Thursday, 7 March 2013

(10.00 am)

DR MICHAEL CURRAN (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good morning, doctor. Can I check that you have your CV to hand?

A. Yes.

Q. Thank you. Dr Curran, you have made only two statements so far as I am aware in relation to your involvement in Raychel's care, and they're both for the inquiry; is that correct?

A. Yes.

Q. The series is 028, and I think you made your first statement on 23 November 2011, and then you made a second statement on 14 June 2012; does that sound about right?

A. Yes.

Q. Can I take it that you weren't asked to and didn't make a statement for the Trust at all, the hospital?

A. Not that I'm aware of.

Q. And you weren't asked to make one for the PSNI either?

A. I received a letter telling me that a policeman was going to contact me, but that never happened.

Q. So you never actually produced a statement?

A. No.

Q. Thank you. I'm going to ask you, subject to anything you give evidence on today, whether you accept as accurate what is in those two witness statements --

A. Yes.

Q. -- broadly speaking?

A. Yes.

Q. Okay, thank you. Because you weren't asked to make a statement any earlier or didn't make one any earlier than 23 November 2011, can I ask you what is your recollection of what happened on the evening of 8 June 2001?

A. Do you want me to take you through --

Q. No, no, just how well do you remember it?

A. I can remember certain things because, obviously, it was a tragedy, but I'll answer your questions as best I can. My memory won't be 100 per cent obviously, but I remember certain things.

Q. I'm wondering what you had to help you in narrating the events in those two inquiry witness statements. What did you see to assist your memory?

A. I had a record of the pager time. I think the Trust had sent out a --

THE CHAIRMAN: Sorry, doctor, you had a record of what?

A. The pager time.

THE CHAIRMAN: Right. What is the pager time?

A. It's the sheet -- the times of my pagers for that night.

MS ANYADIKE-DANES: Mr Chairman, it's his bleep record. I'm going to ask you about that in a while. It's attached to his second statement for the inquiry. So you had that and what do you think the Trust had sent you?

A. I think the Trust had sent a statement from one of the nurses. I think.

THE CHAIRMAN: Plus the inquiry would have made available the hospital notes and records.

MS ANYADIKE-DANES: Yes. Did you see the medical notes and records as well?

A. Yes.

Q. Since then, and as you come now to give your evidence, have you seen anything else? Have you seen any expert reports?

A. Yes, I have received the expert reports from Mr Foster and Mr Orr.

Q. And Mr Orr?

A. Yes.

Q. Anybody else?

A. I've received the other -- I presume the other expert witness statements as well. I read the parts that I thought were relevant to me.

Q. Of course. Have you read any of the transcripts of anybody's evidence?

A. I looked for the first time at the weekend at the transcripts and, realising that some of them were 200 pages long, I searched for my name and I looked at some parts, but to be honest with you I didn't look at -- didn't spend a long time doing it because I think, if I read it, I'd probably get my version of events clouded by reading someone else's statement.

Q. Exactly. You are no longer, of course, at the hospital. Are you still at Limavady? We'll come to your CV in a minute, but is that where you are now?

A. I work as a GP in Magherafelt and Limavady and as a locum.

Q. And have you discussed your evidence with anybody prior to coming -- I don't mean with your lawyers, but with anybody else?

A. I discussed with Dr Devlin because I know he was coming to the inquiry as well. But apart from that, I don't think I've had any contact with any of the other doctors or nurses of Altnagelvin since that time.

Q. Thank you very much. I wonder if we could go now to your CV. It starts at 317-001-002, but perhaps if we could pull up 003 and put alongside it 004.

THE CHAIRMAN: I think it's the middle number which is wrong. It's 317-011-003 and 004.

MS ANYADIKE-DANES: Thank you.

Starting from the right-hand side, that placement at August 2000 to August 2001, that's what you were involved in, when Raychel was admitted, as a pre-reg --

A. Yes.

Q. -- or junior houseman. Do I understand it that that was split into two six-month periods; is that right?

A. That's right, yes.

Q. The first of them was surgical, so from August 2000 to February 2001 you were dealing with surgical matters.

A. Yes.

Q. And then from February 2001 to August 2001, you were dealing with medical matters?

A. Yes.

Q. When you dealt with surgical matters, how much paediatric experience did you have within that?

A. Within the six months of surgery?

Q. Yes.

A. I'd be guessing, but I'd say I was on the paediatric ward no more than a dozen times, maybe, in six months.

Q. So is it fair to say that you weren't terribly experienced in paediatric matters?

A. Very much so.

Q. Then when you started your medical six months, if I can call it that, that didn't involve any paediatric work, did it?

A. None.

Q. So if we just bring it up to what you were actually doing on 8 June, although we'll go into that in more detail, on 8 June you were doing your normal medical day?

A. That's right.

Q. As a JHO, and then in the evening you were acting on-call as a surgical JHO; would that be right?

A. That's correct.

Q. So there would be the possibility that you would come in contact with paediatric patients during that period of time, which in fact you did with Raychel, but you wouldn't have come in contact with paediatric patients since that dozen or so experiences that you had had in your first six months?

A. That's correct.

Q. Can I ask you --

THE CHAIRMAN: Sorry, so during the day you're a medical JHO --

A. Yes.

THE CHAIRMAN: -- then in the evening you're on call, but in effect that means you stay in the hospital, does it? It doesn't mean you go home and you are on call, it means you stay in the hospital.

A. Yes, you're in the hospital.

THE CHAIRMAN: And during the evening are you covering both medical and surgical or just surgical?

A. No, from 5 pm it would be surgical.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: And that arrangement whereby you would come and act as a surgical JHO, how often had that happened before Raychel's admission, roughly?

A. When I would be working in medicine?

Q. Yes.

A. To my recollection, never. For me personally, never.

Q. Was that the first time after you left your surgical JHO work and started your medical JHO work that you'd actually been asked to do surgical JHO work?

A. Yes.

THE CHAIRMAN: How did it come about? Do you remember?

A. The surgical JHO that was due to be working that night, I think was ill, and there would have been six surgical JHOs and six medical JHOs. There would have been a surgical JHO covering the Thursday night and the Saturday, so they would have been unable to do it, and I don't know why the other three surgical JHOs couldn't do it, but for whatever reason they couldn't do it, so then I was asked to do it.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: If you hadn't been covering the surgical

JHO work that evening, would you have been acting as an on-call medical JHO?

A. No.

Q. So you wouldn't have been on call at all that evening?

A. Yes, I wouldn't have been on call at all.

Q. When did you first know that you were going to be on call, if you can remember?

A. I honestly can't remember, but it wouldn't have been more than 24 hours beforehand.

Q. So it might have been that day that you found out?

A. I'm pretty sure it wasn't that day because obviously I wasn't anticipating being on call. When you're anticipating being on call, you make sure you're in bed the night before. I don't think it was that day, but again I don't think it was something that was planned days in advance.

Q. Thank you. Then you stayed on Altnagelvin to be an SHO and you were that for two years; is that right?

A. That's right, yes.

Q. Whilst you were being an SHO, did you do any paediatric work, any surgical work at all?

A. During those two years?

Q. Yes.

A. The answer's probably no, but if there was a medical consult required on a surgical patient it is possible

that I may have attended, but normally that was carried out by the medical registrar. So the answer to your question is probably not. I probably hadn't been on the surgical wards.

Q. Was your care of Raychel that evening on 8 June the last time you had any involvement in a paediatric case whilst you were at Altnagelvin, so far as you can remember?

A. Yes.

Q. Then after that, you go for a year to Edinburgh, also on a medical rotation, and then I think your next brush with paediatrics, if I can put it that way, isn't until you go to Dublin, when you have about six months as an SHO in paediatrics.

A. That's right.

Q. And since 2005, you have transferred into general practice?

A. That's correct.

Q. Was that six months in paediatrics as part and parcel of moving into general practice?

A. Yes, it was to get experience in paediatrics.

Q. Thank you. Then I just want to ask you very briefly about your induction and training and general knowledge of hyponatraemia and fluid balance issues prior to 8 June when you were treating Raychel. Just very briefly, were you aware of the fact that there's an

induction programme at Altnagelvin or there was at the time when you were there?

A. Was I aware?

Q. Were you aware of that?

A. No.

Q. So far as you can recall -- I know it's many years now and you really only have had to think about these sorts of things since 2011 -- nobody drew to your attention that there was an induction programme?

A. Not that I can recollect, no.

Q. I don't want to go into it in any detail at all, but let me just show you something. In fairness to you, Dr Curran, we may be as cross-purposes or you may not appreciate what I mean. Can we pull up 316-004f-018? In fact, if you can pull alongside of that 017. On the left-hand side that's one for the pre-reg -- and that's what you would have been, obviously -- when you came to Altnagelvin. On the right-hand side is one that is a general one and would be applicable to SHOs, and you might have seen that as you stayed on to be an SHO. But if we concentrate on the first one, did you see anything like that at all when you came -- I realise this is dated 31 July 2001 and you came in 2000. But did you see anything like that at all when you came to Altnagelvin?

A. I honestly can't remember.

Q. That's fair enough.

THE CHAIRMAN: Doctor, just to help you, Dr Devlin who gave evidence yesterday described remembering what he called an administrative sort of induction, which fitted in with some of this. For instance if you look at the left-hand page towards the bottom, there's a tour of laboratory facilities and hospital computer systems. In other words, this is not specifically directed at your medical training; it's to help you understand where everything is in Altnagelvin and how the hospital works.

A. When I look at that there, I see it says:

"Death certificate/post-mortem request, Dr Marie Madden."

I remember vaguely some, I suppose, what you might call an induction when there was certainly someone talking about death certificates and post-mortems. But I don't remember anything else on that, no.

MS ANYADIKE-DANES: Thank you. Do you remember at any stage being told that there was an Altnagelvin Junior Doctors' Handbook?

A. No.

Q. I'll pull it up so you can see the front of it and see if this is recognisable to you, 316-004g-001. There we are. Something like that?

A. I don't recognise it. It's possible, but I just don't recognise it.

Q. I think Dr Devlin did, but he said that -- I think he was aware of it, but he didn't use it in particular. I think he said that what he used was a Oxford pocket text. Is that what you used?

A. Yes, a little yellow book that fits in your pocket.

Q. Thank you. And then if we go on very briefly about lectures that might be available to you, were you aware that there were seminars, lectures and so forth as part of your training that were available to you at the hospital and that, for that matter, you were expected to attend?

A. I remember -- this reflects maybe more SHO experience in Altnagelvin, but there were lunchtime meetings on some days, which I would have attended as an SHO in Altnagelvin. They were supposed to be protected time -- I think maybe 12.30 to 1.30 -- but most of the time or at least half the time your ward work prevented you from going to them. It may have been the same as a JHO, there may have been lunchtime meetings, I don't remember as a JHO, but certainly as an SHO in medicine there was.

Q. Did you attend them as an SHO?

A. I did, some of them, where possible.

Q. Just to help you -- and I know you've not had an

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

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

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

A. Yes.

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

And then it talks about:

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

Do you remember anything like that at all?

A. I'm just reading this now, but I can honestly say I don't believe there was ever any fluid balance training certainly that I ever went to in Altnagelvin.

Q. Well, when you would have started, would you have had a supervisor, a consultant, who was there to assist you and guide you and to whom you could refer back? Did you have anybody like that?

A. Sorry, to refer back to for?

Q. For guidance and counselling and so forth.

A. If I had an issue with fluid balance?

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

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

Q. Can you recall who that was for you?

A. No, I'd be guessing.

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

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

remember some lunchtime lectures or meetings.

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

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

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

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

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

Q. Thank you.

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

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

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

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

JHOs.

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

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

A. No, I don't.

THE CHAIRMAN: And that may --

A. In surgery, sorry.

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

A. In medicine I do recall lunchtime meetings.

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

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

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

A. Definitely not.

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

A. Yes.

THE CHAIRMAN: If you go to the second paragraph, it says:

"The lectures on fluid balance were given by an anaesthetist."

So the hospital is not there referring to a lecture given by a paediatrician or by a surgeon, but it's referring specifically to a fluid balance lecture given by an anaesthetist; does that help you?

A. I don't believe there's any fluid balance lectures that I attended as a surgical JHO from anyone.

THE CHAIRMAN: Sorry, in the paragraph above it doesn't say "surgical", it says, "Within the medical division teaching and training programme". Let's understand this properly. This is a letter which refers to teaching of fluid balance within the medical division. So it doesn't say "surgical".

