1 Monday, 4 March 2013
2 (10.00 am)
3 (Delay in proceedings)
4 (10.10 am)
5 THE CHAIRMAN: Good morning. Mr Wolfe?
6 MR WOLFE: Good morning, sir. The next witness is
7 Daphne Patterson, please.
8 MS DAPHNE PATTERSON (called)
9 Questions from MR WOLFE
10 MR WOLFE: Good morning -- Mrs Patterson, is it?
11 A. Ms.
12 Q. Could I ask you, by way of introduction, about some
13 statements you've provided to the tribunal already? You
14 provided inquiry statement WS048/1, on 15 June 2005.
15 A. Yes.
16 Q. And a second statement dated 15 June, coincidentally,
17 2012.
18 A. Yes.
19 Q. Would you wish to adopt those witness statements as part
20 of your evidence to the inquiry?
21 A. Yes.
22 Q. Obviously, the purpose of today, Ms Patterson, is to ask
23 you some questions which generally arise out of your
24 witness statements and that will also form part of your
25 evidence to the inquiry.

1 Could you confirm for me that you're currently
2 employed by the Western Trust in the Altnagelvin
3 Hospital?
4 A. Yes, that's right.
5 Q. And you're employed as a paediatric diabetes specialist
6 nurse?
7 A. That's right.
8 Q. Perhaps it'd be useful if we could have your first
9 statement up on the screen, please. The first page of
10 which sets out your CV, WS048/1 at page 1.
11 Helpfully, at the bottom of the page, we get
12 a little bit of history of your career to date. You
13 were a student nurse for three years at the RBHSC
14 between 1985 and 1988.
15 A. That's right.
16 Q. And as I understand the position, you qualified as
17 a sick children's nurse; is that correct?
18 A. That's right.
19 Q. You qualified in 1988.
20 A. Yes.
21 Q. So does that make you a specialist paediatric nurse in
22 terms?
23 A. Not that course, no. That was my registered sick
24 children's course from January 1985 to 1988.
25 Q. Right. Has that course been built upon in terms of --

1 A. Yes --
2 Q. -- paediatrics.
3 A. -- I did the specialist practise diabetes course that
4 I completed in 2008 in relation to diabetes.
5 THE CHAIRMAN: In fact, if you can give us the full page
6 again, please. It rather looks as if you had done other
7 specific diabetes work before that.
8 A. Yes, I did diploma modules prior to doing my degree in
9 specialist nursing.
10 MR WOLFE: In terms of your career, you appear to have
11 worked in the Royal Belfast Hospital for approximately
12 three years --
13 A. Yes, that's right.
14 Q. -- in the Sick Children's unit. Did you then come out
15 of nursing for a period of time?
16 A. Yes, I was out of nursing from 1991 until March 1999.
17 Q. In the interim, you worked as a childcare worker?
18 A. For approximately two years, just under two years,
19 I worked as a childcare worker.
20 Q. And you did a return-to-nursing course in 1999 --
21 A. Yes.
22 Q. -- and came back into the nursing system, if you like,
23 and commenced work in Altnagelvin as a grade D nurse in
24 the paediatric ward --
25 A. That's right.

1 Q. -- in or about March 1999?
2 A. March 1999.
3 Q. Yes. So by 2001, when Raychel Ferguson came under your
4 care, you were approximately 13 years post qualified.
5 A. Yes, although I hadn't been working in nursing for those
6 13 years, but yes.
7 Q. That was the point I was going to make to you.
8 Approximately five years of that 13 had been spent
9 working as a nurse.
10 A. Yes, that would be correct.
11 Q. I want to ask you some questions about the whole issue
12 of hyponatraemia. In June 2001, had you heard of the
13 term hyponatraemia?
14 A. I hadn't heard of the term hyponatraemia. I was aware
15 that it was a low sodium, but I wouldn't have been aware
16 of the term.
17 Q. Let me explore that with you. I'm asking a very
18 straightforward question. Had you even heard of the
19 word?
20 A. No, I hadn't heard of the word hyponatraemia.
21 Q. Because when you go on to say to me, "I hadn't heard of
22 it, but I was aware it was low sodium", that confuses me
23 somewhat.
24 A. Sorry. I would have been aware of low sodium, but
25 I wouldn't have been aware of the term hyponatraemia.

