, at --
9 THE CHAIRMAN: Number 1, doctor: did you know that
10 Solution No. 18 was changed a few days later and was
11 replaced?
12 A. I did know that.
13 THE CHAIRMAN: Okay. Did you know that, from then on, there
14 would be daily U&Es on all post-operative children
15 receiving IV infusion in Ward 6?
16 A. I didn't know that, but I was now in medicine. But
17 I didn't know that.
18 THE CHAIRMAN: It just happened that that night you were
19 surgical, but you weren't supposed to be surgical
20 generally?
21 A. Yes.
22 THE CHAIRMAN: Okay. Did you know about number 4:
23 "All urinary output to be measured and recorded
24 while IV infusion is in progress."
25 In other words, there was to be a tightening up of

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1 the measurement and recording of urinary output?
2 A. I wasn't aware that that change was being made. Maybe
3 that's because I was in medicine and it wasn't going to
4 affect me the way it would have affected surgical
5 patients.
6 THE CHAIRMAN: Did you know at number 5 that there was to be
7 a chart which would be displayed in Ward 6 to guide you
8 and your medical staff?
9 A. No, I wouldn't have been in Ward 6 ever since, but ...
10 Obviously I agree they're appropriate, but no I wasn't
11 aware of that.
12 THE CHAIRMAN: Thank you.
13 MS ANYADIKE-DANES: If you were aware of these things, how
14 did you become aware of the ones that you were aware of?
15 A. The Solution No. 18 change I was aware of that.
16 Q. How did you become aware of it?
17 A. I think that was talked about by the JHOs that were on
18 the surgical ward.
19 THE CHAIRMAN: Did you understand why it was being changed
20 or just that it was being changed?
21 A. I understood it was being changed because of the
22 hyponatraemia in this case.
23 THE CHAIRMAN: Does that mean that you knew that Raychel's
24 death was being attributed to hyponatraemia?
25 A. No, I didn't know that. I just knew that Raychel had

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1 to Raychel?
2 A. I understood that they were doing it because of the
3 hyponatraemia in Raychel's case, but I didn't understand
4 why one particular fluid was used for years and was then
5 changed to another. I didn't understand why --
6 Solution No. 18 was used for years, as I understand it,
7 and then it was changed obviously to Hartmann's
8 following this case. I knew why it was changed.
9 Q. Well, did you understand that the Solution No. 18 was
10 implicated in the development of Raychel's
11 hyponatraemia?
12 A. I presumed it was.
13 Q. No, did you understand how that could be?
14 A. Well, I presumed, in simple terms, it was because we
15 were replacing fluid that didn't have high enough sodium
16 content.
17 Q. Exactly. When I had been asking you those questions
18 before, when you saw this change now, if you hadn't
19 already appreciated -- you had therefore now appreciated
20 the problem was she's vomiting fluid and what was
21 happening is that she was being replaced with something
22 that was lower in sodium than that which she was
23 vomiting, and that was the problem, and you understood
24 that?
25 A. Yes.

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1 hyponatraemia and, as I was involved, I knew the change
2 was being made.
3 THE CHAIRMAN: Did you understand what the difference was
4 between Solution No. 18 and the fluid which was used
5 subsequently?
6 A. I was aware that Solution No. 18 was low-sodium fluid,
7 0.18 per cent sodium, and the fluid changed to was of
8 a higher sodium content. So I knew the difference
9 in the two fluids, the higher sodium content.
10 MS ANYADIKE-DANES: Had you been involved in prescribing
11 other fluids, Hartmann's, for example, as a JHO?
12 A. Yes, in adult patients.
13 Q. Yes. So did you know, as at the time of Raychel's
14 death, the difference between Hartmann's and
15 Solution No. 18?
16 A. I would have known that Hartmann's -- I think was
17 0.9 per cent sodium, I think, whereas ... Don't quote
18 me, I haven't prescribed fluids for years. I was aware
19 that Solution No. 18 was more glucose and less sodium,
20 whereas Hartmann's was more sodium.
21 Q. When you saw this change that they were going to cease
22 using Solution No. 18 and replace it with Hartmann's or
23 replace it with something that had a higher sodium
24 content, did you understand the significance of why they
25 would be doing that following on from what had happened

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1 Q. Did you also understand or did it make its way out of
2 the meeting in some way that Raychel had received
3 perhaps the wrong type of fluid for replacement? Did
4 you also understand that she'd received too much fluid?
5 A. I had read that in some of the inquiry documents.
6 Q. No, I'm meaning at the time. Did any of that filter out
7 for people to be discussing and appreciating that
8 Raychel had received too much fluid?
9 A. No, no, I didn't realise that until years later when
10 I got the documents, so no.
11 Q. And where you see "Arrange daily U&Es", did you
12 understand that, coming out of that meeting, what people
13 considered a contributory factor was the fact that her
14 electrolyte results were not known over that period of
15 time when she was vomiting and continuing to receive her
16 Solution No. 18?
17 A. Yes.
18 Q. That people had recognised that that was a problem?
19 A. Yes.
20 Q. And then although you say that you were medical at that
21 stage, if I can put it that way, and no longer engaged
22 in surgical work and therefore unlikely to meet this
23 again and maybe that's why you wouldn't have been aware
24 of the notices in Ward 6, it's always possible that you
25 would have been asked to do the very thing that you were

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1 asked to do on 8 June.
2 A. It's possible, but I don't think I would have did it.
3 Q. This is the notice that went up and I'm going to ask you
4 actually where this went and whether you saw it. It's
5 095-011-059j. Did you see that anywhere or have it
6 drawn to your attention?
7 A. No, I have never seen that.
8 THE CHAIRMAN: How often were you back in Ward 6 after
9 Raychel's death?
10 A. To the best of my recollection, I went there once and
11 that was because of a relative or adult that collapsed
12 one night when I was on the cardiac arrest team.
13 Otherwise, I've never been back on Ward 6.
14 THE CHAIRMAN: A relative or adult who was visiting a child?
15 A. Yes.
16 MS ANYADIKE-DANES: And given that what Altnagelvin was
17 doing was actually quite a significant change in its
18 practices -- I know that you said you can't exactly be
19 clear about whether you attended. In fact, I think you
20 don't think you attended Dr Nesbitt's talk and I don't
21 want to go through all the sorts of talks you might have
22 been attending. But was there any discussion about
23 those who had been part of formulating this change
24 in the procedures, communicating that in some more
25 formal way to all the junior doctors as a learning point

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1 years.
2 A. Solution No. 18 -- I wouldn't have been on the
3 paediatric ward doing electrolyte profiles. I wouldn't
4 have been on the paediatric ward, so ...
5 THE CHAIRMAN: As I understand it, you weren't on the
6 paediatric ward, full stop.
7 A. Yes.
8 MS ANYADIKE-DANES: So although it is a dramatic change and
9 you remained in the hospital, it is not one that
10 affected your work going forward, if I can put it that
11 way?
12 A. That's correct.
13 Q. Yes. Then I think finally -- I might just see if
14 anybody has any questions -- you didn't give evidence
15 at the inquest.
16 A. No.
17 Q. Did you know that there was going to be an inquest into
18 Raychel's death?
19 A. I was quite junior at that time, so I didn't really
20 understand necessarily the difference between an
21 inquest, inquiry and investigation. I knew there was
22 going to be some sort of process appropriately; I was
23 never asked to give evidence. In answer to your
24 question, no, I didn't know there was an inquest or
25 inquiry.

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1 quite apart from anything else?
2 A. No. I think if that was the intention, then the 12 JHOs
3 could have been brought to a meeting, a lunchtime
4 meeting or something, and it could have been discussed.
5 But this notice you're showing me, I have never seen
6 that. The points that were changed I would have heard
7 on the grapevine, so to speak, about the Solution No. 18
8 being changed. But there was no sort of formal meeting
9 with JHOs to say: these changes are being implemented.
10 Maybe the six surgical JHOs at the time may have had
11 some sort of meeting with the surgeon.
12 Q. But you're in a training period. Would you have
13 expected, given the significant change --
14 THE CHAIRMAN: It's okay, Ms Anyadike-Danes, I have the
15 point.
16 MS ANYADIKE-DANES: Thank you.
17 You might have answered this and please tell me
18 immediately if you have; I just can't recall if I asked
19 you it. I think you then go on to become a medical SHO.
20 A. Yes.
21 Q. I take it that none of this is anything that you have to
22 deal with during those two years.
23 A. None of the?
24 Q. None of these changes that have been instituted are
25 anything that you have to be alive to during those two

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1 Q. If there was going to be, whether an inquest, which
2 there was, or some sort of internal investigation that
3 Altnagelvin might establish for itself, is that
4 something that you would have expected to be involved
5 in?
6 A. Yes.
7 Q. And when you say "yes" like that, did you ever discuss
8 that with Dr Devlin?
9 A. I didn't ... Sorry, I did discuss with Dr Devlin what
10 had happened. I didn't necessarily discuss with
11 Dr Devlin when and if there would be an inquest.
12 Q. Okay. I just want to put one final point to you
13 because, in fairness, it is something that Mr Foster may
14 be asked about and I don't want you not to have the
15 opportunity to comment on it. It's in his report at
16 223-003-013.
17 Dr Foster wrote two reports. He wrote this report
18 after he'd had the benefit of seeing the witnesses'
19 statements. This is really his comment on the junior
20 house officer statements that he has seen, so he'll have
21 seen yours, Dr Devlin's, and he saw Dr Butler's,
22 although she's not at your level. If you see the
23 italicised part under 8.4, that's really his summary of
24 it, if I can put it that way. So his first view is:
25 "Junior house officers who had no experience of

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1 paediatrics ..."
2 Which is essentially you at that stage:
3 " ... should not have been first on call for
4 surgical children."
5 As you reflect back on that, did you feel exposed?
6 A. At the time in Altnagelvin whenever you're a JHO, you
7 have such a steep learning curve, everything you're
8 doing or many of the things are doing are new to you, so
9 you probably are in many ways naive. Looking back at it
10 now, yes, totally exposed.
11 Q. Yes. And really, his main concern is the missed
12 opportunity, which I think you have acknowledged was
13 a missed opportunity, at 10 o'clock.
14 A. Yes.
15 Q. It was a missed opportunity to put in place a plan of
16 care for Raychel that might have prevented her death.
17 A. I would say to that, if I went back and I had no other
18 patients to see that night and with the information
19 I was given, I would have done the exact same thing, but
20 I wish I didn't.
21 MS ANYADIKE-DANES: I understand. Mr Chairman, can I just
22 check if there are any questions?
23 MR QUINN: Mr Chairman, I do have a series of questions. It
24 might be easier if I put them up now. This is an issue
25 raised by the parents.

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1 that the fluid chart is at the bedside. Let's then look
2 at paragraph 5(a):
3 "I did not find her distressed or actively vomiting
4 when I seen her. I noted her observation from her
5 chart. Her temperature was normal."
6 What chart were those observations made from? What
7 chart would show the temperature?
8 A. There's temperature at the top, pulse is the middle
9 line, respirations at the bottom. There's three
10 separate parts to the page.
11 MR QUINN: Can you look at 020-015-029, please? Where
12 is that particular chart kept?
13 A. I don't know, but I didn't ... That wasn't the chart
14 I was referring to. I don't know where that one's kept.
15 MR QUINN: That's not part of the bedside notes?
16 A. I can only say I didn't see that chart.
17 MR QUINN: Was it part of the charts and notes that were
18 held at the nursing station?
19 A. I can't answer. I haven't seen that.
20 THE CHAIRMAN: What do you mean, if that is not what you
21 mean by the TPR?
22 A. There's another -- I got it in the clinical records from
23 Altnagelvin. There was a chart called a temperature,
24 pulse, respiration -- it's like three graphs or
25 [OVERSPEAKING].

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1 Mr Chairman, if I may ask, was a headache ever
2 reported to the doctor?
3 THE CHAIRMAN: Do you recall that?
4 A. I do not recall anyone telling me about a headache.
5 MR QUINN: May I go on to ask the following be put up,
6 ws028/2, page 5 and 6 together?
7 THE CHAIRMAN: This is your own statement, doctor.
8 MR QUINN: This is the doctor's second statement. The
9 question starts at (m) at the bottom of page 5 and goes
10 into page 6. It reads:
11 "I cannot recall if I spoke to her parents when
12 I assessed Raychel. I did speak to the paediatric
13 nurse. I looked at her bedside chart. I expect I would
14 have looked at her clinical notes, but I cannot recall."
15 The doctor makes a clear distinction between (a) the
16 bedside chart and (b) the clinical notes and could I ask
17 does that mean that -- the bedside chart is kept at the
18 bed and the clinical notes are kept at the nursing
19 station? I just want to make the grounds clear here.
20 Is that correct?
21 A. To the best of my recollection, yes.
22 MR QUINN: So could we then ask precisely what is at the
23 bed? I know I've gone over this ground. The doctor has
24 confirmed that a headache was never reported to him, but
25 we know that the kardex is at the bedside and we know

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1 MS ANYADIKE-DANES: 020-015-028. That's the TPR.
2 A. That's the one there.
3 MR QUINN: That's the chart you mean?
4 A. Yes.
5 MR QUINN: Would you agree that if there was notification of
6 a headache by the parents or a headache was recorded,
7 that that would be a relevant feature of the nurses
8 reporting it to you?
9 MR STITT: I do apologise for butting in, I should have
10 waited until the end of the question. I've been sitting
11 listening at the back, not sitting beside my instructing
12 solicitor, but I thought we'd established a set of
13 ground rules in terms of questions to witnesses --
14 THE CHAIRMAN: Yes, and we are trying to do this for speed
15 because we've overrun significantly and I's trying to
16 get these done quickly rather than me rise, Mr Quinn
17 speak to Ms Anyadike-Danes and then Ms Anyadike-Danes
18 put them through. Because I'm very anxious that the
19 person that you're speaking to at the back of the room,
20 Dr Johnston, is waiting here and is expecting to give
21 his evidence this afternoon and be finished this
22 afternoon -- and he will be finished this afternoon.
23 I'm just trying to speed things up and a little leeway
24 would be very helpful. Mr Quinn, please.
25 MR QUINN: If the previous record could be put up again,

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1 please, 020-015-029. At the bottom right-hand corner of
2 that record, you can see that there's a complaint of
3 headache recorded.
4 A. Yes.
5 MR QUINN: Would that be a relevant feature to report to you
6 if the nurses had recorded a headache?
7 A. Yes, it's just more evidence she was unwell.
8 MR QUINN: When that is put together with the other record
9 on that sheet, that is vomiting plus plus, that also
10 might put up what you call the red flag?
11 A. The vomiting coffee grounds, definitely. Many people
12 may have a headache when they're being sick, but it
13 depends what you mean by "plus plus".
14 MR QUINN: Let's leave it there. Would you agree that
15 a headache, looking at it now retrospectively, perhaps,
16 may be part of the overall picture of hyponatraemia?
17 A. Definitely.
18 MR QUINN: Thank you.
19 THE CHAIRMAN: Any questions before I come to Mr Stitt? No?
20 Mr Stitt, have you any questions?
21 MR STITT: No, I haven't.
22 THE CHAIRMAN: Doctor, unless you have anything else you
23 want to say before you leave the witness box, your
24 evidence is now complete.
25 A. Thank you very much.