A. Sorry, just to clarify, I don't remember any training on fluid balance as a JHO full stop.

THE CHAIRMAN: Okay. Can we follow on down then? Do you then remember that after -- if you look to the penultimate paragraph, starting "in 2002", do you remember that after Raychel died there was a talk specifically prepared by Dr Nesbitt on lessons learned in effect?

A. I was in Altnagelvin until 2003. I don't remember that lecture. I don't know whether it took place for the

surgical division or the medical division or the whole hospital, but I don't remember that lecture.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Right. And just to round it off, if you would pull up 316-004e-019. If you scroll down and you see:

"Wednesday 8 August 2001. Management of fluid balance by Dr Morrow."

That's the sort of thing that I was asking you about. Of course it happens after Raychel, but at this stage you're an SHO.

A. Yes.

Q. 8 August?

A. Yes.

Q. Do you remember anything like that?

A. As a JHO?

Q. As an SHO. Do you remember that sort of thing?

A. No, I would have been an SHO in medicine. I don't know whether that lecture was for the medical division or the whole hospital.

Q. These lectures, as we have understood it, are lectures that were open generally and aimed at JHOs and SHOs. You've said that you don't recall particularly anything very much as a JHO, so I'm now asking you as an SHO particularly as this would have happened after Raychel

had died; do you remember anything like that?

A. I don't remember that lecture. If I was at that lecture, given my contact with Raychel, I would remember that. But the reason for not being at it, I'm not sure.

Q. You might have had a good reason for not being there?

A. I actually think the transition from JHO to SHO, as I recollect, happened on a Wednesday, and it's the first Wednesday, so it may have been that we transferred from JHO to SHO on 1 August or 8 August. So maybe that was the first lecture for the new SHOs or JHOs, but I don't remember the lecture. If I went to it, I would remember that.

Q. Thank you.

THE CHAIRMAN: Is Dr Morrow an anaesthetist?

A. Yes.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Moving from that and speaking generally as to the context in which you operate as a doctor, you would have been aware as a JHO that there are practices and guidance from the GMC --

A. Oh yes.

Q. -- and the general principles that you might have been expected to apply to your work. For example, I presume you would have been aware that it's important, in terms of case notes, to take clear and accurate case notes and

to have them timed and dated and signed. You would accept that, wouldn't you, that that's important?

A. Yes.

Q. And it's important because not only is it recording directions that you might give or interactions with patients and carers, but it's a record for those coming after you so that they understand the care that's being given to a particular patient and maybe even why. It's important in terms of continuity, you would recognise that?

A. It is important, yes.

Q. One's talking about continuity. You would have understood about the principle of a handover between an outgoing team and an incoming team so that there is continuity of care for a patient, you'd have understood that?

A. Are you asking me was there a handover?

Q. I'm firstly asking you would you have understood the importance of that.

A. I can understand that it would be very helpful, yes.

Q. Yes. You would have understood that as a JHO, the principle of it?

A. The principle, yes, definitely.

Q. And you would have been able to see that that can be an important thing to make sure that people understand

the continuing care to be provided to the patient and anything that the incoming team should be alerted to, you can understand the principle of that?

A. Yes, definitely.

Q. You presumably, since you've been frank about your paediatric experience, can understand the principle that the GMC underscores about not overreaching yourself, not overreaching your competence?

A. Yes.

Q. And that that is very important, particularly as you're just starting, that you're careful to make sure that you communicate with your more senior colleagues, you ask questions, and make sure that you don't get out of what should be your comfort zone.

A. Yes.

Q. And then in terms of interacting with patients and their carers, if they're paediatric patients -- although you might not have done very much of that on your own -- you can understand the importance of keeping them informed who you are, what you're doing and why you're doing it in a way that they can understand? You can see the importance of that?

A. Yes.

Q. As it happens, all those things, one way or another, are included in the Altnagelvin junior handbook and the GMC

codes of practice -- and I'm sure the Oxford pocket book that you had -- but you wouldn't, for some of those principles, have necessarily needed that for you to see that those things were all important and that you should have them in your mind.

A. Yes.

Q. I suppose also, because you were starting out, you would understand the importance of establishing a good working relationship with the nurses.

A. Yes.

Q. Can I just ask you, from your point of view, how important was your interaction with the nurses?

A. As a JHO?

Q. Yes.

A. Vital. The training and most of the stuff you're learning as a JHO, day-to-day stuff, is from the nurses. So your interaction with the nurses, you learn most of your trade from that as a JHO and I made a lot of good friends as a JHO and still keep in contact with them. So vital.

Q. These are because nurses, I presume, are in close contact with the patients and the families and they're experienced in a way that you're not?

A. All of those things, yes.

Q. I should have told you --

THE CHAIRMAN: Sorry. In a sense, but the other point is that when you come in as a JHO, whatever about your undergraduate training, you're at the bottom end of a learning curve and, at that bottom end of the learning curve, the people who you will have a lot of contact with who will help you move along the learning curve are the nurses; is that right?

A. Probably more so than the doctors because of the amount of contact, yes, with nurses compared to SHOs.

THE CHAIRMAN: Yes.

A. I just would add to that: your knowledge in medical school, theoretical knowledge, doesn't prepare you for the learning curve of being a JHO.

MS ANYADIKE-DANES: I'm sure that must be true when you're actually dealing directly with the patients. I know that you say that you didn't have it very much to mind, but it may be you can help me with this, whether it was explained to you -- in the Altnagelvin Junior Doctors' Handbook it does refer to the role of the JHO, your pre-registration period, and it refers to the fact that you're assigned -- this is the part that I was referring to earlier -- a supervisor, consultant, but the important thing about that, it says:

"With whom you should meet on a regular basis."

You have mentioned the fact that you thought there

was somebody in charge of the JHOs, but now that I put it to you in that way, which is how it's put in the handbook, were you conscious of having a relationship like that, that you had a consultant supervisor, if I can put it that way, that you would meet on a regular basis and who would presumably assist you in the early part of your training?

A. I suspect I was aware that there was a nominal figure who would be in perhaps a supervisory capacity, but I have no -- I'm pretty sure that my only contact with that person would have been at the end of the six months to sign the form to say you've done your pre-registration surgical six months.

Q. So when you say a nominal figure, that doesn't sound as if it's a person with whom you had a close relationship who was acting as a mentor in some way? It wasn't that sort of thing?

A. No, there's no mentor. There's no person meeting with you every few weeks or every month or every three months to say, "What have you learnt? You should have acquired these skills? What are you having difficulty with --

Q. If you were learning in that way at all, you were learning from the experienced nurses and from the SHOs, registrars and consultants who you accompanied as you followed them round on ward rounds or followed them in

their work?
A. Yes, there would have been surgical -- the JHO would have been on the surgical ward round, which generally took place once or twice a day sometimes. Sometimes there was training on those ward rounds, yes, questions asked, otherwise, your training would have been from -- if you asked the surgical SHO a question or how to do something, they would obviously help you. Lots of times there was no surgical SHO on the ward, so you learned from the nurses.
Q. Thank you. Then just finally, you had been asked about what you understood about the possible dangers where a child was suffering prolonged vomiting following surgery and was in receipt of hypotonic fluids. We don't need to pull it up -- it might assist you to see it.
You were asked in your second witness statement 028/2, page 10. It's the answer to question 9. You say:
"[You] had limited experience at that time and [you] would have considered the main risk with vomiting to be dehydration."
Then you go on to say that you weren't aware of the risk of hyponatraemia.
On the previous page, which we don't need to pull

up, when you're dealing with a similar sort of question, you say that:
"During the JHO year, a JHO would learn most aspects of the job from the SHO and senior nurses. I don't believe I had any experience [and this is the part I want to emphasise] or awareness of the condition of hyponatraemia or other electrolyte imbalance in a post-op paediatric patient."
I don't know whether you have seen a report from the inquiry's expert on the teaching to clinicians of fluid balance and sodium management in Northern Ireland and the Republic of Ireland from 1975 to 2009 to span the period of time we're concerned with in the inquiry. His name is Dr Michael Ledwith; are you aware of that?
A. No.
Q. He produced a report. In the course of it, he discussed what he thought doctors were being taught at that time. If I take you to it and see whether you are aware of being taught these things. 303-046-519. Then if we pull up alongside it 520. You can see he starts off that:
"Until 1996, medical education in Northern Ireland as in the rest of the United Kingdom consisted of two phases."
And he talks about the pre-med and then the pre-med

with the next 2 years forming the pre-clinical years. He sets out the core topics that he regards as being taught at that time. Then if you look at the bottom paragraph he says:
"It was during these years that medical students would learn about the physiological relevance of sodium, its absorption during digestion, its distribution within bodily fluids and its elimination in urine and the vital role played by anti-diuretic hormone and other hormones, their secretion from the hypothalamus, and their effects upon the re-absorption of sodium from the renal tubules would also have been addressed."
If you go across, he refers to what happens then in the clinical years, years 3 to 6:
"It would have been during this year that the basic physiology and pathophysiology of the syndrome of inappropriate anti-diuretic hormone would be taught, the situations in which this might occur, the consequences of inappropriate retention of salt by the kidneys, and the clinical signs caused by this phenomenon would be covered in detail. Some understanding of the use of IV fluids in clinical settings may have been learned in this year."
Does that accord with anything that you remember from your training and education?

A. You mean at Queen's University?
Q. Yes.
A. We certainly did physiology as part of our core studies. As to SIADH, no.
Q. You don't recall being taught about that?
A. No.
Q. Well, can I ask you this: is it possible that you were, but it is just such a long time ago you can't really remember?
A. Yes, definitely it's possible.
Q. So if you were taught those sorts of things, although you may not have come across a child who had hyponatraemia, the principles involved in a child developing it you might have understood?
A. No.
Q. You wouldn't have?
A. If you asked me, "Did I know what hyponatraemia meant at that stage", yes, I know hyponatraemia: hypo, low; natraemia, sodium. But no, my training in fluid balance in general was very little. So the answer to your question is no.
Q. You said you knew what it was.
A. Yes.
Q. If I had asked you in June 2001, "Do you know what hyponatraemia is?", I think from what you have just said

the answer to that would have been, yes, I do know what it is.

A. Yes.

Q. And because you know what it is, you know how it develops, you know why it happens?

A. I don't think one leads on to the other. I know hyponatraemia means low sodium.

Q. Oh. Would you have appreciated how an individual can reach a stage where they have low sodium?

A. Sorry, are you asking me do I know causes of hyponatraemia?

Q. Yes.

A. No, not at that stage, no.

Q. You wouldn't have known that then?

A. No. I wouldn't have seen anyone with hyponatraemia except perhaps when I was in medicine and in that case it would have been maybe drug induced.

Q. Would you have understood the necessity and the function of sodium in the body, the need to maintain electrolytes at a certain level and the consequences if you don't?

A. As a general principle, yes.

Q. So you'd have understood that? Would you have understood as a general principle that if something arises that causes the body to retain too much fluid, then that's likely to have a diluting effect on the

sodium in the body?

A. Yes.

Q. And that would mean if that has that effect, then the consequences of that might be you end up with the low sodium that you've just described as meaning hyponatraemia? You'd understand that?

A. Do you mean if you're giving too much fluid that's got low sodium?

Q. Yes.

A. Yes.

Q. So you'd have understood that in 2001?

A. I would have understood that principle.

Q. If you had sat back and worked it out?

A. Yes.

Q. Yes.

THE CHAIRMAN: Sorry, I don't know what he's saying "yes" to because there were two questions run together.

MS ANYADIKE-DANES: Sorry, I beg your pardon.

In 2001, would you have understood that if a patient had a condition which caused the patient to retain fluid that that could result in the sodium being diluted and therefore leading to the condition of hyponatraemia?

A. If you're asking me if a patient were to retain too much fluid --

Q. Yes.

A. -- and therefore get dilutional hyponatraemia, I understand the concept you're telling me, yes.

Q. And therefore, if I keep it as an open question, is that a concept which, if described to you in that way, you would have understood in June 2001?

A. No.

Q. If I had given you that description in June 2001, you would not have appreciated that that would lead to hyponatraemia?

A. Hyponatraemia wouldn't have been even on my radar. What you said now, if I understand you -- because I want to answer you correctly -- if a patient retains too much water, they will get a dilutional effect on the sodium and therefore get dilutional hyponatraemia.

Q. Yes.

A. That concept as you explain it to me is very straightforward, no problem, but if you are asking me --

Q. Just as we pause there, would you have understood that concept in June 2001?

A. If you had said that to me in June 2001, yes, I would have understood the concept, but you're saying to me today if you said that to me in June 2001.

THE CHAIRMAN: Because it must follow that if you retain too much fluid, then the level of sodium in your body will diminish as you retain more and more fluid.