1 Q. Could I put it in this way to you: you were aware that,
2 in nursing patients, low sodium was an issue that nurses
3 had to be aware of or concerned about, but
4 hyponatraemia, as a term, wasn't something you'd come
5 across?
6 A. I hadn't heard of hyponatraemia in 2001.
7 Q. But you now know that hyponatraemia, if we were using
8 a very basic definition, is essentially low sodium in
9 blood?
10 A. That's right.
11 Q. So in approaching the matter in that way, I think you
12 help us to answer a number of other questions. First of
13 all, you were asked in your witness statement for the
14 inquiry whether you were aware of some of the academic,
15 medical academic articles dealing with hyponatraemia at
16 that time, such as the Arieff article and the Halberthal
17 & Bohn article, and you plainly weren't aware of those?
18 A. No, I wasn't aware of those.
19 Q. Moreover, prior to --
20 THE CHAIRMAN: Sorry, can I ask you: I know that for doctors
21 there are different journals like the British Medical
22 Journal that they keep abreast of. Is there a nursing
23 equivalent? Does the RCN put out anything or does the
24 Nursing and Midwifery Council put out any monthly or
25 two-monthly journal?

1 A. There would be journals for nursing and also for
2 paediatric nursing as well.
3 THE CHAIRMAN: Okay. Do they come into the hospital or
4 do you have to subscribe yourself if you want to read
5 them?
6 A. Normally you would subscribe.
7 THE CHAIRMAN: What sort of names can you think of, off the
8 top of your head?
9 A. There's Paediatric Nursing.
10 THE CHAIRMAN: Okay. Would that be the one that was most
11 relevant to your work?
12 A. Yes.
13 THE CHAIRMAN: Thank you.
14 MR WOLFE: There's a journal, a periodical called
15 Nursing Times.
16 A. Yes. That's right.
17 Q. Is that published monthly?
18 A. I wouldn't be sure.
19 Q. It's not something you take or pick up?
20 A. No.
21 Q. Very well. But it's a well-known nursing publication?
22 A. It is, yes.
23 Q. And from your general knowledge of it, does it contain
24 articles which would be relevant to nursing practice?
25 A. It would, although for paediatrics the Paediatric

1 Nursing journal would probably be more appropriate.
2 Q. Very well. Thank you. We've dealt with your lack of
3 knowledge of the academic articles and, in fact, you
4 tell us in your witness statement that as a nurse you
5 wouldn't be expected to read into matters in that kind
6 of detail.
7 Moreover, by 2001, can I take it you were unaware of
8 the death and inquest of Adam Strain --
9 A. I wasn't aware.
10 Q. -- and you were unaware of the death of Lucy Crawford?
11 A. I wasn't aware.
12 Q. Can I broaden this issue of your knowledge out beyond
13 the specifics of hyponatraemia? I understand your
14 answer with regards to hyponatraemia, but in broader
15 terms, the whole issue of fluid management of children
16 is something that you would have received information
17 and teaching in your undergraduate career; is that fair?
18 A. Yes.
19 Q. The inquiry has retained an expert in the area of
20 nursing education, Professor Mary Hanratty. I wish to
21 put up on the screen an extract from her report and
22 would ask you to read it when I put it up and ask for
23 your comments in relation to it. The extract I want up,
24 please, is 303-048-599. Within that, on this page,
25 Professor Hanratty is commenting on something called the