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1 over the last day or two, we're very close to sorting
2 out entirely any issues about what we call files 21 and
3 22 and what Altnagelvin have called files 1 and 2.
4 MR STITT: Yes, that's not a privilege issue; that's just
5 a reconciliation issue.
6 THE CHAIRMAN: Mr Quinn, I think your solicitor was involved
7 in that issue in 2010 and made submissions and there was
8 some claim for privilege at that point. The only issue
9 upon which submissions were made to us was about the
10 three reports, doctors Warde and Jenkins, and those
11 reports were eventually conceded by the Trust. We have
12 an accurate and complete list of documents, which
13 I think we're very close to doing. I don't think there
14 are any outstanding issues about that.
15 On the DLS inquest file, which is the Altnagelvin
16 inquest file, I understand that we're now to be given
17 a fresh list of documents. The list of documents we had
18 from the other day was seven pages long and runs up to
19 about 230 items.
20 MR STITT: Yes, there are something like five additional
21 documents which were found, not that they were lost, but
22 they hadn't been, for whatever reason, included in the
23 first index. There's no great air of suspicion there,
24 I would suggest, because the documents themselves aren't
25 particularly important. I'm putting forward simply an

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1 (The witness withdrew)
2 THE CHAIRMAN: Okay, thank you. We'll sit again at 2.30 and
3 deal with Dr Johnston's evidence this afternoon.
4 (1.53 pm)
5 (The Short Adjournment)
6 (2.30 pm)
7 (Delay in proceedings)
8 (2.36 pm)
9 THE CHAIRMAN: Is Mr Stitt here?
10 MR LAVERY: Mr Chairman, no.
11 THE CHAIRMAN: I wanted to raise the privilege issue briefly
12 just for an update.
13 MR LAVERY: At this moment, Mr Stitt is in a teleconference
14 with Elaine Way, the chief executive of the Trust. That
15 may have a bearing on the issue. I think my instructing
16 solicitor has gone to see --
17 THE CHAIRMAN: I'll wait one moment. I know he's indicated
18 we'll have an answer this afternoon about whether the
19 Trust is going to assert a claim for privilege.
20 MR LAVERY: I think he expects to address you on that later
21 on. (Pause).
22 THE CHAIRMAN: Mr Stitt, I didn't know you were consulting.
23 What I wanted to raise was the general position about
24 documentation. As I understand it, as a result of
25 discussions primarily involving Ms Dillon and Mr Johnson

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1 administrative oversight.
2 THE CHAIRMAN: Okay. First of all, when will we get the
3 revised list?
4 MR STITT: The revised list is ready. We've got the list.
5 It's a list in which there are four types of reference
6 against the index and that sets out the types of
7 privilege, if privilege is claimed, and whether
8 documents are already before the inquiry and, where
9 they're not before the inquiry, where there's no
10 privilege claimed.
11 THE CHAIRMAN: Will that include the documents which are not
12 currently on the list because of the administrative
13 oversight?
14 MR STITT: Yes, they are in this list, this final list, and
15 they're in bold type.
16 THE CHAIRMAN: That helps.
17 MR STITT: That led to a slight slippage in the numbering
18 when I tried to reconcile yesterday with Mr Coyle and we
19 realised our numbers were a few out. In relation to the
20 privilege point itself, I am due to have a discussion
21 just about now.
22 THE CHAIRMAN: Okay.
23 MR STITT: I will be giving certain advices and I will be
24 listening to what the Trust says and I will be reporting
25 back.

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1 THE CHAIRMAN: Thank you very much. Has that list has been
2 prepared on the basis that the Trust may claim privilege
3 and it sets out what each document is, if privilege is
4 claimed, and what type of privilege is claimed?
5 MR STITT: Yes. Well, in shortened form, privilege is
6 claimed and it's either legal advice privilege or
7 litigation privilege or no privilege.
8 THE CHAIRMAN: Okay. Then there is also the Brangam Bagnall
9 inquest file, which is the Belfast Trust file, isn't
10 that right?
11 MR STITT: Yes, and I'm somewhat behind the black ball on
12 that one. I haven't seen the file and we're a little
13 behind, but we're working on getting this first one
14 finished. We'll move on to that one immediately; I'm
15 yet to see it.
16 THE CHAIRMAN: Next week is scheduled to be the last week in
17 which witnesses from Altnagelvin give evidence. The
18 following week and maybe a day or two in the week after
19 that will involve Mr and Mrs Ferguson giving evidence
20 and also the inquiry's experts. I think there's one
21 exception of Auxiliary Nurse Lynch. So I want to sort
22 it out before the Altnagelvin witnesses finish because
23 there is an increased risk of having to start recalling
24 witnesses if some documentation emerges or if some issue
25 arises. You were going to take instructions in a phone

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1 the Altnagelvin issue --
2 MR STITT: No, I'm talking about Belfast.
3 THE CHAIRMAN: The Belfast issue is -- first of all, the
4 Trust have to decide whether to claim privilege and,
5 then secondly, it has to decide what it's going to claim
6 privilege for; isn't that right?
7 MR STITT: Of course.
8 THE CHAIRMAN: In Claire Roberts' case, the privilege which
9 was waived did not extend to -- and I don't expect it
10 to -- extend to communications from counsel. I think
11 Mr McAlinden QC had advised and although privilege for
12 other documents was waived, privilege for Mr McAlinden's
13 advices was not waived.
14 MR STITT: There were ten items on that list.
15 THE CHAIRMAN: I don't expect there's any issue about that,
16 Mr Quinn. That's clearly --
17 MR QUINN: No [inaudible: no microphone].
18 THE CHAIRMAN: So anything of that specific type, there is
19 not going to be an issue about.
20 MR STITT: That's very clear legal advice privilege, yes.
21 We could narrow it down if you wish me to consider
22 certain areas. There are two, for instance, that occur
23 to me immediately in relation to the Western Trust file.
24 Perhaps there's nothing to be gained by this because
25 we're hoping to come back with a decision this

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1 call shortly; do you expect then that the Altnagelvin
2 inquest file, a decision will be taken on that this
3 afternoon?
4 MR STITT: I would hope so, yes. I have already indicated
5 the time frame laid down yesterday by you, sir, which
6 meant that a decision had to be made this afternoon.
7 And I have no reason to believe that won't be the case.
8 THE CHAIRMAN: And the Belfast Trust file, I'm going to have
9 to press you. I think we need an answer by lunchtime
10 tomorrow because there's some limited time available on
11 Monday to argue any issues about privilege and, in order
12 for that to be achieved, the lists of documents and any
13 claim for privilege which is asserted have to be
14 distributed to the other parties -- particularly to the
15 Ferguson family -- tomorrow, so that they're in
16 a position to consider it over the weekend.
17 MR STITT: Yes. That's going to cause something of
18 logistical problem. Because of the timetabling which
19 was clearly set out in advance, I won't be in the
20 jurisdiction tomorrow and I feel I really should be
21 advising. It's a responsibility which I don't take
22 lightly to advise in relation to privilege and I would
23 ask, sir, that you would give us through Monday to
24 complete that.
25 THE CHAIRMAN: I won't give you through Monday to complete

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1 afternoon.
2 THE CHAIRMAN: We're going to have the Western Trust
3 decision this afternoon. I'm unhappy about the Belfast
4 Trust issue drifting into some day later next week and
5 having to be dealt with separately. The same principles
6 apply, don't they?
7 MR STITT: Might I respectfully suggest, sir, that when I've
8 dealt with the Western Trust, I will be in the room and
9 I can sit at the back of the room and Mr Lavery and
10 myself will be listening to Dr Johnston giving his
11 evidence and, if you'll permit me, if I think there's
12 an important point that I need to interject on, I can
13 come forward and do so, but at the same time I'll be
14 considering that at the back, the Belfast index.
15 THE CHAIRMAN: Just for the sakes of completeness, there are
16 two litigation files which we were alerted to. One is
17 the Western Trust litigation file in respect of Mr and
18 Mrs Ferguson's claim. That's the claim which is
19 effectively stayed, even though you didn't like that
20 word, Mr Quinn. It's effectively stayed pending the
21 outcome of this inquiry.
22 MR STITT: I'm sorry I missed that debate about the staying.
23 THE CHAIRMAN: Let's not go back. There is a litigation
24 file for that. There clearly is litigation privilege;
25 the only question is whether there's any document which

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1 may not be privileged on that list.
2 MR QUINN: I would accept that generally the documents will
3 be privileged, although there may be some that aren't.
4 THE CHAIRMAN: The other thing is that we were told that
5 there's a Belfast Trust litigation file. Mr Quinn, was
6 Belfast Trust sued?
7 MR QUINN: No.
8 THE CHAIRMAN: Is there a second defendant?
9 MR QUINN: Yes, there is a second defendant.
10 THE CHAIRMAN: So the same principles would apply to that.
11 Could we tidy that up too? In other words, the
12 Fergusons' writ is against both trusts.
13 MR QUINN: Yes.
14 THE CHAIRMAN: The Western and Belfast as successors to
15 Altnagelvin and the Royal.
16 MR STITT: I thought that the Belfast one had been
17 discontinued.
18 THE CHAIRMAN: That can be clarified. I'd like to tidy this
19 all up.
20 MR STITT: I'm fairly confident that there is no extant case
21 against Belfast Trust. I'll be corrected as I am still
22 new into this whole affair.
23 THE CHAIRMAN: I'd like that tidied up over the next day or
24 two as well. Okay?
25 MR QUINN: I think we stand corrected. I have just pulled

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1 A. Yes.
2 Q. That is series 317-024. Can I also confirm with you the
3 statements that you've made previously?
4 A. Yes.
5 Q. I think you made a statement to the Trust, which has
6 already been referred to. I think you were also at the
7 back listening to some of Dr Curran's evidence.
8 A. Yes.
9 Q. So your statement to the Trust is dated
10 21 December 2001. And the reference for that is
11 012-013-113. Then you had an amended statement dated
12 7 July 2002, and the reference for that is 021-058-139.
13 If we just pause there for the moment, can you recall
14 what was amended?
15 A. I think the date that I returned from the neonatal
16 intensive care to the paediatric ward. Plus I think the
17 name of the surgical registrar was amended.
18 Q. "El-Shafie" to "Bhalla"?
19 A. Yes.
20 Q. Is that the extent of the amendment?
21 A. I think so, yes.
22 Q. Do you know who asked you to do that?
23 A. I think there was discussion with counsel at the time.
24 Q. I see. Then you have a deposition to the coroner, which
25 is dated 5 February 2003. The reference for that is

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1 out the litigation file that we have and it is only
2 against Altnagelvin Trust.
3 THE CHAIRMAN: Okay. Then that might raise a separate issue
4 about whether there is any privilege attaching, if there
5 was a litigation file, to Belfast Trust.
6 MR QUINN: There shouldn't be any privilege attaching and
7 it is something we should see.
8 THE CHAIRMAN: All right. So Mr Stitt, we'll know this
9 afternoon about Altnagelvin. Sorry, we'll know between
10 this afternoon and tomorrow morning. Ms Dillon and
11 Mr Johnson will sort out any small outstanding issues
12 about files 1 and 2 from Altnagelvin. We'll know by the
13 close of business this afternoon what the Altnagelvin
14 position is about the inquest file. I need to know
15 something tomorrow about the Belfast Trust.
16 MR STITT: I would hope to have some progress report on the
17 Belfast file in Raychel's case by the close of business
18 today.
19 THE CHAIRMAN: Thank you very much.
20 DR JEREMY JOHNSTON (called)
21 Questions from MS ANYADIKE-DANES
22 MS ANYADIKE-DANES: Good afternoon, Dr Johnston.
23 A. Good afternoon.
24 Q. Can I confirm you've got there to your left your
25 curriculum vitae?

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1 012-040-198. And you also were asked to make a PSNI
2 witness statement; is that correct?
3 A. Yes.
4 Q. That's dated 27 April 2006 and the reference for that is
5 095-015-069. In addition to all of that, you've made
6 two witness statements for the inquiry.
7 A. That's correct.
8 Q. The series is 029 and the first is dated 1 July 2005.
9 The second is dated 22 January of this year.
10 A. That's correct.
11 Q. So one way or another, you've been making statements in
12 this matter from about December 2001.
13 A. Yes.
14 Q. Intermittently, obviously.
15 A. Yes.
16 Q. Can I ask you, firstly, subject to anything that you may
17 want to say now in your oral evidence, do you accept
18 those statements as your evidence?
19 A. Yes.
20 Q. Thank you. Can I also ask you, how clear a recollection
21 do you have of what happened in, for you, the early
22 hours of 9 June?
23 A. It's certainly not crystal clear at this stage.
24 Q. Sorry?
25 A. It's not very clear at this stage.

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1 Q. Are some things clear --
2 A. Some things are clear and many things are not totally
3 clear. I have a vague recollection of a number of
4 things at this stage.
5 THE CHAIRMAN: When you reach the points where things are
6 clear or unclear, could you differentiate as best you
7 can?
8 A. Yes.
9 MS ANYADIKE-DANES: Also, we are largely going to be dealing
10 with what happened in those early hours of 9 June 2001.
11 I may also ask you some questions to do with the
12 aftermath of what happened. But unless I tell you
13 different, if you can concentrate on the state of your
14 knowledge and understanding in relation to matters for
15 2001. If you want to make some sort of comparison, let
16 us know, otherwise we'll be thinking we're talking about
17 2001.
18 A. Yes.
19 Q. Thank you. Then can I ask you: what documentation have
20 you seen to assist you? I presume you saw at the
21 relevant time Raychel's medical notes and records.
22 A. Yes.
23 Q. I'm talking about to assist you when you prepared your
24 witness statements.
25 A. Yes.

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1 at June 2001. You had been a doctor for about four
2 years; is that right?
3 A. That's right, yes.
4 Q. And an SHO for three years?
5 A. Yes, I was -- that was my third SHO year.
6 Q. Then if we think about where you did that, you started
7 off at Altnagelvin?
8 A. Yes, as a PRHO.
9 Q. So you did your pre-reg at Altnagelvin and you also
10 did --
11 A. Accident & Emergency.
12 Q. Yes. You did an SHO there as well?
13 A. Yes.
14 Q. And from there you moved on and you've had experience,
15 in terms of Northern Ireland hospitals, in the Mater,
16 the Musgrave, the Royal in Belfast, and Craigavon,
17 Altnagelvin, and the Royal, and the Ulster as well. You
18 came back to Altnagelvin in February 2001.
19 A. The experience in the Ulster was after this paediatric
20 job.
21 Q. Ah. So I think you've already told us in evidence that
22 this was your first dedicated paediatrics rotation.
23 A. That's correct.
24 Q. And you'd had four months of that --
25 A. Yes.