A. I understand the concept you're saying of dilutional hyponatraemia as you explained it to me. Yes, that's straightforward.

MS ANYADIKE-DANES: You understood that?

A. Yes.

Q. Let's put it another way. If you have a patient now who is vomiting a lot, would you understand that that vomit is likely to be rich in electrolytes?

THE CHAIRMAN: Sorry, would you understand when?

MS ANYADIKE-DANES: I beg your pardon, all this is June 2001.

A. No.

Q. You wouldn't have understood that vomit is rich in electrolytes?

A. No. In June 2001, no.

Q. So you wouldn't have understood that if you've got a patient who is vomiting excessively, they are likely in that way to be depleting their sodium unless, of course, that sodium is being replenished in some way. You wouldn't have understood that in 2001?

A. No, no. Can I expand on that?

Q. Yes.

A. When you say "June 2001", obviously I'm trying to separate my knowledge since Raychel from my knowledge prior to Raychel.

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

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

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

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

to write, there may be new patients coming in. We basically were doing what you were asked to do. A busy role, but --

Q. Did you ever have to exert any initiative at all? For example you now know, I take it, that Dr Devlin followed up and administered a pre-prescribed, if I can put it that way, anti-emetic. Dr Gund, the anaesthetist, had said that Raychel should have an anti-emetic if required. And as it happens, the nurses were of the view that it was required, he came and he administered that anti-emetic. I'm not going to get into the full detail of what you did until a little later on, but for these purposes, to explain matters, you came and there wasn't a pre-prescription, if I can put it that way, for the anti-emetic that you administered, so you presumably wrote up a prescription?

A. Yes.

Q. So quite apart from following on from things that had been initiated in the ward round or that you were specifically directed to do by your senior colleagues, were there therefore, like that example, instances where you had to exercise your own initiative about what to do?

A. Yes, to a point, but when I say more senior colleagues, I would consider that would be your SHO, your registrar,

your consultant, but also the nurses. So if you were asked to do a task, you're not going to second-guess someone more experienced, you're going to do the task, you follow what you're asked to do.

Q. We'll come to that in a minute. What I was trying to see if you could help me with is whether you were ever in the position of having to make a decision about what to do about a particular patient, no matter how minor the matter was, were you in the position of having to make decisions?

A. You would show initiative at times, yes.

Q. And when you were doing that, you were involving yourself in patient care, effectively, you weren't just following straight directions?

A. Yes, but it depends on the decision.

Q. And you might, for example, be involved in replacing bags of IV fluid. That might be something you might be asked to do.

A. To replace the cannula?

Q. Yes -- no. To place a catheter or to put up a new bag of fluid when the IV fluid is finished?

A. Certainly, yes.

Q. And if you were doing something like that, might you be expected to think about whether I should ask somebody whether we need another bag at this stage?

A. Possibly, it depends on the context. Possibly.

Q. But the condition of the patient may be such to raise that query in your mind, maybe I should talk to somebody about that?

A. Yes.

Q. Did you know how to calculate the maintenance fluid needs of a child as at June 2001?

A. No.

Q. Had you heard of a thing called the Holliday-Segar formula --

A. No.

Q. -- which is by reference to a child's weight?

A. No. I mean, I guess I would have had a vague idea that you would take the first 10 kilos and multiply by 100, or maybe the next 10 kilos and multiply by 50. But to my best knowledge I never wrote up fluids for a child.

Q. You were aware of the formula, that there was a formula for doing it?

A. I was aware that there was a formula, yes.

Q. Although you never had to calculate what it was for a child and therefore prescribe that amount, would you have been in the position to recognise whether a particular rate seemed high to you, based on that kind of formula?

A. No.

Q. Would it even have crossed your mind to think about whether a rate is too high?

A. No. I wouldn't have queried fluids.

THE CHAIRMAN: Can I take it that when you say you would haven't queried them, does that mean you wouldn't have queried them unless they were obviously very high or obviously very low?

A. Yes, I mean at a -- if I just say about an adult surgical ward, I would have a rough idea to calculate if a person was on 4 litres of fluid in 24 hours or 3 litres, so you'd know what millilitres per hour that was. If it was excessively high, that would raise alarm bells in your head.

MS ANYADIKE-DANES: For a child, because you weren't familiar with paediatric patients, are you saying you wouldn't be aware of what those parameters might be for a child?

A. I think it would depended obviously on the child's weight. Obviously I wouldn't -- adults generally from my knowledge had a set 3 litres of fluid over 24 hours, for instance. So it was easy to have a figure in your head whereby you could say 3,000 divided by 24 equals whatever. In a child, no, you wouldn't have any figure in your head to say that's too high, too low.

Q. Thank you. Can I ask you about the support and

supervision that you received as you were carrying out your task as a surgical SHO? What level of supervision did you receive?

A. As a surgical JHO --

Q. I didn't mean that. Surgical JHO, thank you, sorry.

A. If you clerked in a new patient, then the patients, from recollection, were routinely reviewed by the SHO after you clerked them in. And you would learn from that, obviously. In terms of other formal teaching, it would be on ward rounds. If the consultant had time, he would teach you on some ward rounds, which was very useful. In terms of supervision throughout the remainder of the day you would have had, the surgical SHO would pop in and out of the ward, but more than not they would have been in theatre or clinic. So most supervision otherwise would really be under the wing of the nursing staff.

Q. So would it be fair to say that your work, unless you were literally with a more senior colleague at that time, generally wasn't really supervised by a more senior colleague? On the surgical side, I'm talking about.

A. Your work generally wasn't supervised by a more senior doctor except for maybe new admissions because they were reviewed, or obviously if you contacted your SHO about

something. You could always contact them.

Q. Yes, but absent that, then your work wasn't really going to be supervised and the only people who might raise a concern if they were troubled by what you were proposing to do or what you had done would be the nurses?

A. Yes.

Q. And I think in your witness statement you refer to some of your tasks. Apart from the clerking in, for example, you talked about administering medication intravenously and so forth. That is something you could be doing and you might do that and that wouldn't be necessarily supervised by a more senior colleague, although the nurses were there because they're present on the ward?

A. Yes. I wouldn't be supervised by a more senior doctor.

THE CHAIRMAN: I take it from the way you're answering these questions, doctor, that at that stage in your career you would have regarded nurses as almost senior colleagues; would that be right?

A. Definitely.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Apart from the way that you've just answered the chairman that you would have regarded the nurses as your senior colleagues, and I think you'd answered me before by saying sometimes the SHO would pop

in or out, but more typically they were in the theatre. Did that mean that they weren't very accessible to you?

A. You always could bleep your SHO, but if your SHO was in the theatre assisting in an operation, then sometimes you would bleep them and the theatre nurse might answer, and you'd be told, "We'll get back to you when finished", but you could always bleep them of course. They would on the ward sometimes because they would have to review the new admissions, but more often than not they weren't.

Q. One of the things that you said you were involved in was ward rounds.

A. Yes.

Q. If you can just help me with how the daily post-take ward round worked when you were a surgical JHO. If I can put it in this way: some of the evidence that we have had -- and let's see if you can help if this accords with your recollection -- suggests that the JHO might make up the list of all the new admittances and those who had just had surgery the previous day, might make up a list like that ready for a ward round, and might take the notes of the ward round as the consultant or the registrar proceeds through the ward round. Is that how you recall it?

A. I don't recollect that a JHO would be the one to tell

the consultant: these are the ten new patients. However --

Q. I'm not sure I meant tell them, I mean accumulate to make sure there's a comprehensive list of them. Would that fall to you to do?

A. I think we could have done that, yes.

Q. Then you say you could have done that, so maybe I'll ask you then: what was a typical post-take ward round on Ward 6 so far as you are concerned?

A. On Ward 6?

Q. Yes.

A. The paediatric ward?

Q. Yes.

A. Sorry, I don't think I ever did a post-take ward round on Ward 6.

Q. Ah, okay. Thank you. Did you know that they had them?

A. If I can answer by saying I did urology, it was Ward 7, and then I worked in Ward 9. So typically if you had a post-take ward round in Ward 7, your consultant and you would have -- and the SHO whatever -- done the ward rounds, but you'd have stayed on the ward then to start your jobs. Whereas the consultant and the SHO would then go and see what they called outliers, which would have included Ward 6.

Q. In fact, Mr Zafar, who was a surgical SHO, described

precisely something like that. He did, as you probably will recall now from having looked at Raychel's medical notes and records, the post-take ward round in relation to Raychel on 8 June. It appears that he did it by himself and he was asked to go off, there was only, it seems, one post-take patient, surgical patient, on Ward 6, and he was asked to go and carry out that ward round, which he did. The impression he gave was that other colleagues would be doing the rest of the ward round in other locations, if I can put it that way. Is that the sort of thing that you meant?

A. Yes. I think the JHO was ward-based, so we would have done the ward round with the consultant, but I don't believe we -- certainly I didn't leave Ward 7 to follow the consultant to Ward 6. If the consultant went to Ward 6, I would have stayed on Ward 7, did the ward round for the hour or whatever it took, and then start jobs.

Q. I see.

A. In fact, I don't think I ever did a ward round in Ward 6, post-take or any other ward round.

Q. Thank you. It may be then that you can't help us very much with this, partly because you have said that your experience with surgical paediatric patients was very restricted before Raychel and then you didn't have any

after Raychel. Were you aware of how the responsibilities fell for the surgical patients on Ward 6?

So if I narrow that down for you. In terms of medication and fluids, so far as you are concerned, was it the surgical team who was responsible for them because the patient would be a surgical patient, or was it the paediatric team who would be responsible for them?

A. I would be guessing. I don't think I ever wrote fluids up for a paediatric patient. In terms of medication, my experience of going to the paediatric ward would have been, rarely, to write maybe a discharge letter, so I don't know whose responsibility it is to write up the fluids for the paediatric patients.

Q. Do I take it from that that you wouldn't have been aware of there being any different views as to who was responsible for what in relation to the surgical patients on Ward 6 on fluids, you wouldn't have been aware of that?

A. No.

Q. You probably are aware now that after Raychel's death there was a critical review meeting on 12 June. During that meeting there was a general discussion and part of that discussion was to do with a view that was emerging

that surgeons weren't very good at monitoring their children who were on IV fluids. Was there any kind of tension in relation to that, were you ever aware of that?

A. Sorry, I'm not sure what you mean, tension.

Q. That would be a tension between or potential tension between the nursing staff on Ward 6 and the surgeons and potentially also the paediatricians. But were you ever aware of that feeling that the surgeons weren't very good at monitoring their own patients on Ward 6?

A. It's not something that I really thought about. Having not been asked to write fluids up myself, it's not something I've had to think about.

Q. Leaving aside the fluids, were you ever aware of the fact that the nurses had a feeling that the surgeons, because they were spending a significant amount of their time in theatre and so forth, weren't readily accessible and weren't very good at monitoring their patients on Ward 6? Were you aware of any of that sort of feeling?

A. I could understand if they were, but I wasn't aware that they thought that.

Q. You can understand that that might be the case, but you didn't get that sense from them?

A. Yes.

Q. And although you didn't go to Ward 6 very often, were

you aware of the fact that if you are in Ward 6, which obviously is a paediatric ward, that you had available to you paediatricians to ask questions of if you should have any concerns about what you were going to do in relation to a patient?

A. Oh yes, yes.

Q. And you wouldn't have had any hesitation in doing that?

A. None at all.

Q. Have you ever done that?

A. I can't remember, but as a JHO you knew most people in the hospital, so if you wanted advice you'd ask the person who'd give you the advice you wanted, so I wouldn't have had any hesitation. I can't recall whether or not I ever asked for paediatric advice, but I would have done so.

THE CHAIRMAN: You don't see any reason why you wouldn't have asked a paediatrician for advice if you needed it in relation to a child on Ward 6?

A. Definitely not.

MS ANYADIKE-DANES: In fact, given your level of experience in paediatric matters, would you have considered that an entirely natural thing to do, to ask for the view of a paediatric colleague?

A. Entirely, yes.

Q. Thank you. I want to ask you now about the specifics of

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

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

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

A. Yes, I believe so.

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

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

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

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

Q. She goes on to say:

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

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

A. Yes.

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

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

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

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

Q. So these are unique identifiers, are they?

A. They're just phone extensions.

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

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

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

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

Q. Or the "4138"?

A. No, sorry.

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

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

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

A. Yes.

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

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

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

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

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

A. When I went to Ward 6?

Q. Yes.

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

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

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

THE CHAIRMAN: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS ANYADIKE-DANES: And you did that?