1 pre-registration certificate of nursing education.
2 That isn't a qualification that you hold, is it?
3 A. No. I have a certificate -- I would be a registered
4 sick children's nurse.
5 Q. Yes. She's endeavoured in her report to broadly examine
6 the teaching of nurses from the early 1970s through, and
7 could you read that document and I'll ask you some
8 questions arising out of it. (Pause).
9 You can see that Professor Hanratty is explaining
10 within that report that all students from the early
11 1970s would have received tuition in the importance of
12 the body's ability to maintain fluid balance and the
13 disease processes that could cause a disturbance of it.
14 Can I ask you, is that the kind of teaching you would
15 have experienced as a trainee nurse?
16 A. I cannot recall just specific training in that. What
17 I can recall is the correct administration of
18 intravenous fluids and electrolyte imbalance from
19 a nurse's point of view would be what comes to mind when
20 I think of my training.
21 Q. When you referred to the correct administration of
22 fluids --
23 A. Ensuring that it's prescribed by the doctor and that
24 it's checked by two nurses, one of whom is a registered
25 nurse, and checking the correct dose and rate and the

1 correct fluids for the patient.
2 Q. And we'll see this later on when we look at your
3 interaction with Mr Makar, the surgeon who prescribed
4 Raychel's preoperative fluids. What you mean by that,
5 I take it, is that you were taught in relation to the
6 administrative or the checking aspects of fluid
7 management?
8 A. Yes, that's what I can recall, yes.
9 Q. In terms of managing children who would have had
10 conditions such as gastroenteritis, is that something
11 you had experience of before 2001?
12 A. Yes, I would have looked after children with
13 gastroenteritis, yes.
14 Q. And whether it came through direct teaching or whether
15 it came from in-post experience, you would have
16 appreciated that children with vomiting and diarrhoea
17 were at risk of sodium depletion if their vomiting and
18 diarrhoea was severe?
19 A. Yes. I probably would have. But I believed that it was
20 the doctor who would have been responsible for ensuring
21 their electrolytes were maintained.
22 Q. Yes, but just leaving aside whose responsibility it
23 might have been to correct any sodium abnormality and
24 sticking strictly with, if you like, your knowledge of
25 the impact of such disease processes on fluid balance or

1 electrolyte balance, just to repeat, you would have
2 appreciated that a child with gastroenteritis would have
3 been at risk of developing difficulties if the sodium
4 losses, say from vomit, weren't adequately replaced?
5 A. Yes.
6 Q. And you would say, however, the job of working out how
7 to replace them and what way to replace the losses was
8 a matter for the doctor?
9 A. Yes.
10 Q. In terms of a nursing role in that context, quite often
11 as the inquiry has heard, doctors are not stationed on
12 the ward continually and so it falls to nurses to carry
13 out the monitoring arrangements so that they're able to
14 report to a doctor a full history of a child's
15 condition. Is that a division of labour, if you like,
16 that you would understand and accept?
17 A. Yes, that's right.
18 Q. Clearly, a nurse or a group of nurses will have greater
19 and continuing exposure to a child in that condition.
20 A. Yes, that's right.
21 Q. So you or your nursing colleagues would be in the best
22 position to bring a report of all of the relevant
23 details to a doctor's attention?
24 A. Yes, that's right.
25 Q. The inquiry has heard quite a lot about a substance

1 called Solution No. 18. In 2001, the inquiry
2 understands that that is a fluid that was in widespread
3 use in Altnagelvin and elsewhere in Northern Ireland.
4 Were you aware of other fluids that were available to
5 practitioners in the treatment of patients and children
6 in particular, such as Hartmann's solution?
7 A. I would have been aware of it, but No. 18 Solution was
8 the solution that was used widely.
9 Q. In your experience, when a child was suffering from
10 gastroenteritis, what kind of fluid would be used
11 in that circumstance?
12 A. No. 18 Solution was the fluid that was used widely. It
13 was the recommended fluid at that time.
14 Q. I know it was used widely, but if a child is suffering
15 gastric losses, which as you understood at the time was
16 effectively sodium losses, sodium and potassium, other
17 valuable electrolytes, surely it couldn't have been the
18 case that those fluids were being replaced by
19 a low-sodium fluid?
20 A. I cannot recall any other fluid being used other than
21 No. 18 Solution.
22 Q. So you can't remember Hartmann's being used when
23 a gastroenteritis was being treated?
24 A. I cannot recall, no.
25 THE CHAIRMAN: Can you recall any circumstances in which