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1 Q. Since then, and before coming here to give your
2 evidence, have you seen the witness statements of other
3 witnesses?
4 A. Yes, I have seen the information that was on the
5 website.
6 Q. And you've had an opportunity to look at that, no matter
7 how cursorily?
8 A. Yes, that was before my final statement.
9 Q. Have you seen the expert reports? In particular I have
10 in mind the inquiry's surgical expert, Mr Foster, the
11 Trust's surgical expert Mr Orr, and the inquiry's
12 experts in terms of paediatrics, Dr Scott-Jupp, and
13 anaesthesia, Dr Simon Haynes?
14 A. Yes, I have seen those.
15 Q. You have seen all of that?
16 A. Yes.
17 Q. Thank you. Can I then just go to some aspects of your
18 curriculum vitae or your previous experience? I'm not
19 wishing to go through it all, although I have to say
20 that it's quite extensive and you have included, for
21 which we're grateful, the postgraduate courses and
22 training that you undertook. You've also included some
23 of your publications and extracts from them, which is
24 helpful. Thank you.
25 But if we deal now with your experience as

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1 Q. -- before you were called upon to provide any care to
2 Raychel?
3 A. Yes.
4 Q. You've had that at a high level, an SHO level. So if
5 you were asked to express a view as to how confident you
6 were in terms of dealing with paediatric patients at the
7 time that you came into contact with Raychel, how would
8 you describe that?
9 A. I think I'd like to point out first of all that in the
10 paediatrics there was no PRHO, so basically the SHOs are
11 the lowest level, the first point of care, and certainly
12 in a paediatric SHO post, the SHOs are fairly well
13 supervised by registrars and consultants, and certainly
14 every admission is reviewed by a registrar. So
15 basically, there's a lot of supervision as an SHO in
16 paediatrics. You're not really taking very high-level
17 decisions, especially when you compare that to SHO
18 levels in other specialties, especially in this post
19 where most of the doctors are first term SHOs with no
20 previous experience of paediatrics.
21 Q. So although your grade is as an SHO, in reality that
22 gives us perhaps a slightly misleading picture because
23 you wouldn't be operating the same way as if you were
24 an SHO in other discipline?
25 A. I think certainly the second and third-year SHO -- a

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1 third-year SHO is certainly somebody who's done three
2 years of paediatric experience and somebody ... are
3 totally different than myself who's doing my first
4 paediatric job. Although I've got three years of
5 experience, it's not in paediatrics.
6 Q. Can you help us with trying to describe for us or at
7 least explain the level of supervision that you would
8 have been having as an SHO in your first six months of
9 that rotation, if I can put it that way, in paediatrics?
10 What level of supervision would you have had?
11 A. Certainly the SHO in paediatrics, we would not have --
12 none of us would have discharged patients from the
13 hospital. We would have -- all of the patients that we
14 seen would have been reviewed again by the registrar
15 during an on-call period.
16 Q. And did you have any particular supervisor or was that
17 just a general level of supervision that was carried out
18 for all paediatric SHOs?
19 A. That was general supervision really.
20 Q. And during that first initial period, did you work more
21 closely with a registrar or consultant, or didn't it
22 work in that way?
23 A. I can't remember whether there was a consultant
24 specifically, not that I can recollect. To point out:
25 there's quite a large difference in experience between

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1 you're describing it, can you help in this way, briefly,
2 with what sort of induction you would have had coming
3 into Altnagelvin?
4 A. It's very difficult for me to remember with the passage
5 of time, but I do specifically remember -- because
6 we were looking after the delivery ward, there was a
7 one-day designated neonatal resuscitation day that we
8 did at the Belfast Children's Hospital and that was --
9 SHOs from all of the hospitals in Northern Ireland went
10 to that. It was organised centrally in Belfast for all
11 of us.
12 Q. Given that you have no JHOs, that you're straight in at
13 that level with paediatric patients, was there any other
14 sort of induction?
15 A. I think there were some -- there was some sort of ...
16 The first few days of the job, there was basically some
17 introduction to the different parts of the department
18 and some basic knowledge. I can't remember exactly
19 what was taught on that.
20 Q. I understand. Do you recall if there were any sort of
21 series of ongoing lectures or seminars which were put on
22 which you may or may not have been encouraged to attend?
23 A. Yes, I can recollect two sort of meetings. There was
24 a joint meeting with the obstetric department, if
25 I remember rightly, really sort of obstetric cases and

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1 the different people working on the registrar tier
2 in that department. There are people that are
3 fourth-year qualified and people who are 10 years
4 qualified in paediatrics.
5 Q. You've now explained the fact that it may be that it was
6 a little bit misleading the way that perhaps I referred
7 to you as an SHO and perhaps indicated that you were
8 more experienced and operating at a higher level than
9 you actually were. Can you help us just briefly with
10 what a paediatric SHO's role is or was in Altnagelvin at
11 that time?
12 A. Well, essentially, certainly to see admissions that have
13 come to the ward. GPs would refer patients to
14 a department in the hospital and if the GP would send
15 them, they would -- the GP would refer them, they would
16 come to the paediatric ward and they would be seen by
17 the SHO. And perhaps bloods would be done, simple
18 investigations, and simple management plans and then
19 they would be reviewed by the registrar. And there were
20 other duties. As SHO, we went to the delivery ward and
21 we were involved in the resuscitation of neonates and we
22 did jobs in the neonatal intensive care. Basically, the
23 tasks that we were given were to take bloods, blood
24 gases and chores like that.
25 Q. Given that it was still very much a training position as

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1 neonatal-type emergencies, and then I think there was
2 a -- I think there may have been another teaching
3 session during the week that I remember.
4 Q. If we think then specifically about Ward 6, which is a
5 mixed medical and surgical ward; that's right, isn't it?
6 A. Yes.
7 Q. You have been asked in your witness statement requests
8 for the inquiry to try and explain who had the
9 responsibility for what form of care and treatment of
10 those patients. So if we take the surgical patients --
11 A. Yes.
12 Q. -- particularly those who were post surgery, they're
13 there on Ward 6 and they're only on Ward 6 because
14 they're children --
15 A. Sure.
16 Q. -- but they have paediatric issues, I presume --
17 A. Yes.
18 Q. -- and they have surgical issues?
19 A. Yes.
20 Q. Were you given any guidance as to who is managing those
21 children and in what respects?
22 A. Certainly my recollection is that it was fairly -- it
23 was fairly sort of ... There was a discrete boundary
24 that certainly ... Although the surgical patients were
25 on the paediatric ward, that was the only common

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1 denominator; they were solely managed by the surgical
2 team and the surgical JHO, SHO, registrar, consultant,
3 and we had no involvement with them whatsoever.
4 Q. Does that include their fluid management?
5 A. Yes, it does. As far as I remember, yes.
6 Q. The reason I ask you that is because you probably know
7 by now --
8 A. Yes.
9 Q. -- that there is a difference of view --
10 A. Yes.
11 Q. -- as to who was dealing with what and, leaving aside
12 the immediate post-operative period entirely, and once
13 the child comes on to the ward and let's say from the
14 post-take ward round phase, if you like, there's
15 a difference of view as to whether the surgeons were
16 handling that element of such a child's fluid management
17 or whether they were, but only in discussion and with
18 the guidance of the paediatricians. And then there is
19 another school of thought that thinks maybe the
20 paediatricians were doing it. So there would seem to be
21 some difference.
22 A. Sure.
23 Q. Were you aware of any of that fuzziness, if I can put it
24 that way, at the time?
25 A. Yes. Certainly, it's a lot -- time has passed, but

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1 Q. And that in fact, if another type of fluid was
2 prescribed and there was -- sometimes it was just
3 unilaterally changed.
4 A. Yes.
5 Q. Other times, the doctor or surgeon would be invited to
6 change that and change it to what some have called
7 a ward protocol or ward practice.
8 A. Yes.
9 Q. Were you aware of that happening?
10 A. I was aware that Solution No. 18 was being used for the
11 paediatric medical patients. It was a fluid that
12 I haven't encountered before.
13 Q. You hadn't encountered it before?
14 A. No, because I have not really worked in paediatrics. My
15 memory and recollection is that that was a rule that was
16 applied to the paediatric medical patients, not
17 necessarily to the paediatric surgical patients.
18 Q. Were you ever aware of patients on Ward 6 having
19 anything other than Solution No. 18?
20 A. I can't remember. Certainly I know that I had no
21 involvement with the surgical patients, essentially,
22 until Raychel's -- that night.
23 Q. When you said that they had autonomy over it -- it may
24 be that because it is not something that you were
25 directly involved in, so if you can't help, please

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1 certainly I think any child who came with a surgical
2 condition were seen, start to finish, by surgical
3 doctors. If they came with abdominal pain and basically
4 they weren't seen by a paediatric medical doctor, they
5 were seen by a surgical doctor, and certainly as far as
6 I can remember everything from writing up painkillers to
7 fluid management, that was all managed by the surgeons.
8 Q. So the surgeons therefore would have been managing
9 issues such as what fluid and maybe what rate of fluid
10 they would be on?
11 A. Yes.
12 Q. Whether their electrolytes would be being tested, when
13 IV fluids should stop and were they on sufficient oral
14 intake; all that sort of issue, that's the surgeons?
15 A. Certainly that's what I remember, yes.
16 Q. And can I ask you this then: they didn't have control,
17 did they, as to, or did they, as to what the fluid
18 itself was?
19 A. As far as I remember, basically they were their patients
20 and they had full autonomy on how they were managed from
21 fluid management to analgesia.
22 Q. We have heard from a number of witnesses that the actual
23 type of fluid that was administered on Ward 6 was
24 Solution No. 18.
25 A. Yes.

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1 say -- but did you say that because it was your
2 impression that if a surgeon or a doctor, for that
3 matter, wanted a particular other fluid, Hartmann's,
4 say, because they thought there were good clinical
5 reasons for it, they would simply be able to prescribe
6 that and that fluid would be administered?
7 A. Yes. As far as I was concerned, the paediatric medical
8 team weren't involved with the management of the
9 surgical patients. Sorry, that was my memory and
10 recollection.
11 Q. Well, if we use an example, let's say an example of
12 a child who has gastroenteritis and that child, let's
13 say, is vomiting and has been vomiting for some time.
14 And there's a concern that that child is losing
15 electrolytes as a result of that. Is it your
16 understanding that a fluid could have been prescribed as
17 replacement fluid, which would have addressed that
18 depletion of sodium? So for example, Hartmann's. Could
19 that have happened on Ward 6?
20 A. I think it was possible, but certainly from the --
21 gastroenteritis is a paediatric medical condition and
22 certainly the normal practice would have been to use
23 Solution No. 18 for that.
24 Q. I understand that. But if you had formed the view or
25 your registrar had formed the view that what we need to

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1 address here is not just the hydration/dehydration
2 aspect, but actually a loss of electrolytes and
3 therefore a sodium depletion, that's what we need to
4 address, is it your understanding that that could have
5 been addressed by the administration of a different kind
6 of fluid which had a higher sodium content?
7 A. Yes, I think other fluids could have been used if there
8 was enough clinical information to justify that.
9 Q. And were you aware of whether or not Hartmann's was
10 actually available on Ward 6?
11 A. I cannot remember, but I would suspect that it probably
12 was on the ward or was in the hospital and available.
13 THE CHAIRMAN: Doctor, if a child came in as a paediatric
14 patient, a medical patient with gastroenteritis,
15 am I right in understanding that his or her bloods would
16 be checked, not only on arrival but on the following day
17 to see if there was any issue about the blood?
18 A. Certainly the bloods would have been -- part of our role
19 ... We would have -- as an SHO, we would have seen the
20 patient and checked their bloods as part of their
21 admission and basically they -- depending on the
22 severity of the gastroenteritis, the consultant would
23 have made a decision whether the electrolytes should be
24 checked the next day.
25 THE CHAIRMAN: Right. Can I take it that there are

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1 THE CHAIRMAN: Is that something that happened during your
2 time on the ward?
3 A. I can't specifically recollect that on that paediatric
4 ward, but certainly in my practice as a doctor that
5 happens quite often, yes.
6 THE CHAIRMAN: I'm trying to go back to round about 2001.
7 Is that the sort of thing -- and accepting that you
8 don't remember [OVERSPEAKING].
9 A. I can't specifically remember what happened on Ward 6,
10 but certainly the common practice in most wards and
11 departments is that if the electrolyte abnormality is
12 identified, it's managed, and certainly supplementary
13 electrolytes can be given, either orally or
14 intravenously.
15 MS ANYADIKE-DANES: That same logic, apart from what you
16 were saying when I was asking you earlier, would lead
17 you to, if you thought that what you have is a sodium,
18 you are very low in sodium, so the patient is becoming
19 hyponatraemic, that would lead you to think: maybe we
20 need to, in some way -- whichever way you do it --
21 increase the sodium intake of that child.
22 A. Yes.
23 Q. Logic would suggest that.
24 A. Yes.
25 Q. Is that something you that consider was possible in 2001

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1 inevitably some cases where a child with gastroenteritis
2 has their bloods checked and that the check reveals that
3 the child is getting low in sodium? Does that follow or
4 not?
5 A. Yes, I think certainly from a clinical point of view.
6 Certainly potassium is also another common electrolyte
7 abnormality. I think that's probably -- in
8 gastroenteritis, you're more likely to get a potassium
9 abnormality. Certainly the electrolytes would be
10 checked if there was a suspicion of either of those.
11 THE CHAIRMAN: Okay. And in that event, what I was told
12 a couple of days ago was that what might happen would be
13 the child would be given Solution No. 18, but with
14 additional potassium. So the IV fluid does not change
15 from Solution No. 18, for instance to Hartmann's, but
16 the IV fluid has an additional element added to it so
17 that for instance if there's a potassium deficit,
18 that is corrected.
19 A. Yes, I think you would -- certainly if there was an
20 electrolyte abnormality you would tailor the management
21 to that abnormality. Certainly if there was
22 a deficiency of potassium, additional potassium could be
23 added to a bag or there would be certain bags made up
24 with 20 or 40 millimoles of potassium per litre in them
25 and they could be administered.