A. Yes.

Q. What else did you do?

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

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

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

Q. Exactly.

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

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

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

A. Yes.

Q. So you know that?

A. Yes.

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

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

THE CHAIRMAN: 10 o'clock.

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

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

MS ANYADIKE-DANES: What was her demeanour?

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

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

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

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

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

that Raychel didn't vomit at all after the operation until about 8 o'clock. And she's then vomiting -- even on the chart, which I know is incomplete in terms of recording vomits, that she had vomited a number of times fairly consistently from 8 o'clock in the morning through the morning, through the afternoon, and now into the evening, and you're being called because she's vomiting again in the evening. Did you know from the -- so you don't just go by what -- sorry.

The suggestion from the experts, which you'll be asked to comment on, is that you don't just go by what you're told. Sorry, I should say the suggestion from some of the experts is that you don't just go by what you're told. Should you not also have looked at the records which were available at the bed at least, which included the fluid balance chart?
A. I would disagree with that. Having been in the situation many times when you're asked to do something. Put it another way, if someone -- if a nurse is concerned about a patient, concerned something is abnormal, they won't phone the JHO, they will phone the SHO.
THE CHAIRMAN: So am I to understand from your perspective the fact that she phones you is an indication of the extent of her concern?

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

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

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

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

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

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

raises a concern to you who is more experienced and they say, "Hang on, there's something not right here, we shouldn't be giving just an anti-emetic, we should be doing something more", then you'd do something more, but you can only act in reference to what you've learnt.

MS ANYADIKE-DANES: I understand that. If you had known that there was a previous anti-emetic administered, would you not have wanted to know when it was and what happened in relation to it? Because even though from your point of view you're still going to go and give the anti-emetic because that's what you think is appropriate and that's what more senior people are telling you, but it might have suggested that maybe I'll just tell my SHO about that, if nothing else as a learning point.

A. Sure. I find it difficult because I can't recollect whether I knew or did not know that Raychel had received Zofran prior to it. I may have known that, I just don't recollect that.

Q. Dr Devlin was of the view that if he had been coming again, so he'd known about the first one, which might be because he had administered it or somebody had told him and he was coming again at the time that you came, that that might have been relevant for him to know that and it might have, not necessarily conclusively, but it might have persuaded him that perhaps an electrolyte

test would be appropriate or at least to have discussed that with somebody.

A. If I had known Zofran was given, I don't think it would have changed what I did. And the certain things that would have maybe made me contact the SHO ... But I wouldn't have considered doing a blood test.

Q. Would it have predisposed you to contacting your SHO?

A. The fact that she had a second anti-emetic?

Q. Yes.

A. No.

THE CHAIRMAN: The type of vomiting had changed. And as we understand it, it was now coffee-ground vomiting, which it had not been earlier on in the day. Our understanding is that that indicates an increase in the concern which one might have about vomiting; do you agree with that?

A. Yes.

THE CHAIRMAN: Right. So what had changed since Dr Devlin had been there was that the anti-emetic had been given, but had not brought an end to the vomiting. You say that of itself is not necessarily unusual. She had vomited a number of times. You were being called back and the nature of the vomiting had changed. If you'd known that the nature of the vomiting has changed, which would be apparent from the fluid balance sheet, is that

a factor which you would have had to consider in deciding what to do or who to call, if anybody?

A. Coffee-ground vomiting by definition means there's bleeding somewhere in the upper gastrointestinal tract. It's certainly something I would have been very scared of as a JHO. If in Raychel's case, if there was coffee-ground vomiting, it would have been automatic that I would have asked the SHO to see her.

THE CHAIRMAN: The problem is, doctor, the fact is that coffee-ground vomiting is on the fluid balance sheet.

A. I never looked at the fluid balance sheet.

THE CHAIRMAN: That's the point. The point is whether you should have looked at the fluid balance sheet.

At the end of Raychel's bed, as we understand it, there's very limited information. There's the observation chart, which you refer to as the TPR, there's the kardex and, as we understand it, the only other document there is the fluid balance sheet.

A. That may have been there.

THE CHAIRMAN: I have to say, doctor, I'm working on the basis that it was there because I've been repeatedly told it's there and that's where the entries about the vomiting are. In fact, it was that which had led to you being called.

A. Sir, I totally accept what you're saying. I didn't look

at the fluid balance chart, but the reason I didn't look at the fluid balance chart is because Raychel was on intravenous fluids. I don't write up intravenous fluids as a JHO for a patient. She was on fluids. My concern was to prevent dehydration by giving her the anti-emetic.

THE CHAIRMAN: Sorry, doctor, the fluid balance chart doesn't just tell you about the IV fluid, it also tells you about the amount of vomiting. It gives some hint, which is a bit vague, about the volume of vomits, but it also specifically in Raychel's case would have told you about the type of vomiting, and I now understand from what you're saying that, had you known it was coffee-ground vomiting, you'd have certainly gone to the SHO.

A. Yes.

MS ANYADIKE-DANES: Just to finish that off, since we've been talking about it so much, it's 020-018-037 --

THE CHAIRMAN: Can I take it from these answers, doctor, that you were not told by a nurse that it was coffee-ground vomiting?

A. I was definitely not told it was coffee-ground vomiting.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Here it is. Had you looked at it or had somebody suggested that you did look at it, this is what

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

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

MS ANYADIKE-DANES: I beg your pardon then, Mr Chairman. So you'd have appreciated from that that she passed urine at 10 o'clock and then you would have no knowledge of what she passed or didn't pass from then on, as

I understand from the Altnagelvin records. But in any event, you would have been able to see this pattern, leaving aside everything that comes after 9 o'clock, this pattern of her vomiting. And if you had gone to the next page in the kardex where you signed off, you'd have seen that indeed that anti-emetic was required and it was administered and you'd see that it was administered by Dr Devlin and what time it was administered. Sorry, you wouldn't have seen the time, that's exactly the problem. He didn't indicate the time. So you wouldn't have known that, so you would have had to ask about that. But you'd have seen that it had been administered. And what I'm inviting you to consider is whether it was appropriate for you to come and effectively just administer the anti-emetic or whether you should have taken the opportunity to interrogate a little further as to what was happening, not necessarily so that you yourself could make a diagnosis, but so that you would be armed with information to give your SHO or any other more senior colleague. That's what I'm inviting you to consider, whether you didn't think that you missed an opportunity.

A. Retrospectively, looking back, yes, I could have had more information. Obviously, from looking at the fluid balance chart, coffee-ground vomiting would have been

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

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

A. Yes.

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

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

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

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

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

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

A. Yes.

THE CHAIRMAN: He did say that.

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

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

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

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

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

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

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

THE CHAIRMAN: Okay.

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

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

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

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

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

THE CHAIRMAN: Yes.

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

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

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

An assessment means that he did assess her.

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

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

THE CHAIRMAN: Okay.

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

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

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

A. No.

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

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

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

then. Thank you.

(12.03 pm)

(A short break)

(12.13 pm)

(Delay in proceedings)

(12.18 pm)

MS ANYADIKE-DANES: I want to move on from the three charts or documents that were available to you at the bedside and to consider something else.

Before we got into that territory, I put to you Dr Devlin's view that, had he seen Raychel twice -- so he'd had the benefit of administering the anti-emetic the first time round, come again, then at that stage, leaving aside what contact he might have wanted to make with his senior colleagues -- he might himself have been thinking about electrolyte profiles.

I can't remember if you specifically answered whether, if that were you, you'd seen her first, administered the first anti-emetic, come and given the second one, whether you would have had that view also?

A. No, I don't believe I would have.

Q. I thought that was your answer, but I wanted to give you the opportunity to say that.

THE CHAIRMAN: I just want to develop that a little. Dr Devlin wasn't saying yesterday that he would

definitely have called for a blood test, but I think the real point he was making was the advantage, if a child was seen a number of times, that the same doctor sees her more than once. So if he was there at 6 o'clock and had he been on duty and he was called at 10 o'clock, he would have the knowledge of what he'd seen and observed and had heard at 6 o'clock, which better informs a view which he forms at 10 o'clock.

And the reason I'm interested in your take on this is because it's one of the points that some of the experts have flagged up to me which is when Raychel is seen through the day, but always by different doctors, it makes it more difficult to have continuity of care. It's one thing to say, "Look, the GMC and the Altnagelvin Junior Doctors' Handbook says the notes are supposed to be good and you do your best to make notes as you go along", but that is not as good as being the doctor who has seen the patient twice or three times. As a general point, would you agree with that?

A. Yes. I would agree that if I had seen Raychel twice with vomiting, that the second time I would have acted differently. But that's probably because I'll be seeing the same patient twice with the same problem and also because I would have --

THE CHAIRMAN: You would have known that you had given the

anti-emetic at 6 o'clock, so you would know with the second anti-emetic.

A. Yes. But also I would have had the advantage of knowing what Raychel, say, looked like at 6 o'clock and what Raychel looked like at 10.15. So if I had seen a patient twice, yes, that may have prompted me to act differently.

THE CHAIRMAN: I guess the problem is it's hard to devise a system to deliver that because doctors need to go off duty.

A. Yes. Dr Devlin would have finished and I would have come on.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Firstly, just to give you an opportunity to say it, what difference do you think it might have made?

A. I think if I had seen the same patient twice and had cast eyes on the same patient twice, then as a general rule it probably would have made me at least say first to the nursing staff, "Look, is this quite right?", and then possibly then the SHO -- I don't think it would have prompted blood tests, but I think it would have prompted certainly -- at least a chat with the nurse, if not the nurse and the SHO.

Q. In fairness to you, Dr Devlin wished very much not only

that he had made a note of his examination for you to see, although I'm not sure that if he had done, given the records that you said you looked at, that you'd have actually seen it, but in any event he wished he had made that note and certainly that he had timed when he administered the anti-emetic and also that he had discussed Raychel with you. Is that something that would have been unusual to happen? I don't mean the two of you because you knew each other, but two JHOs in your position to discuss something like that? Would that have been unusual?

A. Yes, the only time you would really have handed over a patient would maybe if a patient had just come in and needed clerked in or if someone was really unwell, but generally if they were really unwell, they would have been seen by the SHO, who would have handed it on to the SHO. So generally there was no handover.

THE CHAIRMAN: I know that Dr Devlin said yesterday that he wished in hindsight that he had spoken to Dr Curran, but I did not understand that to be him saying that that would be in any way as a sort of handover.

MS ANYADIKE-DANES: No, no, I didn't mean it as a handover. I was simply asking, in the circumstances of that case, whether that sort of thing is something you might expect to happen, if I can rephrase it in that way.

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

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

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

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

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

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

your SHO. But I need to put to you that some of the inquiry's experts have formed the view that it isn't just as straightforward as that and that the junior doctors -- yourself and Dr Devlin for that matter -- the do have a role to play in identifying the significance or otherwise of Raychel's condition and it's not simply a matter of administering something that the nurses have indicated they wish to have done.

For example, Simon Haynes says, in his view, from any point in time from late afternoon onwards, the correct course of action was to take a blood sample for electrolyte assay.

In fact, the first point in time for you would have been when you attended at 10 o'clock. And so from his point of view, if it had not already been done, then that is something that you should have known to request.
A. I would disagree with that simply because I know how things worked in Altnagelvin at the time as a JHO. There was no protocol to say if someone was vomiting for X amount of hours that there should be an EP, electrolyte profile. If someone was on IV fluids for a certain length of time, there's no protocol to say they should have an electrolyte profile.
Q. In fact, some of the other experts say much the same sort of thing, so I want to approach it with you in this

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

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

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

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

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

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

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

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

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

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

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

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

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

his registrar and SHO to see the patient urgently."

So he's had that discussion about what he wants you to do and why he wants you to do it, but he refers again that he wants you to get in contact with your registrar and SHO to see the patient urgently; do you recall that?

A. I recall SHO, I do not recall registrar.

Q. Did you appreciate why he wanted you to get in touch with a more senior surgical colleague?

A. I appreciated that Raychel had a seizure, which is urgent, and I appreciated that getting a senior colleague, an SHO, was the right thing to do. But I thought that his intention and my intention was that the bloods was the urgent thing to get away. I'm not sure I understand your question. If you're saying should I have phoned the surgical SHO and waited on the bleep for the surgical SHO and then did the bloods or did the bloods and then phoned the surgical SHO. He did ask me to phone the surgical SHO. He asked me on the phone when he bleeped me and when I went to the ward and talked through what we did. But when I was sending the canister to the lab, he said to me again, "Have you phoned your SHO?", and it's at that point I said, "I'm doing it now".

Q. The question was slightly different, which is whether you appreciated why he wanted you to involve your more

senior colleagues. Did you understand the surgical concern, if I can put it that way?