1 Solution No. 18 wasn't used and another fluid was used
2 in its place?
3 A. No, I cannot recall.
4 THE CHAIRMAN: Okay. So no matter what was wrong with the
5 child on Ward 6, what that child received was
6 Solution No. 18?
7 A. As far as I can recall, yes.
8 MR WOLFE: Could I put up on the screen, please, a couple of
9 answers you've given to questions to the inquiry to date
10 at WS048/2 at page 12? Could we focus at questions 18
11 and 19? You're asked there about your state of
12 knowledge in 2001 when a child was (a) vomiting and (b)
13 in receipt of what has been phrased there as "hypotonic
14 intravenous fluids". Your answer was:
15 "In 2001, I was not aware of the term 'hypotonic'."
16 You're aware of it now?
17 A. Yes.
18 Q. And you were aware of it at the time of answering this
19 question?
20 A. Yes.
21 Q. But in terms of the definition of hypotonic, which is
22 a reference to a low sodium content in the fluid --
23 A. Yes.
24 Q. -- you were aware, in 2001, of the concept of low-sodium
25 fluids?

1 A. I'm not sure that -- I can not recall exactly. No. 18
2 Solution, to me, was the safe solution that was used and
3 I knew that was a fifth of normal saline. In regard to
4 it being a low sodium, I can't recall that I gave
5 that -- I would have been knowledgeable on that.
6 Q. Well, were you aware that Hartmann's had a higher amount
7 of saline?
8 A. The difference for me between Hartmann's and the No. 18
9 Solution would have been that Hartmann's didn't have
10 dextrose more so than the fact of the difference in the
11 amount of sodium.
12 Q. So what you say in your answer to 18 was that, in 2001,
13 you were not aware of any dangers associated with
14 vomiting if a child was receiving intravenous fluids?
15 A. That's right.
16 Q. If a child is vomiting, as we discussed earlier, a child
17 is at risk of electrolyte problems. Do I understand
18 your answers so far to be telling me that you were
19 labouring under the misunderstanding that, regardless of
20 the amount of vomiting which a child might suffer, you
21 didn't think they were ever going to be at risk of
22 a fluid imbalance because Solution No. 18 was in place?
23 A. I would have believed that if the doctor prescribed the
24 appropriate IV fluids, then that would have prevented
25 electrolyte imbalance and that probably was my knowledge

1 in 2001.
2 Q. Could I ask this series of questions in the context of
3 Raychel's situation? You were aware that Dr Makar
4 prescribed fluids for Raychel preoperatively; isn't that
5 right?
6 A. That's right, yes.
7 Q. And you were aware that the fluids were prescribed for
8 maintenance purposes?
9 A. Yes.
10 Q. In other words, they were prescribed by reference to
11 a calculation which, taking into factors such as her
12 weight, led to a rate per hour and an amount per day,
13 which was intended to take account of her body's normal
14 losses; isn't that right?
15 A. That's right.
16 Q. You were also aware, Ms Patterson, that at the time the
17 fluids were being prescribed for her preoperatively, she
18 wasn't vomiting, was she?
19 A. No.
20 Q. The fluids that were prescribed for her by Dr Makar
21 weren't prescribed for her with any gastric losses in
22 mind; isn't that right?
23 A. That's right.
24 Q. So when you think about this logically, how could you
25 have thought that the fluids that were in place would