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1 in Altnagelvin?
2 A. Yes.
3 Q. So it comes down to a matter of judgment really of
4 testing the child, seeing what the child's condition
5 is -- and I think you referred to it as tailoring your
6 fluid management to address whatever is the condition of
7 the child that's causing the difficulty, and in this
8 case, the case the chairman's given you, it's an
9 electrolyte imbalance.
10 A. Yes.
11 Q. And along with that might go an emetic [sic] to try and
12 stop the vomiting --
13 A. Yes.
14 Q. -- or if it was diarrhoea to try and reduce that?
15 A. Yes.
16 Q. I know you have said so far as you were concerned there
17 were fairly clear demarcation lines between who had
18 responsibility for the surgical patients and who had
19 responsibility for the paediatric non-surgical patients,
20 medical patients. But nonetheless, did you have any
21 experience of being called upon to assist with
22 paediatric input, if I can put it that way, to
23 a surgical patient?
24 A. I don't remember being asked to see any surgical
25 patients prior to that.

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1 Q. Was your involvement with Raychel actually the first
2 time that you'd asked to come and assist with
3 a paediatric patient?
4 A. A paediatric surgical patient, as far as I'm aware, yes.
5 Q. Thank you. There is an instance of one of your
6 paediatric colleagues, Dr Butler, being asked to -- when
7 the IV bag had finished, being asked to put another one
8 up. From what you have said, is that a rare sort of
9 thing or might that happen not infrequently?
10 A. I don't remember that happening frequently. Sometimes
11 doctors might be asked to write up painkillers or fluid,
12 whatever, as the nurses can't get hold of a surgical
13 doctor. But I certainly don't remember doing it myself.
14 Q. If you are asked to intervene in that way, I presume
15 from what you've said you're conscious that you're
16 intervening in a surgical patient's treatment.
17 A. Yes.
18 Q. What do you think your responsibilities are once you've
19 been asked by the nurses to intervene in a child like
20 that? Do you notify anybody in the surgical team that
21 you've been asked to do that, do you enter something in
22 the notes to show that? I'm talking about something
23 like replacing a bag or providing some kind of
24 medication.
25 A. Yes, I think -- I can't remember exactly. I can't

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1 A. It's not as simple as -- you could be potentially taking
2 on a sort of larger job than it first appears.
3 Q. So although it seems like a simple enough thing, you
4 would want to know a little bit more about the
5 circumstances of that child before you did something as
6 apparently straightforward as that?
7 A. Yes, yes.
8 Q. Thank you.
9 THE CHAIRMAN: I take it it would be tempting if a bag of
10 fluid for a surgical child had run out, it'd be -- and
11 the nurses can't get a JHO [OVERSPEAKING].
12 A. I think so. I can see how a colleague may get into
13 difficulty. I think you sort of have to weigh up your
14 rapport with the nursing staff. You could be quite
15 unpopular with the nursing staff if there was
16 a point-blank refusal to help out like that. So I can
17 see why some of my colleagues might have done that
18 because they would have perhaps thought that they were
19 helping.
20 THE CHAIRMAN: Yes.
21 MS ANYADIKE-DANES: Thank you. Were you aware, as I think
22 the chairman's just alluded to, that some of the reasons
23 why the nurses might ask a paediatrician to do that is
24 because the surgeons are very often committed
25 elsewhere -- in the theatre and so on -- and you may be

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1 remember being asked to do that on the paediatric ward,
2 to be honest.
3 Q. If you had been, given that in your view there's
4 a fairly clear demarcation line, what approach would you
5 take to how you communicated to the other team that
6 you'd actually been asked by the nurses and had done
7 something like that?
8 A. Well, certainly I would have -- if it was a patient
9 I wasn't familiar with ... I would have rather not done
10 it if I wasn't familiar with the patient rather than to
11 prescribe medication and fluids for a patient who I'm
12 not treating.
13 Q. If you were simply being asked to erect another bag of
14 IV solution, would that have concerned you?
15 A. Well, I can't remember being asked to do that, but
16 certainly I would have had reservations about doing that
17 on a patient I didn't have clinical information about.
18 Q. Why is that?
19 A. Why would I have reservations?
20 THE CHAIRMAN: Because it's not your patient?
21 A. It's not my patient and I don't know whether the bloods
22 were last checked and what the results were, what the
23 patient presented with.
24 MS ANYADIKE-DANES: That's precisely what I was hoping you
25 would expand on.

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1 more accessible to them.
2 A. Yes, I think certainly -- I'm aware that the surgical
3 JHO perhaps covers four or five wards and there may well
4 be a half hour, an hour delay in getting them to come to
5 the ward. So it may be easier for the nursing staff to
6 try and get another doctor to do it, and likewise the
7 surgical SHOs are particularly busy as well. They may
8 have five or six patients on a list to see when they're
9 bleeped. So I can see why there may well be time delays
10 before they come.
11 Q. Before Raychel's death and the critical review incident
12 meeting that happened on 12 June, before that were you
13 aware of any discussion about the difficulties that that
14 sort of availability caused?
15 A. I'm not aware of any discussions regarding that, but
16 certainly my experience is that the surgical JHO and SHO
17 jobs are particularly busy and a lot of hospitals --
18 probably especially in Altnagelvin.
19 Q. Yes. I wonder now if we could come to your attendance
20 with Raychel at about 3.05 in the morning of 9 June.
21 You described in your statement to the Trust on
22 21 December 2001, which was reasonably close to the
23 event -- I presume it was therefore quite reasonably
24 fresh --
25 A. Yes.

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1 Q. Is this the first child that you'd had any dealings with
2 who had actually died at that time for you?
3 A. Yes.
4 Q. So what you say is that at 3.05 you were finishing
5 a paediatric medical admission and then you were asked
6 by Staff Nurse Noble to see Raychel because you were the
7 only doctor readily available. You attended the child
8 who, so far as you could see, was having a generalised
9 tonic seizure and you administered 5 milligrams of
10 diazepam rectally -- you didn't, but the nurse did under
11 your direction -- but the fit was unresponsive to this.
12 Do I understand that to mean that she just carried on
13 fitting?
14 A. That's correct.
15 Q. And then there was a further 10 milligrams administered
16 via an intravenous cannula and that was successful in
17 stopping the seizure. If I just pause there --
18 incidentally, where I'm taking this from is 012-013-114.
19 We don't need to put it up, but that is where it comes
20 from. When you say that that was successful in stopping
21 the seizure -- once a seizure stops what is Raychel's
22 condition? How does she appear after that?
23 A. Essentially, her seizure had stopped. She was
24 unconscious, she was breathing normally, her oxygen
25 saturations were 100 per cent, her respiratory rate was

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1 perhaps look for another cause for the seizure.
2 Certainly, if I remember correctly, her temperature
3 wasn't elevated so that was certainly -- that's what
4 concerned me initially. I was concerned that perhaps
5 there was a more serious cause for the fit because she
6 was afebrile.
7 Q. In a way, if she'd had a temperature, that would have
8 given you a ready explanation for why she might be
9 having a fit?
10 A. Yes, I would have been less concerned if she had had
11 a temperature.
12 Q. So a bit more detective work has to be done to try and
13 establish the cause of that seizure?
14 A. Yes.
15 Q. That means, does it not, looking at her notes, talking
16 to the nurses who will have observed her --
17 A. Yes.
18 Q. -- and trying to see if you can refine what the
19 underlying cause of that seizure might be?
20 A. Yes.
21 Q. Had you seen anything like that before then?
22 A. During paediatrics I would have dealt with a number of
23 seizures or would have had exposure to them and
24 certainly as a doctor working with adults I would have
25 dealt with a number of epileptic fits and other types of

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1 satisfactory, her pulse and her blood pressure was
2 normal. I think that we had placed her in the recovery
3 position in case she vomited, that her airway would be
4 protected, and that would be certainly -- after that
5 amount of medication, that what's we would have
6 expected. We would have expected her to be
7 unresponsive.
8 Q. I was about to ask you that. The diazepam itself could
9 have led to her being unresponsive.
10 A. Yes, we would have expected her to be unresponsive with
11 15 milligrams of diazepam.
12 Q. And then you say that you administered oxygen via a face
13 mask and her vital signs were measured and, so far as
14 you were concerned, they were satisfactory and her
15 oxygen saturation, I think, was 99 per cent and her
16 pulse and temperature, all of that was fairly normal.
17 A. That's correct.
18 Q. Just at that stage, you having managed to stabilise her
19 and got her to that stage, what was your immediate
20 thought as to what had happened?
21 A. Well, the most common cause of seizures -- seizures are
22 quite common in children and usually they are due to
23 a febrile convulsion, so essentially my first sort of
24 port of call was to confirm where her temperature was
25 and certainly, if her temperature wasn't elevated, to

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1 seizures. So management of a seizure -- I would have
2 known how to manage a seizure.
3 Q. So that was a possible candidate, that she could have
4 had an epileptic fit.
5 A. Yes --
6 Q. Would it have looked the same?
7 A. It could have, yes.
8 Q. And you established that there was no history of
9 epilepsy?
10 A. Yes, we established that there was no history of
11 epilepsy and [OVERSPEAKING] I think certainly Staff
12 Nurse Noble sort of confirmed that there was no family
13 history of epilepsy either. So that was --
14 THE CHAIRMAN: Doctor, your evidence is being recorded, and
15 if you could speak a little slower, please. Your voice
16 is very clear and it's loud enough. It's just a little
17 fast. Thank you.
18 A. Certainly if she had a history of epilepsy, that would
19 have reassured me, I would have been less concerned
20 because certainly somebody with epilepsy, the threshold
21 for seizure would be much lower and it's less likely
22 that there would be sort of a significant cause
23 precipitating the seizure.
24 Q. So there were two potentially less concerning things
25 that could have prompted the seizure, both of which

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1 you've ruled out?
2 A. That's correct, yes.
3 Q. Does your concern start to increase as to what really is
4 the problem here?
5 A. Primarily, my first priority was to manage the seizure,
6 to stop the seizure, and to make sure that her airway
7 breathing and circulation were adequately being managed
8 and certainly after that I had to start thinking what
9 were the possible causes of it.
10 Q. Yes. And that you started to do. Before that, you have
11 actually written what, in the circumstances, seemed to
12 be quite a detailed note --
13 A. Yes.
14 Q. -- of exactly what you did and what your initial views
15 are. It's to be found at 020-007-013. Can I ask,
16 though, at that stage, once you've got her to that stage
17 and got a little bit of thinking time, if I can put it
18 that way, did you think that you might involve your
19 registrar?
20 A. At that time, certainly I looked through the hospital
21 notes and certainly there wasn't -- looked through the
22 operation note and it seemed to be -- there was no
23 evidence of a perforated appendix, so there was no
24 reason that she should be septic. Sepsis was another
25 possible cause or some abnormality, for example

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1 A. Yes.
2 Q. What else in terms of notes did you actually look at?
3 A. I can't honestly remember. Certainly I think my main
4 emphasis was the medical notes and the operation note.
5 Q. Let me --
6 A. I can't remember what else I looked at at that time.
7 Q. -- if I can help rather than just ask you to guess at
8 what you might be looking at. Would you have looked at
9 the fluid balance sheet?
10 A. It's possible I could have looked at it, but I can't
11 specifically remember.
12 Q. Let me pull it up and see if this assists in jogging
13 your memory. It's 020-018-037. Does that look like
14 something that you might have considered or wanted to
15 consider?
16 A. I can't remember actually seeing that. I know that
17 either from the -- from this or from the nursing staff
18 I was given some information that there had been
19 vomiting. I do remember that. And I've commented on
20 that in my note at 3.15.
21 Q. Yes, you did comment on it, and I think you were told --
22 at least I think your recollection is that you were told
23 on two or three occasions that she'd vomited.
24 A. I can remember being told that she vomited, but I can't
25 specifically remember how many times.

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1 infection in the abdomen --
2 Q. Can I ask you to pause there for a moment? When you say
3 you looked through her surgical notes, where did you
4 find those?
5 A. At the time that I wrote the note at 3.15 I had the
6 medical notes. I was writing in the medical notes at
7 that time.
8 Q. Did you ask for them specifically or were they there by
9 the bed?
10 A. I can't remember exactly how I got the notes. But
11 certainly ... Just after the fit, I did get the notes
12 somehow.
13 Q. So you would have wanted them when you were at the
14 bed --
15 A. I wanted the medical notes, yes. I asked for them and
16 got them.
17 Q. Thank you. So you look at that and you see that there
18 really didn't seem to be a great problem with the
19 appendix. She had a faecolith, but that was about the
20 height of it. A fairly short actual duration of surgery
21 and everything appeared to be relatively normal apart
22 from perhaps little bit of slightly longer time in
23 waking up. But other than that, if you're looking at
24 that, that all seemed fairly straightforward to you;
25 would that be fair?

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1 Q. Once you were told anything about vomiting at all, would
2 you have wanted to know how many times she had vomited,
3 what the vomiting was like, over what sort of period had
4 she been vomiting? Would you have wanted to have that
5 kind of information?
6 A. From the information that I was given, I think on the
7 basis that she had been vomiting, certainly my main
8 differential diagnosis at that stage was electrolyte
9 abnormality. So basically, certainly from the
10 information I was given that she had vomited, whether
11 that be two times or ten times, I'd already decided that
12 was probably a likely cause or the most likely cause of
13 her seizure.
14 Q. Did you know that she had been vomiting coffee grounds?
15 Was any of that ever mentioned to you?
16 A. I don't specifically remember that. I have heard the
17 evidence regarding coffee grounds, but certainly from an
18 experienced doctor's point of view, coffee grounds
19 doesn't always necessarily mean that somebody's been
20 vomiting blood. Certainly my experience is that quite
21 often coffee grounds -- the lining of the stomach, of an
22 empty stomach of somebody who's not eaten, the lining of
23 their stomach, they can vomit on an empty stomach and
24 produce brown vomit, which quite often is described as
25 coffee grounds, but does not necessarily mean that they

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1 are vomiting up blood.
2 Q. But if there is blood in the vomit --
3 A. Yes.
4 Q. -- is that something that would have been significant to
5 you as you tried to refine what you thought was wrong
6 with Raychel?
7 A. Well, I think certainly if there had been -- if I'd
8 known -- I don't remember being told that there was
9 blood. But certainly if there had been blood, it would
10 probably have indicated that she had probably been
11 vomiting for a longer period of time.
12 THE CHAIRMAN: Doctor, you heard, I think at least some of
13 Dr Curran's evidence this morning.
14 A. Yes.
15 THE CHAIRMAN: He says that he wasn't alert to the fact that
16 it was coffee-ground vomiting.
17 A. Yes.
18 THE CHAIRMAN: But had he known that, that in itself would
19 have raised a red flag and increased his concerns;
20 do you agree with him on that?
21 A. Well, I --
22 THE CHAIRMAN: You don't have to.
23 A. I just want to make a comment. I don't remember and
24 certainly I'm fairly sure I wasn't told that there was
25 coffee-ground vomiting, but I certainly don't --