A. I understood that he wanted a more senior colleague involved because I was a JHO and because Raychel was a surgical patient.

Q. Yes. What in fact he said is at 029/2, page 7:

"I was concerned that Raychel had a serious post-operative surgical cause for her fit and deterioration. I wanted more senior surgical doctors from her team to assess and manage her condition."

So it wasn't perhaps just a matter of going up the chain to more senior paediatric involvement; he actually thought that something surgical might be going on and therefore he wanted senior surgical involvement. Did you understand that from your discussion with him?

A. No. Sorry, I don't know if Dr Johnston felt there was a serious surgical cause.

Q. That's what he's saying.

THE CHAIRMAN: That's what he's saying in the statement. But you understood the urgency was -- in fact there were two urgents. The first urgent was to take the blood samples and the second urgent was to get somebody up the line.

A. More senior.

THE CHAIRMAN: So your response to that was to go

immediately to the ward, immediately take the blood samples and, having done that, then contact the senior surgical colleague?

A. Yes.

MS ANYADIKE-DANES: So then you made contact with Mr Zafar.

A. Yes.

Q. And Mr Zafar was in A&E; is that right?

A. Yes.

Q. What did you explain to Mr Zafar?

A. I told him that one of the surgical patients on Ward 6 had had a seizure, that the paediatric SHO had attended, that we had taken bloods, and I asked him to come as urgent.

Q. You asked him to come urgently?

A. Yes.

Q. Did you convey anything to him if you had -- I'm not sure whether you had conceded whether you appreciated or not. Did you convey anything to him about why Dr Johnston wanted more senior surgical involvement because he was concerned that there was a serious post-operative surgical cause for her fit. Did you convey any of that?

A. I think the fact when I asked him to come as urgent and said, "We have a child who has had a seizure", I think I conveyed the message that he needs to come urgently.

Q. And what did he say to you?

A. He said he was with someone in casualty, but he would be up as soon as he could, which I interpreted to mean he was coming.

Q. When you said you interpreted it to mean he was coming, I can see why you would, is there a period of time that would have elapsed when you would have had another go to see if you could reach him or reach somebody else?

A. I didn't contact him again.

Q. That's what I'm asking you. How much longer, given that all this is urgent, would you have to wait before you formed the view that whatever it was he was doing obviously has got him tied up and he can't free himself and I need to go somewhere else because Dr Johnston has told me he wants senior surgical involvement?

A. As a JHO in that scenario, where a child has just had a seizure, you are fairly scared, you are in that environment, you sought your senior assistance and asked them to come urgently. You are waiting for them to come. I don't think there's a time frame that I would say give him 15 minutes and ring him again, has he forgotten or has he rung the registrar to come in his absence or something. There wasn't a time frame where I was saying I need to ring him again, if that's what you were asking.

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

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

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

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

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

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

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

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

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

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

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

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

a seizure whereby you're flat and unresponsive before you come round, but Raychel wasn't coming round.

Q. Maybe I can ask you to describe then -- after she'd had the seizure and had received the two medications that Dr Johnston administered to her, can you describe what she was like, what was her condition?

A. When I would have got to the ward, Raychel wasn't fitting at that point. Raychel was lying in bed pretty flaccid, not moving, she had high flow oxygen on her, she wasn't responding. But after someone has a seizure, it is common to have a period where they do not respond; that is called the post-ictal phase. Then you expect the patient to improve after that, to come round. Raychel didn't.

Q. Staff Nurse Noble describes Raychel as having intermittent tonic episodes with her pulse rate fluctuating. Was that happening in your presence while Dr Johnston was away?

A. I didn't see Raychel having -- tonic episodes means that the patient would go rigid, rather than clonic,where they would shake.

Q. Intermittent tonic episodes, to be fair to her, is how she described it.

A. I didn't see Raychel have an episode where she went rigid.

Q. Were you aware that her heart rate was fluctuating between 78 and 140?

A. I was aware she had a fast heart rate. I did a heart tracing on her.

Q. So you knew that?

A. Yes.

Q. Mr Ferguson arrives at 4 o'clock and he describes Raychel as being surrounded by people and that she is shaking and trembling in the bed, which might be his description for some sort of activity; did you see that?

A. No.

Q. In fact, did you see anything that made her appear very much different to you than just before Dr Johnston had gone off to find Dr Trainor?

A. During that period?

Q. Yes.

A. No.

Q. She seemed much the same?

A. She hadn't improved, but she seemed the same.

Q. So do you know what prompted Staff Nurse Gilchrist to bleep the doctors? Do you know what prompted that?

A. I fully expected it was her experience in seeing seizures in the past and realising that this wasn't normal, that she wasn't improving.

Q. And when that happened, were you still not concerned

that none of your seniors had got there?

THE CHAIRMAN: I've got the point about the senior surgical team.

MS ANYADIKE-DANES: Then Dr Trainor does arrive and she has certain tasks that you assist in performing; isn't that right?

A. Yes.

Q. Specifically, she wants to know from you where the blood was taken, whether it was taken from the same arm that the drip was running in.

A. Yes.

Q. Did you understand the significance of that?

A. Yes.

Q. Which is?

A. Well, if you take blood from an arm on which a drip is running into, you will most likely get a low sodium, which is just an error, it's an artefact.

Q. So you knew that?

A. Yes.

Q. And you were sure you hadn't done that?

A. Yes.

Q. And that's the information you gave her?

A. Yes.

Q. Did she not want a second round of bloods taken and tested?

A. Yes.

Q. And did you do that?

A. Yes.

Q. And you took those up to where Dr Johnston was, which is where they could be tested quickly; is that right?

A. She wanted, I think, two sets of bloods. One was a blood gas, which was processed in the Special Care Baby Unit where Dr Johnston was. There was also a repeat electrolyte profile, but I can't recall whether that was processed through the main lab again or whether that was done in the Special Care Baby Unit.

Q. In any event, you did that and you -- it seems at about 4.30 -- get to the neonatal intensive care unit to give that arterial blood sample and get it tested.

A. Yes.

Q. When you get back to the ward, it is about 4.40.

A. Yes. That sounds about right.

Q. Do you know at that stage that Dr Trainor has telephoned for Dr McCord to come in when you get back?

A. I was there when Dr McCord turned up, but I don't know when I was told the phone call was made.

Q. And are you there at about 5 o'clock when it seems that Mr Bhalla and Mr Zafar arrive, roughly thereabouts?

A. I can't be exact, but yes, it was roughly about then, yes.

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

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

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

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

someone from the hierarchy in the hospital to chat to all staff involved about the case.

Q. Did you and Dr Curran [sic] -- we know that you did talk about it. Did you talk about it at this stage about what your expectations as to what would happen?

A. To who, sorry?

Q. Dr Curran -- Dr Devlin, I beg your pardon.

A. Yes, I spoke -- sorry, I spoke to Dr Devlin probably the Saturday or Sunday, I would think, that weekend.

Q. And then you said some sort of informal meeting. In fact, there was a critical incident review on 12 June. Do you make a distinction between that, which was very shortly after Raychel's death, and the meeting which you thought was going to happen the following week, or are they much the same sort of thing for you?

A. I can't recollect being at a clinical incident meeting.

Q. No, you weren't at one. I'm asking you whether it was at that meeting that you think you subsequently learnt that all those involved might have to explain the nature of their level of involvement with Raychel; do you think it was coming out of that meeting?

A. It could have been feedback from that meeting, yes. Could have been.

Q. Did Mr Gilliland at any time come to talk to you about what happened?

A. Not to the best of my recollection.

Q. Did that surprise you?

A. Yes, a little bit, I suppose, yes.

Q. We had asked Mr Gilliland whether he went about trying to establish who was in the surgical team who was treating Raychel, and the answer was, no, he didn't. He confirms that he didn't speak with you and had no specific discussions with you. Did anybody speak to the members of the surgical team who had actually been involved with Raychel that you are aware of?

A. Do you mean speak to me or --

Q. No, speak to all of you. There's Dr Devlin, yourself, Mr Zafar, Mr Makar, Mr Bhalla. They're all part of the surgical team who had some sort of involvement in Raychel's care. Were you aware of anybody trying to get together what the surgical team's knowledge was about what had happened?

A. To the best of my recollection, I don't think anyone spoke to me to get -- spoke to me about what happened or my involvement.

Q. And therefore, you're not aware of there being any meeting called where all those surgeons who'd been involved with Raychel gathered together and tried to understand what had happened or give some account of their involvement from the surgical perspective?

A. Yes, I wasn't aware of that.

Q. You weren't aware of that?

A. No.

Q. Did you know that Mr Zafar, for example, had attended the critical incident meeting?

A. No.

Q. Or Mr Makar?

A. I don't think I was -- I mean, if I was invited or asked to attend, I would have attended, so I don't know who did or did not attend.

Q. Okay. If I take you to what appears to be the outcome of that. Apart from the fact that you weren't really very clear on what was happening or what the level of surgical involvement in that critical incident review meeting was, and you say that this is a death which obviously would be the subject of discussion and comment, were there any discussions as to what was happening in that meeting? For example, views expressed like I have put to you earlier about the availability of surgical teams, the need to carry out electrolyte testing and so forth. Did any of that find its way out of the meeting into discussion amongst the doctors?

A. No, not amongst the JHOs.

Q. Not amongst the JHOs. Were you aware that procedures changed shortly after Raychel's death?

A. I was aware that there was changes to be made following Raychel's death. Yes, I was aware that following that critical incident there were changes to be made.

Q. 095-011-059g. This is the action points coming out of that meeting. What I want to ask you about is was any of this information communicated to you and the other JHOs to indicate a change in how things were to be done? You can see, for example, at --

THE CHAIRMAN: Number 1, doctor: did you know that Solution No. 18 was changed a few days later and was replaced?

A. I did know that.

THE CHAIRMAN: Okay. Did you know that, from then on, there would be daily U&Es on all post-operative children receiving IV infusion in Ward 6?

A. I didn't know that, but I was now in medicine. But I didn't know that.

THE CHAIRMAN: It just happened that that night you were surgical, but you weren't supposed to be surgical generally?

A. Yes.

THE CHAIRMAN: Okay. Did you know about number 4:

"All urinary output to be measured and recorded while IV infusion is in progress."

In other words, there was to be a tightening up of

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

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

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

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

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

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

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

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

paediatrics ..."

Which is essentially you at that stage:

" ... should not have been first on call for surgical children."

As you reflect back on that, did you feel exposed?

A. At the time in Altnagelvin whenever you're a JHO, you have such a steep learning curve, everything you're doing or many of the things are doing are new to you, so you probably are in many ways naive. Looking back at it now, yes, totally exposed.

Q. Yes. And really, his main concern is the missed opportunity, which I think you have acknowledged was a missed opportunity, at 10 o'clock.

A. Yes.

Q. It was a missed opportunity to put in place a plan of care for Raychel that might have prevented her death.

A. I would say to that, if I went back and I had no other patients to see that night and with the information I was given, I would have done the exact same thing, but I wish I didn't.

MS ANYADIKE-DANES: I understand. Mr Chairman, can I just check if there are any questions?

MR QUINN: Mr Chairman, I do have a series of questions. It might be easier if I put them up now. This is an issue raised by the parents.

Mr Chairman, if I may ask, was a headache ever reported to the doctor?

THE CHAIRMAN: Do you recall that?

A. I do not recall anyone telling me about a headache.

MR QUINN: May I go on to ask the following be put up, wS028/2, page 5 and 6 together?

THE CHAIRMAN: This is your own statement, doctor.

MR QUINN: This is the doctor's second statement. The question starts at (m) at the bottom of page 5 and goes into page 6. It reads:

"I cannot recall if I spoke to her parents when I assessed Raychel. I did speak to the paediatric nurse. I looked at her bedside chart. I expect I would have looked at her clinical notes, but I cannot recall."

The doctor makes a clear distinction between (a) the bedside chart and (b) the clinical notes and could I ask does that mean that -- the bedside chart is kept at the bed and the clinical notes are kept at the nursing station? I just want to make the grounds clear here. Is that correct?

A. To the best of my recollection, yes.

MR QUINN: So could we then ask precisely what is at the bed? I know I've gone over this ground. The doctor has confirmed that a headache was never reported to him, but we know that the kardex is at the bedside and we know

that the fluid chart is at the bedside. Let's then look at paragraph 5(a):

"I did not find her distressed or actively vomiting when I seen her. I noted her observation from her chart. Her temperature was normal."

What chart were those observations made from? What chart would show the temperature?

A. There's temperature at the top, pulse is the middle line, respirations at the bottom. There's three separate parts to the page.