1 have kept Raychel safe, notwithstanding her gastric
2 losses?
3 A. It was the doctor's responsibility to calculate the
4 rates and the type of fluid for a child.
5 Q. Yes, I know that. You're now moving in to talk about
6 role or responsibility. But in terms of your knowledge,
7 you have said to the inquiry that you didn't think
8 a child was at risk or you didn't think there were any
9 dangers if a child was in receipt of low-saline fluids,
10 notwithstanding vomiting, perhaps to a period of
11 12 hours post-operatively. How does that make sense?
12 A. During my time of looking after Raychel, she wasn't
13 vomiting.
14 Q. Sorry, I am conscious of that.
15 A. Sorry.
16 Q. Let's take it out of Raychel's specifics then and deal
17 with the point that's on the screen. You're telling the
18 inquiry that you weren't aware of any dangers to a child
19 who's vomiting if they're in receipt of hypotonic
20 fluids. And I'm saying to you, how does that make
21 sense? First of all, hypotonic fluids, by definition,
22 are low saline, and, secondly, when we looked at it
23 in the context of Raychel's case, they weren't being
24 prescribed at a time when Raychel was vomiting.
25 Could I put to you a point that Sally Ramsay, the

1 nursing expert who the inquiry has retained -- have you
2 read her report?
3 A. Yes.
4 Q. She says that, at a minimum, she would expect:
5 "... a registered nurse to be aware that fluid loss
6 from vomiting, if not replaced intravenously, can result
7 in dehydration and electrolyte imbalance."
8 Is that something you were unaware of in 2001?
9 A. Sorry, can you repeat that again, please?
10 Q. Maybe I'll put it up on the screen to assist you. It's
11 224-004-013. You can see at the top of the page there:
12 "As a minimum, I would expect a registered nurse to
13 be aware that fluid loss from vomiting, if not replaced
14 intravenously, can result in dehydration and electrolyte
15 imbalance. I consider it is a medical responsibility
16 [the point you're making] to determine the fluid to
17 prescribe and to make the necessary assessments for
18 a medical diagnosis, including ordering laboratory
19 tests."
20 In 2001 were you aware that, if a patient is
21 suffering fluid loss from vomiting, it needed to be
22 replaced intravenously?
23 A. Yes, if they were vomiting they would require IV fluids.
24 Q. Yes. Are you saying that the misapprehension that you
25 were labouring under was that you thought

1 Solution No. 18 was the suitable fluid to replace these
2 losses?
3 A. Yes, that was the fluid that was used in 2001.
4 Q. Just to finalise Ms Ramsay's point, she has expressed
5 surprise, Ms Patterson, that nurses such as yourself
6 could have thought that, when an infusion is in place,
7 a child is getting adequate hydration regardless of
8 output or intake. In other words, she's surprised
9 at the lack of understanding which you have articulated
10 today. Back in 2001, were you aware of the distinction
11 between a maintenance regime and a replacement regime?
12 A. I wouldn't have been aware of the difference between
13 maintenance and deficit, no.
14 Q. I think when I asked you earlier about Raychel's
15 specific case, you understood that Dr Makar was
16 prescribing for maintenance.
17 A. Yes.
18 Q. You understood that?
19 A. Yes, but that was her fluids that he had prescribed for
20 her, yes.
21 Q. Did you not have experience of a situation where, if
22 a child had vomited or had diarrhoea, that a doctor
23 perhaps would come along and revisit the fluids that had
24 been prescribed for maintenance and write another
25 prescription to replace fluids that had been lost; had