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1 A. I think, even at that stage, I would have had enough
2 experience to know that coffee-ground vomiting -- what's
3 described as brown vomit -- brown vomit is quite often
4 described as coffee grounds and that probably didn't
5 include any blood, even --
6 THE CHAIRMAN: So your differential diagnosis of electrolyte
7 imbalance doesn't depend on the number of vomits and
8 doesn't depend on the vomit being coffee grounds, even
9 if that's an accurate description?
10 A. Yes, well, I think coffee grounds basically -- most
11 people who vomit on an empty stomach vomit brown vomit.
12 Certainly I think there is a perception that if
13 something is described as "coffee grounds", that it is
14 stale blood and I don't think that's necessarily true.
15 I think certainly I had come to the conclusion that
16 electrolyte abnormality was my main sort of
17 differential. I think if Raychel had been vomiting
18 profusely over a longer time period, that probably made
19 it even more likely.
20 THE CHAIRMAN: Thank you.
21 MS ANYADIKE-DANES: In fairness, Dr Scott-Jupp, who is the
22 inquiry's paediatric expert, doesn't think even true
23 coffee-ground vomiting is necessarily diagnostic of
24 severe or prolonged vomiting. He says that bit's not
25 infrequently seen in children with mild vomiting

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1 THE CHAIRMAN: But [OVERSPEAKING].
2 A. I certainly think that there has been an overemphasis on
3 coffee-ground vomiting certainly from a clinical point
4 of view. Quite often junior doctors and nursing staff
5 will describe vomit as coffee grounds and there's no
6 blood in it, it's just stomach lining. That's my
7 experience. I suppose it's my experience, after
8 16 years being qualified, but certainly coffee-ground
9 vomiting I think has been overemphasised, the
10 significance of it. It may be that they have just
11 vomited on an empty stomach. There may not be any blood
12 in it. I think there is certainly a perception by some
13 junior doctors and nursing staff that "coffee ground"
14 means there's blood in the vomit. Certainly people
15 describe coffee-ground vomit as brown vomit.
16 MS ANYADIKE-DANES: I understand.
17 A. Yes.
18 Q. In fact it's recorded here twice, maybe three times.
19 But in any event, given your knowledge as it was in
20 2001, without the benefit of the experience you have
21 since gained, if you had been alerted to the fact that
22 there had been a number of incidents of coffee-ground
23 vomiting by an experienced nurse, would that have been
24 something that you would have wanted to know and would
25 that have featured in any way in your --

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1 illnesses who have only vomited two or three times
2 previously. He stresses that it's the frequency and
3 severity of vomiting which is critical in his view.
4 A. Yes, I would agree with that.
5 Q. So if you were going to consider the vomiting at all as
6 part of your differential diagnosis, what you would have
7 been wanting to know is how often was she doing it?
8 A. Yes.
9 Q. How much was she producing and how much retching and
10 straining was associated with it; would that be fair?
11 A. Yes.
12 THE CHAIRMAN: Sorry, maybe I picked you up wrongly a few
13 minutes ago, doctor. I thought that you said whether
14 she had vomited twice or 10 times wasn't really central
15 to your diagnosis of electrolyte abnormality. Did
16 I pick you up --
17 A. I can't remember. From the information I was given,
18 I can't remember what information I was given, whether
19 it was vomiting two times or 10 times. I came to the
20 conclusion that electrolyte abnormality was the most
21 likely abnormality. Certainly if somebody's been
22 vomiting for a prolonged period of time and large
23 amounts, that makes it even more likely.
24 MS ANYADIKE-DANES: Does that mean you could have got to
25 your view almost irrespective of the number of vomits

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1 just from knowing that she was on IV fluids, she was
2 post surgery, and she had had a seizure?
3 A. Yes.
4 Q. And would that be enough to have a working --
5 A. I think there were no other obvious causes for the
6 seizure, so basically I thought that was the most
7 likely.
8 Q. Thank you. Did you know at the time that she had
9 a headache or had complained of a headache?
10 A. I can't recollect being given that information.
11 Q. If you had, would that have reinforced your view or made
12 any difference at all?
13 A. I think in retrospect, certainly a headache is
14 associated with hyponatraemia, but certainly I think
15 it's not something that I considered at the time.
16 I can't remember if I was given that information.
17 Q. So you were on the track of an electrolyte abnormality,
18 but not on hyponatraemia, if I can put it that way?
19 A. Not specifically, no.
20 Q. Yes. That meant that you needed to get her bloods
21 tested --
22 A. That's correct.
23 Q. -- in order to see what the position was.
24 A. That's correct.
25 Q. Can you help me with this: while you were sort of

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1 see what could be done, you weren't thinking that she'd
2 now come over, if I can put it that way, become
3 a paediatric patient, and you would be calling your
4 senior people and the paediatric team would thereafter
5 be looking after her? That's not how you saw it.
6 A. Certainly, I think that if I hadn't been on the ward,
7 I think the surgical JHO or SHO would have been bleeped
8 to see her; I wouldn't have been bleeped and I wouldn't
9 have been involved necessarily.
10 Q. Yes. Just a point back, when you were asking -- you
11 were not quite sure what you were told about the
12 vomiting. We've passed it by, but just so that the
13 record is there, it's 012-040-200. We don't have to
14 pull it up. What you say is:
15 "I had been told Raychel had been reasonably well.
16 I may have been told that she had vomited once or
17 twice."
18 And the person that you think may have told you that
19 was Nurse Noble. In addition to that, you were of the
20 view that Nurse Noble had told you that she had had
21 abdominal pain, she had had her appendicectomy, she had
22 vomited and she had received an anti-emetic.
23 A. That's correct.
24 Q. That was the basic information that you had before you
25 got started.

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1 gathering your thoughts and the information that you
2 could to form a view, at any stage at all did you think,
3 "I will just contact my registrar"?
4 A. Certainly I think when I've gathered all the
5 information, certainly my impression was that it was
6 a surgical -- it was a surgical patient looked after by
7 a surgical team and, as far as I was concerned, the most
8 likely cause was electrolyte abnormality and certainly
9 caused by vomiting plus or minus intravenous fluids, and
10 certainly as far as I was concerned that's
11 post-operative care of the surgical team.
12 Q. Correct me if this is an unfair way of characterising
13 what you're saying, but you had been called, you wanted
14 to stabilise her --
15 A. That's correct.
16 Q. -- have the appropriate kind of tests in train, if I can
17 put it that way --
18 A. That's correct.
19 Q. -- with a view to then getting the more senior people in
20 the surgical team, since she was a surgical patient, and
21 they would take over her care? Was that your thinking?
22 A. Certainly that was -- at 3.15, that was certainly what
23 I had in mind. That was my plan, yes.
24 Q. So you weren't thinking that because you'd been called
25 and started the very necessary work to stabilise her and

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1 A. That's correct.
2 Q. The next thing is to get the result so that you know
3 what to do and also, for that matter, get the senior
4 surgical team involved. That's what leads you to
5 contact Dr Curran.
6 A. That's correct.
7 Q. You may have heard as I was going through with him his
8 recollection of what he was being told.
9 THE CHAIRMAN: The gist of it is he agrees with you that you
10 wanted two things done urgently. You wanted him to work
11 on the bloods to get them checked, but his recollection
12 is that you wanted him to get his SHO. I think if
13 there's a difference between you and him, your
14 statements seem to indicate that you were asking for the
15 SHO and the registrar.
16 A. That's correct.
17 THE CHAIRMAN: How clear are you that you were asking for
18 the registrar and not just the --
19 A. I'm clear that the registrar was asked for. I'm clear
20 about that because I was concerned and I excluded
21 febrile convulsion and epilepsy.
22 MS ANYADIKE-DANES: In fact, if we look at your medical note
23 at 020-007-013. You can see right down at the bottom
24 you say:
25 "Review by registrar/consultant."

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1 A. Yes.
2 Q. Did that indicate that actually at that stage when you
3 were writing that, which was timed at 3.15, you actually
4 weren't particularly interested in getting the surgical
5 SHO, what you really wanted was the surgical registrar
6 or, alternatively, the surgical consultant?
7 A. That's correct.
8 THE CHAIRMAN: On your side of the house, the paediatric
9 side of the house, for you to get to a consultant, would
10 you inevitably go through the registrar?
11 A. Yes.
12 THE CHAIRMAN: So I'm trying to work out if there's any
13 misunderstanding or just that this is a hierarchical
14 nature of things. There's no doubt that Dr Curran did
15 respond. He came as quickly as he could, he did get
16 involved in the bloods, and when you asked him again,
17 "Is there somebody senior coming?", he said he was
18 contacting them now. In the same way as if you wanted
19 your consultant you would go through the registrar, does
20 it fit with that hierarchical approach that if he wanted
21 the registrar, he would go to go through his SHO?
22 A. I think not necessarily. I think the threshold for
23 phoning a consultant would be much higher than for
24 phoning a registrar, even from a JHO, because the
25 consultant is at home and it is 3 o'clock in the morning

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1 Dr Curran is a very, very junior doctor and faced with
2 something that was probably completely out of his
3 experience to receive a bleep like that. Is it your
4 understanding that you had communicated to him in a way
5 that he could grasp that you wanted him to, as quickly
6 as he could, get his registrar down to Ward 6?
7 A. Yes. As far as I was aware, that's what was
8 communicated.
9 Q. You've heard his evidence because you were at the back
10 when he was going through it. He didn't contact his
11 registrar, he doesn't believe, because he believed,
12 in the way the chairman has said, that there's
13 a hierarchy to these things. He would typically contact
14 his SHO, not that it was impossible for him to contact
15 his registrar, but it would be typical to contact the
16 SHO and then the SHO would contact the registrar and
17 matters would proceed in that way. And that he had done
18 that, he had contacted his SHO and the response he had
19 received was that his SHO was dealing with a patient in
20 A&E, couldn't come immediately, but would come
21 presumably as quickly as he could. And that was the one
22 and only contact that he had with any more senior
23 surgical colleague until about 5 o'clock when both the
24 registrar and the SHO arrive at the treatment room.
25 Were there any exchanges between you as the time

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1 as well.
2 THE CHAIRMAN: Whereas the registrar --
3 A. The registrar's in the hospital in an on-call room.
4 MS ANYADIKE-DANES: From the way you have put it there,
5 would the expectation be that the registrar would be
6 contacted and the registrar could bring in the
7 consultant if necessary?
8 A. That's correct.
9 Q. Is that --
10 A. Yes.
11 Q. -- a fair reading of your note there?
12 A. Yes.
13 Q. Irrespective of whether Dr Curran understood it in that
14 way, so far as you were concerned, what you were trying
15 to do is to get him to somehow get hold of his registrar
16 and, if the registrar thought it appropriate, bringing
17 in the consultant?
18 A. Yes.
19 Q. And if we are at when you would have wanted that to
20 happen in relation to you having stabilised her at this
21 time and writing this note, 3.15, when would you have
22 been wanting that senior surgical involvement?
23 A. I wanted it then. I wanted it at 3.15.
24 Q. In various places in your two inquiry witness statements
25 one constantly sees the reference to "urgently".

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1 moved on from 3.15 about trying to see if he could go --
2 A. Certainly. My understanding was that they had been
3 contacted at 3.15 and then certainly when it came to --
4 after the bloods were sent, some time after 3.30, they
5 still haven't arrived, then I asked him again: what's
6 happening, why aren't they here? And then I was under
7 the impression that he contacted them again at that
8 stage.
9 Q. Again?
10 A. Yes, after 3.30.
11 Q. I see.
12 A. I was under the impression that he had contacted both
13 the registrar and the SHO. That was the understanding
14 that I had. I can't specifically remember what was
15 actually said, but certainly that was my understanding
16 that they had both been contacted and that they were
17 actually both going to come quite soon.
18 Q. Given that you hadn't seen them, is that part of your
19 thinking in going to see your registrar?
20 A. Yes, it was.
21 Q. So had they come when you had wished them to be there,
22 that might have been the end of the paediatric
23 involvement, if I can put it that way?
24 A. Yes.
25 Q. But you couldn't do that. You had to obviously carry on

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1 treating her as best as you could and your view was that
2 this was a situation sufficiently serious that, if you
3 couldn't get a higher level involvement from the
4 surgeons, you'd have to have a higher level involvement
5 from your own paediatric team.
6 A. That's correct.
7 Q. I now want to ask you about the bloods and to clarify
8 exactly what was going on. Because if one looks at your
9 witness statements, it's possible to get the impression
10 that there was a bit of confusion --
11 A. Yes.
12 Q. -- as to what was happening about the bloods. Dr Curran
13 has explained that you put in a sort of code in the
14 computer and that directs whether the bloods are going
15 to go to biochemistry or whether they are going to go to
16 haematology. As it happens, it is possible to want
17 bloods to be tested in both labs.
18 A. Yes.
19 Q. And when that happens, do you have two samples with
20 their respective different destinations or do you send
21 them to one lab and they split them up and send them?
22 A. There are two different destinations so far as
23 I remember. There's a specific code for biochemistry
24 and there's a specific code for haematology, so they can
25 go in two different chutes.

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1 Q. And as I understand it, that's not what happened.
2 A. It doesn't appear to be.
3 THE CHAIRMAN: But the alternative route is for him to put
4 them down on one canister, but to ring both labs --
5 A. Yes.
6 THE CHAIRMAN: -- which is what he said he would normally do
7 in that situation. If that's going to cause any delay,
8 it's going to be seconds rather than hours, isn't it?
9 A. What happened was I think certainly I phoned and
10 certainly biochemistry hadn't received it and they
11 hadn't started processing it.
12 THE CHAIRMAN: So we don't know where the mistake happened,
13 but you caught on to the fact that you didn't have the
14 result that you needed and you secured that result?
15 A. Yes. There was some time and phone calls made to sort
16 of chase that up.
17 MS ANYADIKE-DANES: If you're going to do that, just put it
18 down the one chute and then -- as I understand it, the
19 labs are proximate to each other.
20 A. Yes.
21 Q. Then presumably you need to tell them get that other
22 sample urgently to the other lab.
23 A. Yes.
24 Q. Otherwise, presumably, they don't know to do that.
25 A. Yes. Dr Devlin or Dr Curran in his oral evidence said

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1 Q. There are actually two physical chutes?
2 A. Yes. It wasn't abnormal for some of the doctors to send
3 them to one destination.
4 Q. And then at that destination, do they then send them to
5 the [OVERSPEAKING] --
6 A. They were perhaps -- the labs were next to each other,
7 so they would be handed over or thrown into the next
8 lab.
9 Q. Was that common?
10 A. I think so. As far as I'm aware it was common, yes.
11 Q. Did you know at the time which of the results you wanted
12 to get back soonest, if I can put it that way?
13 A. Yes, biochemistry.
14 Q. And had you explained that to Dr Curran?
15 A. Yes, I had explained that certainly my main concern was
16 an electrolyte abnormality, that's why I wanted bloods
17 taken urgently -- and an electrolyte abnormality would
18 mean biochemistry.
19 Q. And was it your expectation that the bloods that were
20 going to be tested to produce the electrolytes would
21 have the appropriate code on and go down the bit of the
22 chute that takes them to the biochem lab and the other
23 bloods would have a different code and be sent off down
24 to the haematology lab?
25 A. That was my expectation, yes.