MR QUINN: Can you look at 020-015-029, please? Where is that particular chart kept?

A. I don't know, but I didn't ... That wasn't the chart I was referring to. I don't know where that one's kept.

MR QUINN: That's not part of the bedside notes?

A. I can only say I didn't see that chart.

MR QUINN: Was it part of the charts and notes that were held at the nursing station?

A. I can't answer. I haven't seen that.

THE CHAIRMAN: What do you mean, if that is not what you mean by the TPR?

A. There's another -- I got it in the clinical records from Altnagelvin. There was a chart called a temperature, pulse, respiration -- it's like three graphs or [OVERSPEAKING].

MS ANYADIKE-DANES: 020-015-028. That's the TPR.

A. That's the one there.

MR QUINN: That's the chart you mean?

A. Yes.

MR QUINN: Would you agree that if there was notification of a headache by the parents or a headache was recorded, that that would be a relevant feature of the nurses reporting it to you?

MR STITT: I do apologise for butting in, I should have waited until the end of the question. I've been sitting listening at the back, not sitting beside my instructing solicitor, but I thought we'd established a set of ground rules in terms of questions to witnesses --

THE CHAIRMAN: Yes, and we are trying to do this for speed because we've overrun significantly and I's trying to get these done quickly rather than me rise, Mr Quinn speak to Ms Anyadike-Danes and then Ms Anyadike-Danes put them through. Because I'm very anxious that the person that you're speaking to at the back of the room, Dr Johnston, is waiting here and is expecting to give his evidence this afternoon and be finished this afternoon -- and he will be finished this afternoon. I'm just trying to speed things up and a little leeway would be very helpful. Mr Quinn, please.

MR QUINN: If the previous record could be put up again,

please, 020-015-029. At the bottom right-hand corner of that record, you can see that there's a complaint of headache recorded.

A. Yes.

MR QUINN: Would that be a relevant feature to report to you if the nurses had recorded a headache?

A. Yes, it's just more evidence she was unwell.

MR QUINN: When that is put together with the other record on that sheet, that is vomiting plus plus, that also might put up what you call the red flag?

A. The vomiting coffee grounds, definitely. Many people may have a headache when they're being sick, but it depends what you mean by "plus plus".

MR QUINN: Let's leave it there. Would you agree that a headache, looking at it now retrospectively, perhaps, may be part of the overall picture of hyponatraemia?

A. Definitely.

MR QUINN: Thank you.

THE CHAIRMAN: Any questions before I come to Mr Stitt? No? Mr Stitt, have you any questions?

MR STITT: No, I haven't.

THE CHAIRMAN: Doctor, unless you have anything else you want to say before you leave the witness box, your evidence is now complete.

A. Thank you very much.

(The witness withdrew)

THE CHAIRMAN: Okay, thank you. We'll sit again at 2.30 and deal with Dr Johnston's evidence this afternoon.

(1.53 pm)

(The Short Adjournment)

(2.30 pm)

(Delay in proceedings)

(2.36 pm)

THE CHAIRMAN: Is Mr Stitt here?

MR LAVERY: Mr Chairman, no.

THE CHAIRMAN: I wanted to raise the privilege issue briefly just for an update.

MR LAVERY: At this moment, Mr Stitt is in a teleconference with Elaine Way, the chief executive of the Trust. That may have a bearing on the issue. I think my instructing solicitor has gone to see --

THE CHAIRMAN: I'll wait one moment. I know he's indicated we'll have an answer this afternoon about whether the Trust is going to assert a claim for privilege.

MR LAVERY: I think he expects to address you on that later on. (Pause).

THE CHAIRMAN: Mr Stitt, I didn't know you were consulting. What I wanted to raise was the general position about documentation. As I understand it, as a result of discussions primarily involving Ms Dillon and Mr Johnson

over the last day or two, we're very close to sorting out entirely any issues about what we call files 21 and 22 and what Altnagelvin have called files 1 and 2.

MR STITT: Yes, that's not a privilege issue; that's just a reconciliation issue.

THE CHAIRMAN: Mr Quinn, I think your solicitor was involved in that issue in 2010 and made submissions and there was some claim for privilege at that point. The only issue upon which submissions were made to us was about the three reports, doctors Warde and Jenkins, and those reports were eventually conceded by the Trust. We have an accurate and complete list of documents, which I think we're very close to doing. I don't think there are any outstanding issues about that.

On the DLS inquest file, which is the Altnagelvin inquest file, I understand that we're now to be given a fresh list of documents. The list of documents we had from the other day was seven pages long and runs up to about 230 items.

MR STITT: Yes, there are something like five additional documents which were found, not that they were lost, but they hadn't been, for whatever reason, included in the first index. There's no great air of suspicion there, I would suggest, because the documents themselves aren't particularly important. I'm putting forward simply an

administrative oversight.

THE CHAIRMAN: Okay. First of all, when will we get the revised list?

MR STITT: The revised list is ready. We've got the list. It's a list in which there are four types of reference against the index and that sets out the types of privilege, if privilege is claimed, and whether documents are already before the inquiry and, where they're not before the inquiry, where there's no privilege claimed.

THE CHAIRMAN: Will that include the documents which are not currently on the list because of the administrative oversight?

MR STITT: Yes, they are in this list, this final list, and they're in bold type.

THE CHAIRMAN: That helps.

MR STITT: That led to a slight slippage in the numbering when I tried to reconcile yesterday with Mr Coyle and we realised our numbers were a few out. In relation to the privilege point itself, I am due to have a discussion just about now.

THE CHAIRMAN: Okay.

MR STITT: I will be giving certain advices and I will be listening to what the Trust says and I will be reporting back.

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

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

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

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

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

out the litigation file that we have and it is only against Altnagelvin Trust.
THE CHAIRMAN: Okay. Then that might raise a separate issue about whether there is any privilege attaching, if there was a litigation file, to Belfast Trust.
MR QUINN: There shouldn't be any privilege attaching and it is something we should see.
THE CHAIRMAN: All right. So Mr Stitt, we'll know this afternoon about Altnagelvin. Sorry, we'll know between this afternoon and tomorrow morning. Ms Dillon and Mr Johnson will sort out any small outstanding issues about files 1 and 2 from Altnagelvin. We'll know by the close of business this afternoon what the Altnagelvin position is about the inquest file. I need to know something tomorrow about the Belfast Trust.
MR STITT: I would hope to have some progress report on the Belfast file in Raychel's case by the close of business today.
THE CHAIRMAN: Thank you very much.

DR JEREMY JOHNSTON (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good afternoon, Dr Johnston.
A. Good afternoon.
Q. Can I confirm you've got there to your left your curriculum vitae?

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

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

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

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

at June 2001. You had been a doctor for about four years; is that right?
A. That's right, yes.
Q. And an SHO for three years?
A. Yes, I was -- that was my third SHO year.
Q. Then if we think about where you did that, you started off at Altnagelvin?
A. Yes, as a PRHO.
Q. So you did your pre-reg at Altnagelvin and you also did --
A. Accident & Emergency.
Q. Yes. You did an SHO there as well?
A. Yes.
Q. And from there you moved on and you've had experience, in terms of Northern Ireland hospitals, in the Mater, the Musgrave, the Royal in Belfast, and Craigavon, Altnagelvin, and the Royal, and the Ulster as well. You came back to Altnagelvin in February 2001.
A. The experience in the Ulster was after this paediatric job.
Q. Ah. So I think you've already told us in evidence that this was your first dedicated paediatrics rotation.
A. That's correct.
Q. And you'd had four months of that --
A. Yes.

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

third-year SHO is certainly somebody who's done three years of paediatric experience and somebody ... are totally different than myself who's doing my first paediatric job. Although I've got three years of experience, it's not in paediatrics.

Q. Can you help us with trying to describe for us or at least explain the level of supervision that you would have been having as an SHO in your first six months of that rotation, if I can put it that way, in paediatrics? What level of supervision would you have had?

A. Certainly the SHO in paediatrics, we would not have -- none of us would have discharged patients from the hospital. We would have -- all of the patients that we seen would have been reviewed again by the registrar during an on-call period.

Q. And did you have any particular supervisor or was that just a general level of supervision that was carried out for all paediatric SHOs?

A. That was general supervision really.

Q. And during that first initial period, did you work more closely with a registrar or consultant, or didn't it work in that way?

A. I can't remember whether there was a consultant specifically, not that I can recollect. To point out: there's quite a large difference in experience between

the different people working on the registrar tier in that department. There are people that are fourth-year qualified and people who are 10 years qualified in paediatrics.

Q. You've now explained the fact that it may be that it was a little bit misleading the way that perhaps I referred to you as an SHO and perhaps indicated that you were more experienced and operating at a higher level than you actually were. Can you help us just briefly with what a paediatric SHO's role is or was in Altnagelvin at that time?

A. Well, essentially, certainly to see admissions that have come to the ward. GPs would refer patients to a department in the hospital and if the GP would send them, they would -- the GP would refer them, they would come to the paediatric ward and they would be seen by the SHO. And perhaps bloods would be done, simple investigations, and simple management plans and then they would be reviewed by the registrar. And there were other duties. As SHO, we went to the delivery ward and we were involved in the resuscitation of neonates and we did jobs in the neonatal intensive care. Basically, the tasks that we were given were to take bloods, blood gases and chores like that.

Q. Given that it was still very much a training position as

you're describing it, can you help in this way, briefly, with what sort of induction you would have had coming into Altnagelvin?

A. It's very difficult for me to remember with the passage of time, but I do specifically remember -- because we were looking after the delivery ward, there was a one-day designated neonatal resuscitation day that we did at the Belfast Children's Hospital and that was -- SHOs from all of the hospitals in Northern Ireland went to that. It was organised centrally in Belfast for all of us.

Q. Given that you have no JHOs, that you're straight in at that level with paediatric patients, was there any other sort of induction?

A. I think there were some -- there was some sort of ... The first few days of the job, there was basically some introduction to the different parts of the department and some basic knowledge. I can't remember exactly what was taught on that.

Q. I understand. Do you recall if there were any sort of series of ongoing lectures or seminars which were put on which you may or may not have been encouraged to attend?

A. Yes, I can recollect two sort of meetings. There was a joint meeting with the obstetric department, if I remember rightly, really sort of obstetric cases and

neonatal-type emergencies, and then I think there was a -- I think there may have been another teaching session during the week that I remember.

Q. If we think then specifically about Ward 6, which is a mixed medical and surgical ward; that's right, isn't it?

A. Yes.

Q. You have been asked in your witness statement requests for the inquiry to try and explain who had the responsibility for what form of care and treatment of those patients. So if we take the surgical patients --

A. Yes.

Q. -- particularly those who were post surgery, they're there on Ward 6 and they're only on Ward 6 because they're children --

A. Sure.

Q. -- but they have paediatric issues, I presume --

A. Yes.

Q. -- and they have surgical issues?

A. Yes.

Q. Were you given any guidance as to who is managing those children and in what respects?

A. Certainly my recollection is that it was fairly -- it was fairly sort of ... There was a discrete boundary that certainly ... Although the surgical patients were on the paediatric ward, that was the only common

denominator; they were solely managed by the surgical team and the surgical JHO, SHO, registrar, consultant, and we had no involvement with them whatsoever.

Q. Does that include their fluid management?

A. Yes, it does. As far as I remember, yes.

Q. The reason I ask you that is because you probably know by now --

A. Yes.

Q. -- that there is a difference of view --

A. Yes.

Q. -- as to who was dealing with what and, leaving aside the immediate post-operative period entirely, and once the child comes on to the ward and let's say from the post-take ward round phase, if you like, there's a difference of view as to whether the surgeons were handling that element of such a child's fluid management or whether they were, but only in discussion and with the guidance of the paediatricians. And then there is another school of thought that thinks maybe the paediatricians were doing it. So there would seem to be some difference.

A. Sure.

Q. Were you aware of any of that fuzziness, if I can put it that way, at the time?

A. Yes. Certainly, it's a lot -- time has passed, but

certainly I think any child who came with a surgical condition were seen, start to finish, by surgical doctors. If they came with abdominal pain and basically they weren't seen by a paediatric medical doctor, they were seen by a surgical doctor, and certainly as far as I can remember everything from writing up painkillers to fluid management, that was all managed by the surgeons.

Q. So the surgeons therefore would have been managing issues such as what fluid and maybe what rate of fluid they would be on?

A. Yes.

Q. Whether their electrolytes would be being tested, when IV fluids should stop and were they on sufficient oral intake; all that sort of issue, that's the surgeons?