1 you any experience of that?
2 A. I cannot recall. Again, it would have been a doctor's
3 responsibility to prescribe and calculate the rate of IV
4 fluids.
5 THE CHAIRMAN: That's right, but I think what Mr Wolfe is
6 asking you is whether you recall any situation in which
7 a child was getting one sort of fluid and the doctor
8 came along and gave a prescription for a different type
9 of fluid instead.
10 A. No, I cannot recall that, no.
11 THE CHAIRMAN: Do you understand how, looking back on it,
12 that seems a little surprising? Because the point that
13 Mr Wolfe is making to you is that the type of fluid
14 given to Raychel before her operation shouldn't
15 necessarily be the type that is given to her after her
16 operation, particularly if she has prolonged vomiting.
17 A. Yes, with the knowledge that I have now, yes, but in
18 2001, No. 18 Solution was the fluid that was used.
19 THE CHAIRMAN: Okay. Thank you.
20 MR WOLFE: Have you had an opportunity to read a report,
21 a nursing report, provided by the PSNI, which is on the
22 inquiry papers and which was prepared by Sue Chapman?
23 A. No. I'm not familiar with that one.
24 MR WOLFE: Again, it's fair to point out, Mr Chairman, and
25 I know that you have read this report, that Sue Chapman

1 in general terms, having looked at this for the PSNI,
2 doesn't believe that the nursing input in Raychel's case
3 was particularly poor, doesn't believe it was
4 particularly poor. But she has raised a number of
5 points in her report which refer to her expectation of
6 what nursing knowledge should have been at that time.
7 Could I have up on the screen, please, 095-019-085?
8 Could we go back a page and have 084 and 085 together,
9 please? What Ms Chapman has said, starting at the
10 bottom of the left-hand page, is, at paragraph 5.12 --
11 and this is in the context of a generally sympathetic
12 report to the nursing input in Raychel's case. What she
13 says is:
14 "Intravenous fluid may also be administered to
15 'replace' ongoing losses due to vomiting or diarrhoea.
16 These losses are generally replaced by an equal volume
17 of 0.9 per cent saline with additional potassium. This
18 does not form part of the maintenance fluid, but should
19 be prescribed on the fluid chart with clear instructions
20 for its administration. It is important that the
21 attending doctors and nurses are aware of the aim of the
22 regime (to replace ongoing losses and correct
23 dehydration) in order to ensure it is administered
24 safely."
25 So she's pointing up in that report, Ms Patterson,

1 the need for nurses and indeed clinicians to be aware of
2 the distinction between maintenance and replacement
3 fluids. And as I understand your answers, that is
4 a distinction you claim you were unaware of at the time?
5 A. I cannot recall that a child got replacement fluids of
6 normal saline at that time.
7 Q. But even taking it out of your experience of actual
8 cases and just thinking about this logically one last
9 time, before we move on: a child gets maintenance fluids
10 for the purpose of replacing normal bodily fluid losses;
11 isn't that right?
12 A. That's right.
13 Q. If that child's case developed so that he or she has
14 become unwell so that vomit is leaving the body, and
15 when vomit leaves the body sodium leaves the body, and
16 you would agree that sodium is a valuable fluid for the
17 body's health; isn't that right?
18 A. That's right.
19 Q. And you would have known that in 2001?
20 A. That's right.
21 Q. And when the body loses this valuable source of fluid,
22 surely you would have known that while it might be
23 a doctor's responsibility to work the problem out,
24 surely you would have known, as a nurse, that a new
25 fluid regime needed to come in to play to deal with that

1 vomit, to deal with that developing state of unwellness?
2 A. I cannot recall it being used, another fluid being used.
3 Q. At that time, can you remember electrolyte tests being
4 done on children?
5 A. Yes, I can.
6 Q. The inquiry's heard some evidence on this, and it would
7 appear that, within the paediatric medical setting,
8 children on intravenous fluids were the subject of
9 a regular daily electrolyte regime or electrolyte
10 testing; can you remember that?
11 A. Yes, I cannot recall how frequently they would have had
12 it done, but yes, I do remember them getting it done.
13 Q. Did you have any understanding from a nursing
14 perspective of why electrolytes were tested?
15 A. To check the electrolyte levels, yes.
16 Q. And what if serum sodium or potassium was low in
17 a child's electrolytes, what would be the expected
18 response to that?
19 A. Again, the doctor would have dealt with that.
20 Q. But once the doctor dealt with it, what would you
21 understand to have changed?
22 A. The doctor would have prescribed the appropriate fluids.
23 Q. So if there's a problem with the electrolytes, the
24 doctor would look at the existing fluid regime and
25 perhaps alter it?