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1 that he had made the labs aware that the samples were
2 coming.
3 Q. So that should have happened?
4 A. Yes.
5 Q. But for some reason it hasn't. And the upshot of the
6 whole phone call is to find out they're still there in
7 the haematology lab and to get them moved quickly to the
8 biochemistry lab. You say there was a delay in that.
9 Do you have any sense of whether that was a significant
10 delay in terms of what you were wanting to do?
11 A. I think it's very difficult to recollect actual times.
12 I suspect it may have been perhaps maybe 10 or
13 15 minutes.
14 Q. Yes. And that meant you weren't able to determine
15 whether, if it was an electrolyte problem, whether the
16 problem was too much or too little sodium or some other
17 issue, and therefore couldn't actually start to
18 administer anything to address it?
19 A. That's correct.
20 Q. You also are performing a 12-lead ECG to rule out
21 a cardiac cause.
22 A. Yes. Essentially, one of the reasons why I did an ECG
23 was if there was an abnormality in potassium -- if there
24 was a gross abnormality in potassium, there would be ECG
25 changes that could perhaps be treated before a blood

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1 result was available.
2 Q. Can I ask you this: how quickly, all things being
3 equal -- and I know that they aren't always -- can you
4 get a result back from the biochem lab if you're really
5 on their case and saying this is absolutely urgent,
6 I must have it back? How quickly can you get it back?
7 A. I think it's very difficult for me to remember exactly
8 what the processes were in Altnagelvin. Certainly my
9 experience would be in most hospitals maybe a minimum of
10 30 minutes.
11 Q. 30 minutes?
12 A. Yes. Somewhere between 30 minutes to an hour.
13 Q. If you felt that in the scheme of things that that
14 perhaps is a little too long for me and I just want to
15 have some sense of what I'm dealing with here, can you
16 also get a blood gas analysis done which would give you
17 an idea of where the sodium is?
18 A. It is possible, yes.
19 Q. I know it's not as accurate --
20 A. Yes.
21 Q. -- but it gives you some sort of idea of where you are.
22 A. Yes. It is possible.
23 Q. Did you have any thinking that you might do that?
24 A. I don't -- it's not something which I considered.
25 I think -- I'm not sure whether I was aware that the

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1 the blood gas machine offered those figures and
2 certainly my experience would be that certainly not many
3 people would treat on the basis of those alone without
4 another laboratory sample result.
5 Q. So if anything was going to happen in that direction,
6 you would need to have somebody with perhaps more
7 experience to know that there was a machine like that,
8 which could produce those sorts of results, and also to
9 be able to factor in for the potential differences
10 between that and the true result and exercise that
11 degree of judgment over what to do, but you at your
12 level didn't feel that you really could embark on such
13 a course?
14 A. Yes, from my experience most people -- and certainly not
15 very many doctors that I'd seen beforehand -- would not
16 treat electrolyte abnormality on a blood gas result.
17 They would treat it on the basis of a laboratory result.
18 Q. So before you go and get more senior help yourself,
19 you're seeing Raychel at 3.15, it takes you some time,
20 maybe 15 minutes or so to stabilise her, and then you're
21 off to see Dr Trainor at 4 o'clock. So there's about
22 half an hour period before you go and talk to Dr Trainor
23 to get --
24 A. Yes. I'm not totally sure what the timescale was when
25 I left the ward. I think some time between 3.30 and

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1 blood gas machine in the hospital -- not all blood gas
2 machines give electrolyte. And the other thing is I am
3 not sure what the -- whether that would be an accurate
4 enough measurement to start prescribing quite important
5 intravenous fluids.
6 Q. There was a machine in the neonatal unit, wasn't there?
7 A. Yes, there was.
8 Q. And what would that produce?
9 A. Certainly at that time I wasn't aware that that did
10 electrolytes, and again even if it did do electrolytes
11 it wouldn't have been a measurement that I would have
12 been happy to prescribe fairly -- sort of high levels of
13 potassium or sodium with.
14 Q. Yes. I think the evidence that we've received is it
15 wouldn't give you an accurate one, but it might give you
16 an order of magnitude, for example if the result came
17 back and it said 119 or something, then you'd know
18 presumably it's -- the tolerance of it would be enough
19 to know that you were dealing with a low sodium issue --
20 A. Yes.
21 Q. -- and that might be of some assistance --
22 A. Yes.
23 Q. -- while you are waiting for a more accurate result.
24 A. Yes. Certainly, it's not something which I considered.
25 I think I ... I don't remember whether I was aware that

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1 4 o'clock. I think it may have been before 4 o'clock.
2 Q. You're right. Although some have thought it was 4, in
3 fact there's a range of views. As you might imagine,
4 people aren't being terribly precise about these things
5 when they're concerned about Raychel's condition. But
6 you have it in your inquiry statements at some time
7 between 3.30 and 3.45 and Dr Trainor thinks it was about
8 4.15.
9 A. Yes.
10 Q. So there's quite a difference in space as to what was
11 happening. And the question I want to ask you is: once
12 you had got her stabilised and you had had the bloods
13 sent off, but obviously you haven't got a result and
14 you are not really expecting a result for a little bit
15 of time because you know that's what it takes, is there
16 any reason why you don't go then and there to Dr Trainor
17 and say, "This is what I found, this is what I am
18 dealing with, what do you suggest"?
19 A. I think there were two things I wanted. One was to get
20 the bloods off. Ideally I would have wanted a blood
21 result, but there was a delay. The other thing was the
22 ECG. I wanted an ECG. The ECG machine wasn't on the
23 ward and had to be got from another ward and certainly
24 there were a number of ECGs done and I didn't leave the
25 ward until the ECG was done.

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1 Q. I understand. Is it --
2 A. I left very shortly after the ECG was done.
3 Q. Yes. Is it possible to contact Dr Trainor from where
4 you were in the ward or would you have to go somewhere
5 else to make the phone call to bleep her?
6 A. There would have been phones at the nursing station,
7 again time has passed, I don't actually remember exactly
8 what happened. But it would have been my normal
9 customary practice to bleep her or to phone.
10 Q. We understand that where Raychel was positioned actually
11 wasn't very far away from the nursing station. The
12 reason I'm pressing you a little bit about this is that
13 you have acknowledged that your paediatric experience
14 was not great at that stage.
15 A. That's correct.
16 Q. You've done the most essential thing in stabilising her
17 and having bloods sent off to get information that
18 a more senior colleague is likely to need, if I can put
19 it that way. But it might be that there is time passing
20 where a more experienced person could actually have
21 embarked upon some treatment of Raychel then and there
22 if I can put it that way.
23 A. I think there's a number of issues. One, I was quite
24 busy sort of getting the ECG, chasing up blood results.
25 Two, I expected the senior surgical team to arrive, and

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1 45 minutes for a senior surgeon to arrive and they
2 hadn't arrived. I would have expressed all of those
3 concerns to her.
4 Q. And your view as to what you thought was the actual
5 cause of this?
6 A. Yes, I'd have explained that as well, and I was waiting
7 for the blood result.
8 Q. So your view was that you thought there was an
9 electrolyte problem, you had sent off the bloods, they
10 hadn't come yet, but that's your best view as to what
11 the problem was at the moment?
12 A. That's correct.
13 Q. Yes. Am I right in saying that it wasn't you who were
14 bleeped by Ward 6, it's Dr Trainor; is that correct?
15 A. I can't remember. From my witness statements, it would
16 appear that I was bleeped.
17 Q. Ah, you were bleeped?
18 A. Yes.
19 Q. What were you told when you were bleeped?
20 A. I believe from my witness statement that was made
21 12 years ago that the child -- Raychel had deteriorated
22 and they wanted somebody -- the nurses would like
23 a doctor, a more senior doctor to come now.
24 Q. These sometimes can be terms of art, words like
25 "deteriorate". When you heard that, what did that

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1 I think ... And basically, when those things were done,
2 when the bloods -- that was chased up and the ECG was
3 done at that stage ... Rather than wait for the blood
4 result at that stage, I was concerned enough before the
5 blood result came back, I would -- after the surgeons
6 hadn't arrived and the blood result hadn't come back --
7 even before the blood result came back, I thought
8 I would get in contact with Dr Trainor.
9 Q. So really once you've done your EEG [sic], there's no
10 senior surgical help arrived, so at that stage that's
11 when you go and find your registrar?
12 A. Yes.
13 Q. Thank you. In fact, it's whilst you're explaining
14 things to your registrar that there's a bleep
15 in relation to Raychel's condition from Ward 6.
16 A. That's correct.
17 Q. Can I ask you, do you recall what you told Dr Trainor,
18 what the nature of your discussion was?
19 A. Well, I can't recall exactly what was said, but I think
20 I would have told her what my concern -- one, that the
21 child had a seizure, that there wasn't sort of a less
22 serious cause for the seizure, that the child was
23 afebrile, there was no history of epilepsy. I would
24 have explained to her it was a surgical patient, but
25 I was concerned because I had been waiting 30,

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1 connote to you? Did you think that maybe she had
2 recommended fitting? What did it mean to you?
3 A. I can't remember exactly in what way that was described.
4 Q. But in any event, you communicated that directly to
5 Dr Trainor?
6 A. Yes.
7 Q. And she went off. Obviously, that's appropriate, she's
8 the more senior and you stayed looking after her
9 patients.
10 A. That's correct.
11 Q. You are there when Dr Curran meets you there with
12 a blood sample.
13 A. I can't fully remember that, but from the statements
14 that were made at the time it would appear that way.
15 Q. So you're staying there dealing with the matters that
16 she was dealing with and the evidence that we have from
17 the witness statement is that the discussion between
18 Dr Trainor and Dr Curran is that she wants repeat bloods
19 done and he comes up with the arterial blood sample and
20 the place to get that checked is where you are because
21 there's a machine that can do that.
22 A. That's correct.
23 Q. That's what happens. He informs you of the electrolyte
24 results that he receives.
25 A. I can't remember, to be honest.

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1 Q. But he tells you about Raychel's deterioration, how she
2 is at that stage, does he?
3 A. I can't remember exactly what was said at that time.
4 Q. Okay. When you next go back, is that because Dr Trainor
5 has asked for you to assist her? Is that how you get
6 back to the treatment room, if I can put it that way?
7 A. I can't remember again, to be honest. I don't know
8 whether I finished my task or was asked to come back.
9 Certainly I can't remember what the reason was I came
10 back, but I did come back to the ward sort of a short
11 time after being in the neonatal intensive care unit.
12 Q. When you went back there, is it correct that in terms of
13 medical assistance it was Dr Trainor, Dr Curran and
14 yourself?
15 A. That's correct. Initially. There were other doctors
16 that came --
17 Q. Yes, later, but at that stage?
18 A. Yes.
19 Q. Did you know that Dr Trainor had contacted her
20 consultant?
21 A. I know that he was contacted. I can't remember at what
22 stage he was contacted. He was contacted -- I can't
23 remember at what stage he was contacted, but I remember
24 that he was contacted and he came into the hospital.
25 Q. Did you see Raychel's father when you came back?

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1 Q. Do you know what had been done in the intervening period
2 about her IV fluids?
3 A. I can't remember exactly what was done with the
4 IV fluids.
5 Q. At some point we understand that the regime was changed.
6 She was put to half-normal saline, the rate was reduced
7 and there's a prescription written up, although it's not
8 signed as to who administered it. Therefore we don't
9 know when it was administered, but we understand that's
10 what happened. Are you aware of when that happened
11 yourself?
12 A. I was aware that the regime was changed and I was aware
13 that there was sort of three times normal saline was
14 prescribed to be given, but I can't remember exactly
15 when that was.
16 Q. Just so that we're clear about it, there was a while
17 when we wondered whether it had actually happened at
18 all. But so far as you're concerned, there's no issue
19 with that: it did happen, it's just that you don't know
20 when it happened?
21 A. Certainly I can't -- things ... Dr Trainor was in
22 charge sort of from 4.45 onwards, so basically I was
23 just doing sort of jobs for her. I wasn't fully aware
24 of exactly what was happening and at what time.
25 Q. Do you know apart from the changing of the fluids -- and

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1 A. I was on the ward for a period of time, sort of from
2 whatever, 4.45, 5 o'clock onwards, for the next hour or
3 two, so I remember the family being there, but I can't
4 remember whether they were there sort of just after
5 I arrived on the ward or if they came later on.
6 Q. We have a time -- all these things are difficult, we get
7 them from different sources and see what is the
8 consensus. It would appear that, at about 4.40, you and
9 Dr Curran arrive back in the treatment room and
10 Dr Trainor wants you to insert a second IV cannula to
11 take two blood samples because she's thinking perhaps
12 meningitis or something of that sort.
13 A. I remember her taking the blood sample, inserting the
14 cannula and I think I gave antibiotics at that stage
15 under her instruction.
16 Q. Did she explain to you at all her thinking as to what
17 she thought was the problem with Raychel at that stage?
18 A. I think -- um, she was covering the possibility that
19 there was -- could be meningitis. So for that reason,
20 she wanted bloods for that to cover -- investigate that
21 and for antibiotics to be given in case the child had
22 meningitis.
23 Q. At that stage, when you get back, do you know her serum
24 sodium levels are low?
25 A. That's correct, yes.