A. Certainly that's what I remember, yes.

Q. And can I ask you this then: they didn't have control, did they, as to, or did they, as to what the fluid itself was?

A. As far as I remember, basically they were their patients and they had full autonomy on how they were managed from fluid management to analgesia.

Q. We have heard from a number of witnesses that the actual type of fluid that was administered on Ward 6 was Solution No. 18.

A. Yes.

Q. And that in fact, if another type of fluid was prescribed and there was -- sometimes it was just unilaterally changed.

A. Yes.

Q. Other times, the doctor or surgeon would be invited to change that and change it to what some have called a ward protocol or ward practice.

A. Yes.

Q. Were you aware of that happening?

A. I was aware that Solution No. 18 was being used for the paediatric medical patients. It was a fluid that I haven't encountered before.

Q. You hadn't encountered it before?

A. No, because I have not really worked in paediatrics. My memory and recollection is that that was a rule that was applied to the paediatric medical patients, not necessarily to the paediatric surgical patients.

Q. Were you ever aware of patients on Ward 6 having anything other than Solution No. 18?

A. I can't remember. Certainly I know that I had no involvement with the surgical patients, essentially, until Raychel's -- that night.

Q. When you said that they had autonomy over it -- it may be that because it is not something that you were directly involved in, so if you can't help, please

say -- but did you say that because it was your impression that if a surgeon or a doctor, for that matter, wanted a particular other fluid, Hartmann's, say, because they thought there were good clinical reasons for it, they would simply be able to prescribe that and that fluid would be administered?

A. Yes. As far as I was concerned, the paediatric medical team weren't involved with the management of the surgical patients. Sorry, that was my memory and recollection.

Q. Well, if we use an example, let's say an example of a child who has gastroenteritis and that child, let's say, is vomiting and has been vomiting for some time. And there's a concern that that child is losing electrolytes as a result of that. Is it your understanding that a fluid could have been prescribed as replacement fluid, which would have addressed that depletion of sodium? So for example, Hartmann's. Could that have happened on Ward 6?

A. I think it was possible, but certainly from the -- gastroenteritis is a paediatric medical condition and certainly the normal practice would have been to use Solution No. 18 for that.

Q. I understand that. But if you had formed the view or your registrar had formed the view that what we need to

address here is not just the hydration/dehydration aspect, but actually a loss of electrolytes and therefore a sodium depletion, that's what we need to address, is it your understanding that that could have been addressed by the administration of a different kind of fluid which had a higher sodium content?

A. Yes, I think other fluids could have been used if there was enough clinical information to justify that.

Q. And were you aware of whether or not Hartmann's was actually available on Ward 6?

A. I cannot remember, but I would suspect that it probably was on the ward or was in the hospital and available.

THE CHAIRMAN: Doctor, if a child came in as a paediatric patient, a medical patient with gastroenteritis, am I right in understanding that his or her bloods would be checked, not only on arrival but on the following day to see if there was any issue about the blood?

A. Certainly the bloods would have been -- part of our role ... We would have -- as an SHO, we would have seen the patient and checked their bloods as part of their admission and basically they -- depending on the severity of the gastroenteritis, the consultant would have made a decision whether the electrolytes should be checked the next day.

THE CHAIRMAN: Right. Can I take it that there are

inevitably some cases where a child with gastroenteritis has their bloods checked and that the check reveals that the child is getting low in sodium? Does that follow or not?

A. Yes, I think certainly from a clinical point of view. Certainly potassium is also another common electrolyte abnormality. I think that's probably -- in gastroenteritis, you're more likely to get a potassium abnormality. Certainly the electrolytes would be checked if there was a suspicion of either of those.

THE CHAIRMAN: Okay. And in that event, what I was told a couple of days ago was that what might happen would be the child would be given Solution No. 18, but with additional potassium. So the IV fluid does not change from Solution No. 18, for instance to Hartmann's, but the IV fluid has an additional element added to it so that for instance if there's a potassium deficit, that is corrected.

A. Yes, I think you would -- certainly if there was an electrolyte abnormality you would tailor the management to that abnormality. Certainly if there was a deficiency of potassium, additional potassium could be added to a bag or there would be certain bags made up with 20 or 40 millimoles of potassium per litre in them and they could be administered.

THE CHAIRMAN: Is that something that happened during your time on the ward?

A. I can't specifically recollect that on that paediatric ward, but certainly in my practice as a doctor that happens quite often, yes.

THE CHAIRMAN: I'm trying to go back to round about 2001. Is that the sort of thing -- and accepting that you don't remember [OVERSPEAKING].

A. I can't specifically remember what happened on Ward 6, but certainly the common practice in most wards and departments is that if the electrolyte abnormality is identified, it's managed, and certainly supplementary electrolytes can be given, either orally or intravenously.

MS ANYADIKE-DANES: That same logic, apart from what you were saying when I was asking you earlier, would lead you to, if you thought that what you have is a sodium, you are very low in sodium, so the patient is becoming hyponatraemic, that would lead you to think: maybe we need to, in some way -- whichever way you do it -- increase the sodium intake of that child.

A. Yes.

Q. Logic would suggest that.

A. Yes.

Q. Is that something you that consider was possible in 2001

in Altnagelvin?

A. Yes.

Q. So it comes down to a matter of judgment really of testing the child, seeing what the child's condition is -- and I think you referred to it as tailoring your fluid management to address whatever is the condition of the child that's causing the difficulty, and in this case, the case the chairman's given you, it's an electrolyte imbalance.

A. Yes.

Q. And along with that might go an emetic [sic] to try and stop the vomiting --

A. Yes.

Q. -- or if it was diarrhoea to try and reduce that?

A. Yes.

Q. I know you have said so far as you were concerned there were fairly clear demarcation lines between who had responsibility for the surgical patients and who had responsibility for the paediatric non-surgical patients, medical patients. But nonetheless, did you have any experience of being called upon to assist with paediatric input, if I can put it that way, to a surgical patient?

A. I don't remember being asked to see any surgical patients prior to that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

just from knowing that she was on IV fluids, she was post surgery, and she had had a seizure?

A. Yes.

Q. And would that be enough to have a working --

A. I think there were no other obvious causes for the seizure, so basically I thought that was the most likely.

Q. Thank you. Did you know at the time that she had a headache or had complained of a headache?

A. I can't recollect being given that information.

Q. If you had, would that have reinforced your view or made any difference at all?

A. I think in retrospect, certainly a headache is associated with hyponatraemia, but certainly I think it's not something that I considered at the time. I can't remember if I was given that information.

Q. So you were on the track of an electrolyte abnormality, but not on hyponatraemia, if I can put it that way?

A. Not specifically, no.

Q. Yes. That meant that you needed to get her bloods tested --

A. That's correct.

Q. -- in order to see what the position was.

A. That's correct.

Q. Can you help me with this: while you were sort of

gathering your thoughts and the information that you could to form a view, at any stage at all did you think, "I will just contact my registrar"?

A. Certainly I think when I've gathered all the information, certainly my impression was that it was a surgical -- it was a surgical patient looked after by a surgical team and, as far as I was concerned, the most likely cause was electrolyte abnormality and certainly caused by vomiting plus or minus intravenous fluids, and certainly as far as I was concerned that's post-operative care of the surgical team.

Q. Correct me if this is an unfair way of characterising what you're saying, but you had been called, you wanted to stabilise her --

A. That's correct.

Q. -- have the appropriate kind of tests in train, if I can put it that way --

A. That's correct.

Q. -- with a view to then getting the more senior people in the surgical team, since she was a surgical patient, and they would take over her care? Was that your thinking?

A. Certainly that was -- at 3.15, that was certainly what I had in mind. That was my plan, yes.

Q. So you weren't thinking that because you'd been called and started the very necessary work to stabilise her and

see what could be done, you weren't thinking that she'd now come over, if I can put it that way, become a paediatric patient, and you would be calling your senior people and the paediatric team would thereafter be looking after her? That's not how you saw it.

A. Certainly, I think that if I hadn't been on the ward, I think the surgical JHO or SHO would have been bleeped to see her; I wouldn't have been bleeped and I wouldn't have been involved necessarily.

Q. Yes. Just a point back, when you were asking -- you were not quite sure what you were told about the vomiting. We've passed it by, but just so that the record is there, it's 012-040-200. We don't have to pull it up. What you say is:

"I had been told Raychel had been reasonably well. I may have been told that she had vomited once or twice."

And the person that you think may have told you that was Nurse Noble. In addition to that, you were of the view that Nurse Noble had told you that she had had abdominal pain, she had had her appendicectomy, she had vomited and she had received an anti-emetic.

A. That's correct.

Q. That was the basic information that you had before you got started.

A. That's correct.

Q. The next thing is to get the result so that you know what to do and also, for that matter, get the senior surgical team involved. That's what leads you to contact Dr Curran.

A. That's correct.

Q. You may have heard as I was going through with him his recollection of what he was being told.

THE CHAIRMAN: The gist of it is he agrees with you that you wanted two things done urgently. You wanted him to work on the bloods to get them checked, but his recollection is that you wanted him to get his SHO. I think if there's a difference between you and him, your statements seem to indicate that you were asking for the SHO and the registrar.

A. That's correct.

THE CHAIRMAN: How clear are you that you were asking for the registrar and not just the --

A. I'm clear that the registrar was asked for. I'm clear about that because I was concerned and I excluded febrile convulsion and epilepsy.

MS ANYADIKE-DANES: In fact, if we look at your medical note at 020-007-013. You can see right down at the bottom you say:

"Review by registrar/consultant."

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

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

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

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

treating her as best as you could and your view was that this was a situation sufficiently serious that, if you couldn't get a higher level involvement from the surgeons, you'd have to have a higher level involvement from your own paediatric team.

A. That's correct.

Q. I now want to ask you about the bloods and to clarify exactly what was going on. Because if one looks at your witness statements, it's possible to get the impression that there was a bit of confusion --

A. Yes.

Q. -- as to what was happening about the bloods. Dr Curran has explained that you put in a sort of code in the computer and that directs whether the bloods are going to go to biochemistry or whether they are going to go to haematology. As it happens, it is possible to want bloods to be tested in both labs.

A. Yes.

Q. And when that happens, do you have two samples with their respective different destinations or do you send them to one lab and they split them up and send them?

A. There are two different destinations so far as I remember. There's a specific code for biochemistry and there's a specific code for haematology, so they can go in two different chutes.

Q. There are actually two physical chutes?

A. Yes. It wasn't abnormal for some of the doctors to send them to one destination.

Q. And then at that destination, do they then send them to the [OVERSPEAKING] --

A. They were perhaps -- the labs were next to each other, so they would be handed over or thrown into the next lab.

Q. Was that common?

A. I think so. As far as I'm aware it was common, yes.

Q. Did you know at the time which of the results you wanted to get back soonest, if I can put it that way?

A. Yes, biochemistry.

Q. And had you explained that to Dr Curran?

A. Yes, I had explained that certainly my main concern was an electrolyte abnormality, that's why I wanted bloods taken urgently -- and an electrolyte abnormality would mean biochemistry.

Q. And was it your expectation that the bloods that were going to be tested to produce the electrolytes would have the appropriate code on and go down the bit of the chute that takes them to the biochem lab and the other bloods would have a different code and be sent off down to the haematology lab?

A. That was my expectation, yes.

Q. And as I understand it, that's not what happened.

A. It doesn't appear to be.

THE CHAIRMAN: But the alternative route is for him to put them down on one canister, but to ring both labs --

A. Yes.

THE CHAIRMAN: -- which is what he said he would normally do in that situation. If that's going to cause any delay, it's going to be seconds rather than hours, isn't it?

A. What happened was I think certainly I phoned and certainly biochemistry hadn't received it and they hadn't started processing it.

THE CHAIRMAN: So we don't know where the mistake happened, but you caught on to the fact that you didn't have the result that you needed and you secured that result?

A. Yes. There was some time and phone calls made to sort of chase that up.

MS ANYADIKE-DANES: If you're going to do that, just put it down the one chute and then -- as I understand it, the labs are proximate to each other.

A. Yes.

Q. Then presumably you need to tell them get that other sample urgently to the other lab.

A. Yes.

Q. Otherwise, presumably, they don't know to do that.

A. Yes. Dr Devlin or Dr Curran in his oral evidence said

that he had made the labs aware that the samples were coming.

Q. So that should have happened?

A. Yes.

Q. But for some reason it hasn't. And the upshot of the whole phone call is to find out they're still there in the haematology lab and to get them moved quickly to the biochemistry lab. You say there was a delay in that. Do you have any sense of whether that was a significant delay in terms of what you were wanting to do?