1 A. If they felt they needed to, yes.
2 Q. And if a child is vomiting or has diarrhoea while on
3 intravenous fluids, would that be a situation where
4 electrolyte testing might need to be considered?
5 A. Yes, if the doctor wanted to carry out electrolytes,
6 yes.
7 Q. Within the surgical setting in paediatrics, can you
8 assist the inquiry in terms of whether electrolyte
9 testing was something that formed part of the response
10 from surgeons, whether it was something that they took
11 seriously or whether they had it in their list of things
12 to do with children who became ill in that way?
13 A. I cannot recall in 2001 that being carried out
14 regularly, no.
15 Q. Are you saying that it wasn't carried out regularly?
16 A. Not on surgical patients, no.
17 THE CHAIRMAN: Did you understand why a difference was drawn
18 between surgical and paediatric, surgical and medical?
19 A. The surgical doctors were responsible for the surgical
20 children.
21 THE CHAIRMAN: Yes. And the paediatricians are responsible
22 for the medical children.
23 A. Yes.
24 THE CHAIRMAN: But here you have children sharing a ward and
25 some of them will get electrolyte testing on a regular

1 basis and apparently some other patients won't; did you
2 understand why that distinction was drawn?
3 A. I cannot recall at that time.
4 THE CHAIRMAN: Thank you.
5 MR WOLFE: If a child under your care in the paediatric ward
6 was suffering from repeated vomiting during the course
7 of a day, and if that child was on an intravenous fluid,
8 what would be the nursing responsibility in terms of
9 communications with the doctor in that setting in 2001?
10 A. I would have ensured the doctor was aware of the
11 vomiting and asked the doctor to come and assess the
12 child.
13 THE CHAIRMAN: And what stage would the vomiting have to
14 reach before you involved the doctor? Can I take it
15 that you wouldn't call a doctor if a child vomited once?
16 Other things being equal, that wouldn't be enough to
17 bring in a doctor, would it?
18 A. It's difficult to comment on a situation you are not
19 actually in, but no, I don't think with one vomit
20 I would have called a doctor, but you'd have taken into
21 consideration other observations of the child as well.
22 THE CHAIRMAN: But as the child vomits a second time,
23 a third time, a fourth time, then it becomes more likely
24 that you will call a doctor, does it?
25 A. Yes, that would be correct, yes.

1 THE CHAIRMAN: Thank you.
2 MR WOLFE: And it appears to have been the case that in 2001
3 in Altnagelvin, certainly in Raychel's case, but the
4 impression is, from some of the evidence, that it was
5 more general than this, that the first response, if you
6 like, to a nursing call for assistance with a surgical
7 child would have come from a junior house officer as
8 opposed to anybody more senior. Again, can you help us
9 with that, Ms Patterson? Was that your experience?
10 A. As far as I can recall, yes.
11 Q. And junior house officers start their rotations, I think
12 is the phrase they like to use, in or about August, and
13 certainly by the time of Raychel's admission in June
14 clearly they'd gone through approximately nine or ten
15 months of work as a JHO. But as I understand it, that
16 would have been split between work on the
17 paediatric/medical side and then work in the surgical
18 side; is that your recollection?
19 A. Yes, they would have started in the August time.
20 Q. Sorry, perhaps I shouldn't have said "paediatric/medical
21 side". They start on the medical side and then go into
22 surgery.
23 A. I would not be definite on that. I wouldn't like to
24 comment.
25 Q. If a junior house officer did present himself, did you