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1 you're not entirely sure when that happened or
2 presumably you don't know at whose instruction that
3 happened.
4 A. Well, Dr Trainor was in charge from when she arrived, so
5 until Dr McCord arrived, so --
6 Q. It's difficult to say, I think he comes possibly about
7 5-ish or something like that. It's difficult to say.
8 Quite a lot seems to happen at 5 o'clock.
9 A. Yes.
10 Q. Please say if you can't, but are you able to tell even
11 whether that reduction had happened before Dr McCord
12 came?
13 A. I wouldn't be able to remember that.
14 Q. I understand. Do you know if Dr Trainor had instituted
15 any other -- let's call it fluid management, any other
16 medication that could assist, mannitol, or even
17 discussed doing that?
18 A. I don't remember.
19 Q. You don't remember?
20 A. No.
21 Q. What when you arrived was Raychel's condition?
22 A. Um ... I remember at some stage that she was in the
23 treatment room. I can't remember whether that happened
24 before I arrived or after I arrived.
25 Q. I think it's possibly before you arrived, but you can't

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1 remember --
2 A. No, I remember that certainly her breathing became more
3 shallow. Again I'm not sure whether that started before
4 I arrived or after I arrived and she required bag-mask
5 ventilation. Again, I can't remember --
6 Q. Do you know who was doing that?
7 A. Again, I can't remember exactly what was happening, but
8 I remember certainly anaesthetists were called. I think
9 they were called after I arrived.
10 Q. Ah.
11 A. I could be ... I could be wrong there. But from what
12 I remember, the anaesthetists were called after
13 I arrived.
14 Q. I may have pre-empted you then.
15 A. Dr Allen and Dr Date.
16 Q. Maybe I should ask you to think about that again and
17 I was wrong in pre-empting you. Do you have any sense
18 now that you look back on it as to whether Raychel was
19 still on the ward when you got back with Dr Curran or
20 not?
21 A. I can't remember to be honest.
22 Q. Okay. Do you know what her CNS condition was? Do you
23 know whether at that stage her pupils were fixed and
24 dilated?
25 A. I remember her pupils being fixed and dilated. I can't

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1 investigate, anything else Dr Trainor might have said
2 about what she was doing and why she was doing it?
3 A. I know that there was -- certainly when there was
4 discussion about how the hyponatraemia should be
5 managed, and again I've got a vague recollection and
6 I think there was difficulty on obtaining third normal
7 saline. I don't think that was readily available if
8 I remember. Again, it's a vague recollection.
9 Q. I understand. Can you recall at all Dr Trainor
10 telephoning Dr McCord?
11 A. I can't. I can't remember that exactly. I do
12 remember -- I remember I was there when Dr McCord
13 arrived.
14 Q. Yes. You said you were there when Dr McCord arrived?
15 A. Yes.
16 Q. And I think you were less sure about Dr Allen and
17 Dr Date. Do you think you could also have been there
18 when they arrived?
19 A. I remember them being there. I can't remember whether
20 they -- I think they arrived after I arrived the second
21 time.
22 Q. Okay. Do you remember Mr Zafar and Mr Bhalla arriving?
23 A. Um ... Not really. There were a lot of people there at
24 that stage.
25 Q. I understand. Dr McCord at that stage is the only

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1 remember the timing of that, whether that arrived after
2 I was on the ward or at what stage, but I do remember it
3 was a significant finding at the time. Certainly
4 I remember noting that. Certainly it was within an hour
5 of me arriving on the ward a second time.
6 Q. Well, would this be fair to characterise your
7 involvement, that really by the time -- once you had got
8 Dr Trainor involved, in terms of somebody who was
9 actively dealing with Raychel's condition and trying to
10 ascertain what the underlying problem was, that then
11 passed to Dr Trainor?
12 A. Yes.
13 Q. And you were dealing with whatever instructions she was
14 giving you?
15 A. That's correct.
16 Q. So all that you could really help us with is, when you
17 were there in her presence, to what extent you observed
18 what she did and understood the logic of it or she
19 explained to you what she was doing and understood?
20 That's the height of what you can help us with?
21 A. That's correct.
22 Q. I know that you were some time out before you came back
23 from the ward where you had gone to, the neonates, but
24 are you able to recollect, other than the query over
25 whether there was perhaps meningitis that one should

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1 consultant. Do you recall what was said to him about
2 Raychel at that time, irrespective of what might have
3 been said over the telephone, to allow him to get
4 started in doing whatever he could still do at that
5 stage?
6 A. I remember there was a discussion between him and Staff
7 Nurse Noble, between him and Dr Trainor.
8 Q. Do you remember the sort of thing they were discussing?
9 A. Not exactly, no.
10 Q. So at this stage now, there don't appear to be any tasks
11 that you're being asked to carry out.
12 A. No.
13 Q. Are you aware of the family being there? By that I mean
14 Raychel's parents.
15 A. Yes, I remember they were in the treatment room.
16 I remember them being there.
17 Q. At some stage they have both come into the room even
18 though you don't remember precisely when each one came
19 in?
20 A. Yes.
21 Q. Do you recall anybody speaking to them during that time?
22 A. Again vaguely. I think I vaguely recollect Dr Trainor
23 and Dr McCord talking to them.
24 Q. And then, in due course, Raychel's taken to have
25 a CT scan. Ultimately she's transferred to the

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1 Children's Hospital. What is the last time you recall
2 seeing her or being where she's being treated?
3 A. I can't remember whether it was sort of after the
4 CT scan or before the CT scan. It was sort of probably
5 around that time.
6 Q. Do you know what the outcome of the CT scan was? Do you
7 recall it being discussed or hearing it?
8 A. Well, certainly from the clinical point of view, we knew
9 her pupils were fixed and dilated. Certainly the
10 expectation was that the CT scan would show cerebral
11 oedema. Certainly, my recollection is that the CT
12 confirmed that.
13 Q. Did you get any sense of what the clinicians there in
14 Altnagelvin thought might happen when she was
15 transferred to the Royal?
16 A. Well, I think certainly at that stage I think a lot of
17 people were very concerned, I think, with the fixed and
18 dilated pupils and cerebral oedema. I think most people
19 knew that probably it wasn't going to be a very
20 successful outcome.
21 Q. Had you ever had a patient who had reached the stage of
22 having fixed and dilated pupils, irrespective of whether
23 they were paediatric or adult?
24 A. Yes, I'd have come across a number of adults who had
25 fixed and dilated pupils.

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1 you say there were quite a lot of clinicians there at
2 the end. There were representatives of all three
3 disciplines?
4 A. Yes.
5 Q. At some point Dr Nesbitt arrives as well, who's the
6 consultant anaesthetist.
7 A. Yes.
8 Q. You have the consultant paediatrician, you have the
9 consultant anaesthetist. Did you expect at all that
10 Raychel's own consultant would arrive in due course?
11 A. Yes. I think certainly my experience would have been
12 that certainly a surgeon or a consultant would -- likes
13 to be informed of any patient under their care who's
14 in extremis and certainly most consultants would like to
15 be informed and certainly if a patient's under their
16 care, especially a child, that had deteriorated or
17 certainly would like to be informed of the scenarios.
18 Q. And if informed, would you expect such a consultant to
19 arrive?
20 A. Yes. I would have ... I think I would have expected
21 that, yes, in this situation.
22 Q. And you, of course, now are senior yourself. But who in
23 your experience would you have been expected to be
24 speaking to the parents?
25 A. Well, consultants -- sort of the consultants from the

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1 Q. And --
2 A. I would have known that that would have been a poor
3 prognostic indicator of brain damage.
4 Q. Yes. In your experience, has there ever been any
5 recovery from that? Just in your experience.
6 A. I would have known that it would have been highly
7 unlikely to get recovery from that.
8 Q. Yes. Did you hear any discussion as to the reason that
9 Raychel was being transferred to the Children's
10 Hospital?
11 A. No, I wasn't really party to that.
12 Q. And can you help me with this: that does happen and when
13 do you first hear that Raychel has died?
14 A. Well, I think -- certainly I think I was under the
15 understanding that certainly that was the likely outcome
16 right from whatever ... from 6 am that morning. But
17 I can't remember exactly about when I was told
18 officially. Certainly working in the hospital, working
19 in the paediatric department, certainly there would have
20 been -- I could have been. The staff would have known
21 and I would have been told by some of the staff members.
22 It wouldn't have been official. I would have heard
23 through the grapevine as such.
24 Q. Yes. There's one question which is out of order and I'm
25 sorry about that, I meant to ask it earlier. That is,

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1 different teams.
2 Q. And would you have included in that Raychel's own
3 consultant?
4 A. I would have, yes.
5 Q. So you hear that she has died. I don't know if you
6 said -- did you hear the day she died or --
7 A. I can't remember exactly. I would have been kept
8 updated with information. Working in the paediatric
9 department, I would have been briefed fairly regularly
10 on what was happening.
11 Q. Were you aware of the fact that there was going to be
12 a critical incident review meeting on the 12th, which
13 was the Tuesday?
14 A. Yes, I was aware that certainly there would be -- there
15 would be further investigations and further meetings
16 regarding --
17 Q. Apart from the fact that you were aware of the fact that
18 there would be a meeting --
19 A. Yes.
20 Q. -- and some sort of investigation as to what had
21 happened, were you specifically alive to the fact that
22 there was a critical incident meeting on the Tuesday to
23 discuss the case?
24 A. I can't remember, to be honest. I know that there were
25 certainly discussions sort of between the surgeons and

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1 the paediatricians. I can't remember exactly what
2 meetings there were or whether I attended.
3 Q. That was going to be my next question.
4 A. Yes.
5 Q. It's not entirely clear because I don't think that
6 we have a full note of everybody who was there. We've
7 certainly got an indication of some who were there. Do
8 I take it from your answer that you don't recall whether
9 you were or not?
10 A. I remember certainly Dr McCord and Dr Gilliland sort of
11 having discussions and some of the junior doctors were
12 around. And I do actually remember being in the
13 boardroom in Altnagelvin with a number of doctors. But
14 I can't remember exactly what the discussions were about
15 or what that meeting was called -- whether that was
16 a critical review or whether there was a critical review
17 after that.
18 THE CHAIRMAN: The critical review came very quickly. It
19 came on the Tuesday, if that helps give you a time frame
20 for it.
21 A. I remember being in the boardroom and there were a lot
22 of doctors that were involved that were there. I can't
23 remember exactly what was discussed.
24 THE CHAIRMAN: And nurses?
25 A. Yes, I remember certainly Sister Millar was there.

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1 one, the continued use of Solution No. 18. So that
2 rings a bell, whether it's at that meeting or another
3 meeting.
4 A. I think certainly -- I think certainly it was the use of
5 Solution No. 18 for surgical patients ... I think there
6 was fairly clear instructions that it wasn't going to be
7 used for surgical patients any longer.
8 THE CHAIRMAN: There's a second issue on the surgical side
9 was to start to copy what was happening on the
10 paediatric side, namely the electrolyte or the blood
11 sampling and electrolyte testing of surgical patients on
12 Ward 6; do you remember that?
13 A. I don't specifically remember that.
14 THE CHAIRMAN: Okay. The third one was a discussion to the
15 effect that Raychel had received too much fluid; do you
16 remember a discussion to that effect?
17 A. I don't remember that specifically.
18 THE CHAIRMAN: Okay.
19 MS ANYADIKE-DANES: Well, can I ask you about that? At the
20 time you came to look at Raychel, I think you said that
21 you don't recall looking at her fluid balance chart.
22 A. I don't remember that specifically.
23 Q. But you'd have known that she was on IV fluids,
24 obviously.
25 A. Yes.

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1 MS ANYADIKE-DANES: Yes. Do you remember the sort of thing
2 that was being discussed?
3 A. I can't remember exactly what was discussed. I remember
4 there were informal discussions about the use of
5 Solution No. 18 between Dr McCord and Mr Gilliland on
6 the use of it and how appropriate it was.
7 Q. Were they of one mind that Solution No. 18 was no longer
8 appropriate?
9 A. The paediatricians were still under the impression that
10 it was -- even certainly for paediatric medical
11 patients, it was still appropriate at that stage.
12 Q. So there was a difference of view?
13 A. I think certainly the consensus was that it wasn't
14 appropriate for surgical patients, but it was
15 appropriate for paediatric medical patients. Again,
16 I was very junior and was sort of peripheral to the
17 discussions. But that was sort of my recollection of
18 it.
19 THE CHAIRMAN: Can I ask you this. We've been told that
20 there was a critical incident review meeting on Tuesday
21 the 12th.
22 A. Yes.
23 THE CHAIRMAN: There's a bit of uncertainty about who
24 exactly was there, but a number of significant people
25 were there. Among the things which were discussed was,

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1 Q. And you'd have known what IV fluids she was on.
2 A. Yes.
3 Q. Did you know what rate she was on?
4 A. I can't remember that. I can't remember that.
5 Q. Okay. Let me frame it a slightly different way. Would
6 you have wanted to know what rate she was on?
7 A. Um ... Well, certainly if it was excessive, it would
8 have certainly rung alarm bells and certainly would have
9 rung more alarm bells. It'd be another red flag.
10 Q. But in order to know whether you're in that terrain,
11 you have to know what the rate is.
12 A. Yes.
13 Q. If you were told the rate was 80 ml an hour and in fact
14 it had been that rate without change, both prior to her
15 surgery and after her surgery and had just literally
16 continued on without any review or any further
17 consideration apparently, what would you have thought
18 about that rate? Leave aside the type of fluid, but the
19 rate.
20 A. Yes, well, certainly at this stage I'm not that familiar
21 with rates of fluid in children. Certainly I'd have to
22 go back to the formulas. I don't know what was the
23 recommended -- what was the recommended rate for a child
24 at that rate.
25 Q. You would have known at that time, would you, that there

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1 was a formula, the Holliday-Segar formula, that allows
2 to you calculate what an hourly maintenance rate would
3 be?
4 A. I think certainly it was 4 ml an hour for the first hour
5 and --
6 Q. It comes up at about 65 ml for --
7 A. -- 2 ml an hour for the second 10 kilograms and 1 ml and
8 hour for every kilogram after that.
9 Q. The guidance we've received is that for a child of
10 Raychel's weight, 25 kilograms, somewhere between 65 and
11 67 ml an hour would have been an appropriate rate.
12 Although it's perhaps some time since you were
13 involved --
14 A. Is that maintenance rate?
15 Q. A maintenance rate, yes. Although it's some time since
16 you would have been involved in doing any of that, at
17 that time, four months into your paediatric SHO period,
18 do you think that you would have understood what an
19 appropriate rate was for Raychel?
20 A. I would, yes. There was certainly a concern certainly
21 from a paediatric viewpoint, certainly the concern was
22 always underestimating the rate and under-hydrating
23 a child, especially with gastroenteritis. Certainly
24 I think there would have been less -- there would have
25 been a tendency to have less concern about

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1 direction, then you might have wanted to know these
2 sorts of things?
3 A. Yes.
4 MS ANYADIKE-DANES: Mr Chairman, we don't need to pull it
5 up, but the reference for the Holliday-Segar formula is
6 312-010-001. It provides, with hours and weight and so
7 forth, a way of calculating it.
8 Just to follow on from what the chairman has just
9 asked you, were you aware that because of that potential
10 for IADH or SIADH that very often the post-operative
11 fluids are reduced to accommodate for that? Were you
12 aware of that?
13 A. I can't remember whether I would have been aware of that
14 at that time. I think certainly there's a lot of
15 factors that have to be taken into consideration, sort
16 of post-operatively, sort of urine output, sort of fluid
17 lost during the operation, insensible losses --
18 Q. Yes.
19 A. -- and whether the child's got a temperature.
20 Q. Well, then after Raychel's died and there's been
21 a meeting of some sort, which you think you attended,
22 leaving aside a difference as to how to treat a change
23 in fluid regime between the surgeons and the -- or the
24 anaesthetist, rather, and the paediatricians because
25 I think it was Dr Nesbitt who had done the research and