A. I think it's very difficult to recollect actual times. I suspect it may have been perhaps maybe 10 or 15 minutes.

Q. Yes. And that meant you weren't able to determine whether, if it was an electrolyte problem, whether the problem was too much or too little sodium or some other issue, and therefore couldn't actually start to administer anything to address it?

A. That's correct.

Q. You also are performing a 12-lead ECG to rule out a cardiac cause.

A. Yes. Essentially, one of the reasons why I did an ECG was if there was an abnormality in potassium -- if there was a gross abnormality in potassium, there would be ECG changes that could perhaps be treated before a blood

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

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

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

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

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

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

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

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

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

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

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

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

remember --
A. No, I remember that certainly her breathing became more shallow. Again I'm not sure whether that started before I arrived or after I arrived and she required bag-mask ventilation. Again, I can't remember --
Q. Do you know who was doing that?
A. Again, I can't remember exactly what was happening, but I remember certainly anaesthetists were called. I think they were called after I arrived.
Q. Ah.
A. I could be ... I could be wrong there. But from what I remember, the anaesthetists were called after I arrived.
Q. I may have pre-empted you then.
A. Dr Allen and Dr Date.
Q. Maybe I should ask you to think about that again and I was wrong in pre-empting you. Do you have any sense now that you look back on it as to whether Raychel was still on the ward when you got back with Dr Curran or not?
A. I can't remember to be honest.
Q. Okay. Do you know what her CNS condition was? Do you know whether at that stage her pupils were fixed and dilated?
A. I remember her pupils being fixed and dilated. I can't

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

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

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

Children's Hospital. What is the last time you recall seeing her or being where she's being treated?

A. I can't remember whether it was sort of after the CT scan or before the CT scan. It was sort of probably around that time.

Q. Do you know what the outcome of the CT scan was? Do you recall it being discussed or hearing it?

A. Well, certainly from the clinical point of view, we knew her pupils were fixed and dilated. Certainly the expectation was that the CT scan would show cerebral oedema. Certainly, my recollection is that the CT confirmed that.

Q. Did you get any sense of what the clinicians there in Altnagelvin thought might happen when she was transferred to the Royal?

A. Well, I think certainly at that stage I think a lot of people were very concerned, I think, with the fixed and dilated pupils and cerebral oedema. I think most people knew that probably it wasn't going to be a very successful outcome.

Q. Had you ever had a patient who had reached the stage of having fixed and dilated pupils, irrespective of whether they were paediatric or adult?

A. Yes, I'd have come across a number of adults who had fixed and dilated pupils.

Q. And --

A. I would have known that that would have been a poor prognostic indicator of brain damage.

Q. Yes. In your experience, has there ever been any recovery from that? Just in your experience.

A. I would have known that it would have been highly unlikely to get recovery from that.

Q. Yes. Did you hear any discussion as to the reason that Raychel was being transferred to the Children's Hospital?

A. No, I wasn't really party to that.

Q. And can you help me with this: that does happen and when do you first hear that Raychel has died?

A. Well, I think -- certainly I think I was under the understanding that certainly that was the likely outcome right from whatever ... from 6 am that morning. But I can't remember exactly about when I was told officially. Certainly working in the hospital, working in the paediatric department, certainly there would have been -- I could have been. The staff would have known and I would have been told by some of the staff members. It wouldn't have been official. I would have heard through the grapevine as such.

Q. Yes. There's one question which is out of order and I'm sorry about that, I meant to ask it earlier. That is,

you say there were quite a lot of clinicians there at the end. There were representatives of all three disciplines?

A. Yes.

Q. At some point Dr Nesbitt arrives as well, who's the consultant anaesthetist.

A. Yes.

Q. You have the consultant paediatrician, you have the consultant anaesthetist. Did you expect at all that Raychel's own consultant would arrive in due course?

A. Yes. I think certainly my experience would have been that certainly a surgeon or a consultant would -- likes to be informed of any patient under their care who's in extremis and certainly most consultants would like to be informed and certainly if a patient's under their care, especially a child, that had deteriorated or certainly would like to be informed of the scenarios.

Q. And if informed, would you expect such a consultant to arrive?

A. Yes. I would have ... I think I would have expected that, yes, in this situation.

Q. And you, of course, now are senior yourself. But who in your experience would you have been expected to be speaking to the parents?

A. Well, consultants -- sort of the consultants from the

different teams.

Q. And would you have included in that Raychel's own consultant?

A. I would have, yes.

Q. So you hear that she has died. I don't know if you said -- did you hear the day she died or --

A. I can't remember exactly. I would have been kept updated with information. Working in the paediatric department, I would have been briefed fairly regularly on what was happening.

Q. Were you aware of the fact that there was going to be a critical incident review meeting on the 12th, which was the Tuesday?

A. Yes, I was aware that certainly there would be -- there would be further investigations and further meetings regarding --

Q. Apart from the fact that you were aware of the fact that there would be a meeting --

A. Yes.

Q. -- and some sort of investigation as to what had happened, were you specifically alive to the fact that there was a critical incident meeting on the Tuesday to discuss the case?

A. I can't remember, to be honest. I know that there were certainly discussions sort of between the surgeons and

the paediatricians. I can't remember exactly what meetings there were or whether I attended.

Q. That was going to be my next question.

A. Yes.

Q. It's not entirely clear because I don't think that we have a full note of everybody who was there. We've certainly got an indication of some who were there. Do I take it from your answer that you don't recall whether you were or not?

A. I remember certainly Dr McCord and Dr Gilliland sort of having discussions and some of the junior doctors were around. And I do actually remember being in the boardroom in Altnagelvin with a number of doctors. But I can't remember exactly what the discussions were about or what that meeting was called -- whether that was a critical review or whether there was a critical review after that.

THE CHAIRMAN: The critical review came very quickly. It came on the Tuesday, if that helps give you a time frame for it.

A. I remember being in the boardroom and there were a lot of doctors that were involved that were there. I can't remember exactly what was discussed.

THE CHAIRMAN: And nurses?

A. Yes, I remember certainly Sister Millar was there.

MS ANYADIKE-DANES: Yes. Do you remember the sort of thing that was being discussed?

A. I can't remember exactly what was discussed. I remember there were informal discussions about the use of Solution No. 18 between Dr McCord and Mr Gilliland on the use of it and how appropriate it was.

Q. Were they of one mind that Solution No. 18 was no longer appropriate?

A. The paediatricians were still under the impression that it was -- even certainly for paediatric medical patients, it was still appropriate at that stage.

Q. So there was a difference of view?

A. I think certainly the consensus was that it wasn't appropriate for surgical patients, but it was appropriate for paediatric medical patients. Again, I was very junior and was sort of peripheral to the discussions. But that was sort of my recollection of it.

THE CHAIRMAN: Can I ask you this. We've been told that there was a critical incident review meeting on Tuesday the 12th.

A. Yes.

THE CHAIRMAN: There's a bit of uncertainty about who exactly was there, but a number of significant people were there. Among the things which were discussed was,

one, the continued use of Solution No. 18. So that rings a bell, whether it's at that meeting or another meeting.

A. I think certainly -- I think certainly it was the use of Solution No. 18 for surgical patients ... I think there was fairly clear instructions that it wasn't going to be used for surgical patients any longer.

THE CHAIRMAN: There's a second issue on the surgical side was to start to copy what was happening on the paediatric side, namely the electrolyte or the blood sampling and electrolyte testing of surgical patients on Ward 6; do you remember that?

A. I don't specifically remember that.

THE CHAIRMAN: Okay. The third one was a discussion to the effect that Raychel had received too much fluid; do you remember a discussion to that effect?

A. I don't remember that specifically.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Well, can I ask you about that? At the time you came to look at Raychel, I think you said that you don't recall looking at her fluid balance chart.

A. I don't remember that specifically.

Q. But you'd have known that she was on IV fluids, obviously.

A. Yes.

Q. And you'd have known what IV fluids she was on.

A. Yes.

Q. Did you know what rate she was on?

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

Q. Okay. Let me frame it a slightly different way. Would you have wanted to know what rate she was on?

A. Um ... Well, certainly if it was excessive, it would have certainly rung alarm bells and certainly would have rung more alarm bells. It'd be another red flag.

Q. But in order to know whether you're in that terrain, you have to know what the rate is.

A. Yes.

Q. If you were told the rate was 80 ml an hour and in fact it had been that rate without change, both prior to her surgery and after her surgery and had just literally continued on without any review or any further consideration apparently, what would you have thought about that rate? Leave aside the type of fluid, but the rate.

A. Yes, well, certainly at this stage I'm not that familiar with rates of fluid in children. Certainly I'd have to go back to the formulas. I don't know what was the recommended -- what was the recommended rate for a child at that rate.

Q. You would have known at that time, would you, that there

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

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

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

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

have come about two days later because Dr Nesbitt did his research within the next 24 to 48 hours and Solution No. 18 then came off.

A. Okay.

THE CHAIRMAN: By the way, had you heard in this context that word had come from the Royal in Belfast that they had stopped using Solution No. 18 some time earlier?

A. No.

MS ANYADIKE-DANES: And then the next action point seems to be something that's going to be instituted more or less immediately, which is:

"To arrange daily U&Es on all post-operative children receiving IV infusion."

You were a paediatrician, so it wouldn't be something that would directly affect you. But it would be the children on the ward where you were. Were you aware of this, that this was going to happen?

A. I was aware that there were proposals, but I'm not aware of this document specifically.

Q. I'm not asking you about the document. I'm asking you about the issue. Were you aware that there was a general concern -- or maybe concern is too high -- but it had been noted that the paediatricians seemed to have U&Es on their patients checked perhaps more frequently than the surgeons did? Were you aware of that?

A. Well, I wasn't really familiar with what the practice was on the surgical side, but I was aware of what happened on the paediatric side, and certainly I think they were ... They did check the U&Es appropriately.

Q. I understand that.

A. Probably more commonly than the surgeons did.

Q. But the nurses who would be alive to that difference and, as we understand from the evidence, Sister Millar certainly was alive to that difference and expressed some concern about it. They are nurses that you would be interacting with frequently -- or at least would have been at that stage.

A. Yes.

Q. And that is why I ask you whether you are aware of the nurses having that view or anybody having that view.

A. I can't remember to be honest.

Q. Then there's other matters that really are directed towards the surgical personnel, if I can call them that, and you wouldn't have known anything about that. What about 5? In fact 4:

"All urinary output should be measured and recorded while IV infusion progress is in place."

Were you aware of that?

A. I can't remember that specifically.

Q. Well, were you aware of urinary output being measured at

all, just prior to that?

A. Yes. I think certainly it would be standard practice, certainly. Again, it depends on the clinical situation. If there are concerns that -- the greater the level of concern, the more the level of recording and monitoring, including urinary output.

Q. That must be --

A. It may not have been routine, but certainly on patients where fluid balance is an issue, it would have been measured accurately.

Q. Let's leave aside the surgical patients for a moment who you didn't have any familiarity with and focus on the medical paediatric patients. Was their urinary output, if I can put it that way, routinely measured if they are on IV fluids?

A. I can't remember specifically but certainly if we had somebody who was dehydrated with gastroenteritis, my recollection would be that urinary output would have been measured. It would have been part of their management.

Q. Apart from catheterisation, how was it being recorded?

A. Well, again, it depends on the age of the child. Certainly if it's an older child, they can sort of perhaps urinate into a pot, whereas in a younger child perhaps it's a matter of weighing nappies and things

like that.

Q. And given that parents quite often are on that ward, to some extent looking after their children in a way, and maybe taking them to the toilet or the children may be old enough to do that themselves, how did all that get addressed if what you're trying to do is get as accurate a record as possible of their urinary output?

A. I can't remember exactly, but certainly the other thing as part of the assessment of children, urinary tract infection would be a diagnosis that would quite often need to be excluded, so quite often there would be quite sort of complex methods of collecting urine samples from even small children and the staff would have been familiar with that.

Q. Okay. And then if you see the other two:

"The chart for IV fluid infusion rates to be displayed."

Were you aware of that?

A. I can't remember that specifically, but certainly we would have -- it was a point that would have been documented quite well within the paediatric medical side, infusion rates. There would have been a lot of supervision from certainly at least the registrar level to make sure that infusion rates were sort of adequate or accurate.

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

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

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

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

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

THE CHAIRMAN: Yes.

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

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

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

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

MR STITT: I will certainly --

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

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

THE CHAIRMAN: You understand --

MR STITT: I understand why you're asking.

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

MR STITT: I was not that senior counsel.

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

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

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

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

MR STITT: That's been noted.

THE CHAIRMAN: Thank you very much.

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

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

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

(5.00 pm)

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

I N D E X