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1 over-hydrating a child because they would have been able
2 to pass urine usually. They would normally have had
3 good renal function.
4 Q. Let me put this up for you since you asked about it --
5 THE CHAIRMAN: A child's ability to pass urine can be
6 adversely affected by surgery, can't it?
7 A. Yes, with hormone -- inappropriate ADH secretion.
8 THE CHAIRMAN: So while a child with gastroenteritis might
9 be able to pass urine fine, a child who's coming out of
10 surgery might not?
11 A. Yes.
12 MS ANYADIKE-DANES: Would you have been aware of that in
13 2001?
14 A. I would have been aware of inappropriate ADH secretion,
15 but --
16 Q. Associated with surgery or any trauma or stress?
17 A. I would have been aware of it, but certainly I would
18 have known that it's -- I would have known about it, but
19 it would have been ... I wouldn't have had much
20 experience of it from a practical point of view.
21 Q. I understand. But once you're in the territory of
22 electrolytes, all these things become slightly relevant,
23 don't they?
24 A. Yes.
25 Q. And so if you were going to move much further down that

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1 therefore was most concerned about the continued use of
2 Solution No. 18. How did the clinicians' view as to
3 what should now happen get itself communicated to the
4 junior doctors?
5 A. Again, with the passage of time, I can't remember much,
6 to be honest. But certainly I think from -- I think
7 certainly there was greater emphasis -- especially on
8 the surgical side -- as regards prescribing of fluids
9 and, again, doing U&Es or electrolyte profiles.
10 Q. Let me pull up this, which is what we understand is an
11 action plan that was agreed at that meeting.
12 095-011-059g.
13 THE CHAIRMAN: That meeting being the critical incident
14 review at which you may not have been present.
15 A. Yes.
16 MS ANYADIKE-DANES: We see the first point is:
17 "To review the evidence for the use of routine
18 post-operative low-electrolyte IV infusion and suggest
19 changes as the evidence indicates."
20 At that stage it was being proposed that there
21 shouldn't be a change to the use of Solution No. 18
22 until the results of that review. So there's going to
23 be no change there.
24 A. Yes.
25 THE CHAIRMAN: Sorry, in fact that change then appears to

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1 have come about two days later because Dr Nesbitt did
2 his research within the next 24 to 48 hours and
3 Solution No. 18 then came off.
4 A. Okay.
5 THE CHAIRMAN: By the way, had you heard in this context
6 that word had come from the Royal in Belfast that they
7 had stopped using Solution No. 18 some time earlier?
8 A. No.
9 MS ANYADIKE-DANES: And then the next action point seems to
10 be something that's going to be instituted more or less
11 immediately, which is:
12 "To arrange daily U&Es on all post-operative
13 children receiving IV infusion."
14 You were a paediatrician, so it wouldn't be
15 something that would directly affect you. But it would
16 be the children on the ward where you were. Were you
17 aware of this, that this was going to happen?
18 A. I was aware that there were proposals, but I'm not aware
19 of this document specifically.
20 Q. I'm not asking you about the document. I'm asking you
21 about the issue. Were you aware that there was
22 a general concern -- or maybe concern is too high -- but
23 it had been noted that the paediatricians seemed to have
24 U&Es on their patients checked perhaps more frequently
25 than the surgeons did? Were you aware of that?

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1 all, just prior to that?
2 A. Yes. I think certainly it would be standard practice,
3 certainly. Again, it depends on the clinical situation.
4 If there are concerns that -- the greater the level of
5 concern, the more the level of recording and monitoring,
6 including urinary output.
7 Q. That must be --
8 A. It may not have been routine, but certainly on patients
9 where fluid balance is an issue, it would have been
10 measured accurately.
11 Q. Let's leave aside the surgical patients for a moment who
12 you didn't have any familiarity with and focus on the
13 medical paediatric patients. Was their urinary output,
14 if I can put it that way, routinely measured if they are
15 on IV fluids?
16 A. I can't remember specifically but certainly if we had
17 somebody who was dehydrated with gastroenteritis, my
18 recollection would be that urinary output would have
19 been measured. It would have been part of their
20 management.
21 Q. Apart from catheterisation, how was it being recorded?
22 A. Well, again, it depends on the age of the child.
23 Certainly if it's an older child, they can sort of
24 perhaps urinate into a pot, whereas in a younger child
25 perhaps it's a matter of weighing nappies and things

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1 A. Well, I wasn't really familiar with what the practice
2 was on the surgical side, but I was aware of what
3 happened on the paediatric side, and certainly I think
4 they were ... They did check the U&Es appropriately.
5 Q. I understand that.
6 A. Probably more commonly than the surgeons did.
7 Q. But the nurses who would be alive to that difference
8 and, as we understand from the evidence, Sister Millar
9 certainly was alive to that difference and expressed
10 some concern about it. They are nurses that you would
11 be interacting with frequently -- or at least would have
12 been at that stage.
13 A. Yes.
14 Q. And that is why I ask you whether you are aware of the
15 nurses having that view or anybody having that view.
16 A. I can't remember to be honest.
17 Q. Then there's other matters that really are directed
18 towards the surgical personnel, if I can call them that,
19 and you wouldn't have known anything about that. What
20 about 5? In fact 4:
21 "All urinary output should be measured and recorded
22 while IV infusion progress is in place."
23 Were you aware of that?
24 A. I can't remember that specifically.
25 Q. Well, were you aware of urinary output being measured at

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1 like that.
2 Q. And given that parents quite often are on that ward, to
3 some extent looking after their children in a way, and
4 maybe taking them to the toilet or the children may be
5 old enough to do that themselves, how did all that get
6 addressed if what you're trying to do is get as accurate
7 a record as possible of their urinary output?
8 A. I can't remember exactly, but certainly the other thing
9 as part of the assessment of children, urinary tract
10 infection would be a diagnosis that would quite often
11 need to be excluded, so quite often there would be quite
12 sort of complex methods of collecting urine samples from
13 even small children and the staff would have been
14 familiar with that.
15 Q. Okay. And then if you see the other two:
16 "The chart for IV fluid infusion rates to be
17 displayed."
18 Were you aware of that?
19 A. I can't remember that specifically, but certainly
20 we would have -- it was a point that would have been
21 documented quite well within the paediatric medical
22 side, infusion rates. There would have been a lot of
23 supervision from certainly at least the registrar level
24 to make sure that infusion rates were sort of adequate
25 or accurate.

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1 Q. Were you aware that Altnagelvin was proposing to change
2 or redesign its fluid balance documentation, literally
3 change the charts upon which the information was
4 recorded?
5 A. I can't remember that.
6 Q. Let me just put up the notice that I think the chairman
7 had referred to. That's 095-011-059j. Although this is
8 in some -- well, the first part of it is directed
9 towards the surgical patients. Were you aware of seeing
10 a notice like this?
11 A. I don't remember this specifically, but I do remember
12 that certainly -- certainly immediately after sort of
13 the events that certainly I think there was an agreement
14 that Solution No. 18 wouldn't be used for surgical
15 patients.
16 Q. Yes. This makes very clear the distinction that you're
17 talking about: the surgical patients are going to go to
18 a changed regime and the medical patients remain on --
19 but was there any attempt to gather together the junior
20 doctors because this is now a change in regime, if I can
21 put it that way, and explain that so it was disseminated
22 in that way and everybody would be clear as opposed to
23 putting up a notice on a noticeboard?
24 A. I can't remember exactly. I can't remember
25 specifically.

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1 (4.37 pm)
2 (A short break)
3 (4.50 pm)
4 THE CHAIRMAN: Mr Stitt?
5 MR STITT: Mr Chairman, I have got some good news and some
6 not quite so good news. The good news is that the two
7 files from the Western Trust, which had caused some
8 difficulties in terms of the actual indexing, the
9 differences have been reduced to a note by the inquiry
10 solicitor. My instructing solicitor has read through it
11 and has made what he regards as a few alterations. And
12 because of another commitment, the inquiry solicitor
13 cannot be here at this time. So it's proposed that
14 there will be a short discussion when we rise with
15 Ms Conlon to deal with the --
16 THE CHAIRMAN: She is not here either. We can pick it up
17 tomorrow morning. Ms Dillon said to me what she would
18 like to do -- is Mr Johnson available tomorrow?
19 MR STITT: Yes.
20 THE CHAIRMAN: Well, if she and Mr Johnson can sign off on
21 this note tomorrow, then it can be circulated to all the
22 parties.
23 MR STITT: That can be done by e-mail. That was the
24 anticipation.
25 This afternoon's discussion is not crucial. It was

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1 Q. Were you aware of Dr Nesbitt giving a talk in relation
2 to Raychel's case?
3 A. I can't remember that. I left at the end of July, so
4 perhaps it might have been after that.
5 MS ANYADIKE-DANES: Thank you.
6 MR QUINN: I have only one issue. The only issue is that
7 this witness, Dr Johnston, did he hear anyone saying
8 that Raychel may be going to Belfast for surgery?
9 That is did he hear anyone offering false hope given
10 that he knew her pupils were fixed and dilated?
11 A. I don't remember that specifically, no.
12 MR QUINN: Okay. Finally, the family have instructed me to
13 say to Dr Johnston that they acknowledge that in their
14 view Dr Johnston did all that could be expected of him
15 to do.
16 THE CHAIRMAN: Thank you, Mr Quinn. I hope that's of some
17 assistance to the doctor.
18 Doctor, unless there's anything else you want to say
19 before you leave, your evidence is now complete.
20 Thank you for your assistance, you're free to go.
21 (The witness withdrew)
22 THE CHAIRMAN: Mr Stitt, the stenographer's asked for a few
23 minutes' break. Shall we take five minutes and then
24 we'll come back to deal with whatever you have to tell
25 me? Thank you.

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1 just to discuss a couple of points, but it can be done
2 by e-mail, so that won't be a problem and my instructing
3 solicitor, I'm confident in saying, believes we'll get
4 this ironed out tomorrow morning.
5 THE CHAIRMAN: Okay.
6 MR STITT: The second point is the Belfast Brangam Bagnall
7 inquest file. My fears were ill-founded. Some time
8 spent in the chamber today has enabled me to go through
9 it and to form a view that I can advise the
10 Belfast Trust tomorrow morning or tonight by e-mail as
11 to what privilege they're entitled to claim. The claim
12 is, of course, theirs, but I don't anticipate it's going
13 to be controversial given your earlier remarks, sir.
14 The majority of the documents I'm referring to are
15 clearly solicitor to the client, advising pure legal
16 advice and to counsel and fee notes to counsel and stuff
17 like that. There really isn't anything which I can
18 anticipate -- maybe I'm wrong, but I don't anticipate it
19 being a matter of controversy. And I will endeavour to
20 move that on maybe even through my solicitor this
21 afternoon.
22 THE CHAIRMAN: Okay.
23 MR STITT: The third area is the DLS file and the privilege
24 that will be claimed in relation to any part of it. The
25 Trust at Altnagelvin have met this afternoon. I had an

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1 in-depth discussion with them, explaining the types of
2 privilege and explaining the issues, reminding them of
3 what you had said in relation to the wider areas to be
4 considered and reminding them of certain decisions which
5 had been made by others in the past.

6 THE CHAIRMAN: Yes.

7 MR STITT: Currently as I stand, they are meeting and
8 discussing this and they have asked me if I would be
9 brave enough to ask you, sir, to allow them to continue
10 to do that through tomorrow morning, when they will have
11 an answer by, they hope, lunchtime, which can be
12 communicated by e-mail in the form of the schedule to
13 the file with an indication as to which number documents
14 privilege would be claimed and the nature of the
15 privilege that would be claimed in relation to it.

16 THE CHAIRMAN: Okay. If I have that document by 12 noon, it
17 allows the inquiry to circulate it to the other parties
18 tomorrow, and then if there is any claim for privilege
19 which is controversial, we'll deal with that at some
20 point on Monday. But what I would like, Mr Stitt, if
21 it's at all possible, in case there's any controversy
22 about this, is it possible for each Trust -- although I
23 suspect really here the focus is more on the
24 Western Trust -- to have a person present on Monday who
25 would have the authority to give you instructions on

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1 this slipped through the net at some point and I'm very
2 anxious to get it sorted out as early as we can next
3 week. Since the board is still meeting, if you could
4 get a message to the board -- and I think we're focusing
5 here more on Western than Belfast -- if they could
6 possibly agree that someone could down on Monday and,
7 while this is being debated, if there's any controversy
8 they might be able to give you instructions if any
9 further instructions are required.

10 MR STITT: Just for the record, sir, you have used the term
11 "the board" with a capital B on a number of occasions.
12 This is not a formal board meeting. This is individuals
13 getting together with authority to consider the issues.

14 THE CHAIRMAN: Well then, dare I suggest that if there are
15 various individuals who are taking this decision outside
16 the framework of a formal meeting of the board of the
17 Trust, then it might also be possible for them to agree
18 that one of them would have the authority to come here
19 on Monday to develop that if needs be.

20 MR STITT: That's been noted.

21 THE CHAIRMAN: Thank you very much.

22 Okay. Beyond that, ladies and gentlemen, we've got
23 Dr Butler on Monday and Staff Nurse Gilchrist.
24 Dr Butler's involvement, we know, is limited to a single
25 intervention, but that might not be the only issue she's

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1 behalf of the Trust in relation to anything further
2 which arises?

3 This would not necessarily have to be the chairman
4 or the chief executive. If the Trust board -- in light
5 of whatever decision it reaches today, and in
6 anticipation of some debate on Monday -- could have
7 somebody here who could have the authority to give you
8 any further instructions that you require without any
9 matter having to be referred back to another meeting of
10 the board at some point.

11 MR STITT: I will certainly --

12 THE CHAIRMAN: Could you see if you can do that?

13 MR STITT: Yes. As I'm standing, I can't commit to
14 anything. I can commit to doing our best to fulfil that
15 request.

16 THE CHAIRMAN: You understand --

17 MR STITT: I understand why you're asking.

18 THE CHAIRMAN: I don't want to end up next week going
19 backwards and forwards on different issues. It's not
20 your fault personally, but I was told last July that
21 this issue was being referred to senior counsel for
22 advice and I won't go over all that ground again, but it
23 is rather late still to be debating it in March.

24 MR STITT: I was not that senior counsel.

25 THE CHAIRMAN: I think I said that. I understand that, but

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1 asked about, but her evidence, I would hope, would be
2 short. Staff Nurse Gilchrist has more evidence to give,
3 but we've already heard quite a lot of evidence from
4 nurses on that shift, so we'll get through those two
5 witnesses and I suspect -- it might be better on Monday
6 to get the evidence started and then deal with any
7 privilege controversies at, say, 2 o'clock. Okay?

8 Thank you very much indeed. Monday morning at
9 10 o'clock.

10 (5.00 pm)

11 (The hearing adjourned until 10.00 am on
12 Monday, 11 March 2013)

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