1 feel that, as a nurse at that time, clearly with more
2 experience of nursing children than a JHO would have had
3 in terms of caring for children, did you feel any need
4 to assist or prompt or give more information to a JHO
5 than you would generally have given to a more senior
6 doctor?
7 A. I would have felt that the JHO could speak to their
8 senior doctor then if they had concerns ...
9 Q. So the regime was that the JHO would typically be the
10 first up in your experience and then you would leave it
11 to the JHO to make the decision on whether a more senior
12 input was required?
13 A. Yes, I would inform the doctor -- I would have informed
14 the doctor of the child's condition.
15 Q. Yes, and then leave it to him or her to make the call?
16 A. Yes, they would have contacted ...
17 THE CHAIRMAN: I'm not talking about Raychel now, but in
18 general terms, would you have needed to give a clearer
19 steer to a JHO than you would have had if it was
20 a registrar or consultant who came along?
21 A. In general terms, probably, yes, you would.
22 THE CHAIRMAN: Because they're less experienced?
23 A. Yes.
24 THE CHAIRMAN: And you might feel you can make a bigger
25 contribution by helping a less experienced doctor than

1 you might have to make with a more experienced doctor?
2 A. Yes.
3 MR WOLFE: You commenced duty on 7 June 2001 at about 7.45
4 in the evening; isn't that right?
5 A. That's right.
6 Q. By which stage the inquiry knows that Raychel was being
7 triaged through the Accident & Emergency department.
8 A. Yes.
9 Q. And it is the case that she was admitted by Dr Makar and
10 admitted, obviously, to Ward 6, where you were working;
11 isn't that right?
12 A. Yes.
13 Q. You were at that time starting a night shift.
14 A. That's right.
15 Q. And you would work until approximately 8 o'clock the
16 next morning.
17 A. Yes.
18 Q. When Raychel made her way to the ward, were you in
19 essence her and her family's first point of contact?
20 A. Yes, I admitted Raychel to the ward.
21 Q. At that time, would you have appreciated the reason for
22 her being there? In other words, that she'd been
23 admitted with a view to an appendicectomy.
24 A. That's right, yes.
25 THE CHAIRMAN: Can I ask you, did you know when she was

1 admitted whether there was definitely to be an operation
2 that night or whether it was a possibility depending on
3 how things went?
4 A. The consent form had been signed, but it wasn't definite
5 that she was going to theatre that night.
6 THE CHAIRMAN: And what did it depend on that you can
7 recall? If it wasn't definite she was going to go to
8 theatre that night, what needed to happen for it to
9 become definite?
10 A. She hadn't been seen by the anaesthetist when she came
11 to the ward, so the anaesthetist would usually assess
12 them before they would go to theatre.
13 THE CHAIRMAN: Right.
14 MR WOLFE: When Raychel came on to the ward, you describe in
15 your witness statement that she was alert and
16 complaining of only slight abdominal pain --
17 A. Yes. That's right.
18 Q. -- and you carried out initial observations; isn't that
19 correct?
20 A. Along with Staff Nurse Bryce.
21 Q. Yes. Perhaps it might assist you in your recollection
22 if we put up on the screen some of your work with
23 Raychel on that night. 020-015-029, please. We can
24 see, at the top of the page, an entry which seems to be
25 timed at 9.50 pm.

1 A. Yes.
2 Q. Is that your writing all across the top line?
3 A. Mine would be the dates and the time and the temperature
4 and my signature and then the comments are mine as well.
5 Q. So the "temp", "pulse", "blood pressure" and
6 "respiratory rate" and "pain rating"; is that the
7 work --
8 A. Temperature is mine.
9 Q. Temperature's yours?
10 A. Yes.
11 Q. And the rest of it?
12 A. The rest of it would be Staff Nurse Bryce.
13 Q. So at that time you were working in tandem?
14 A. Yes.
15 Q. Were you literally with the child together as she was
16 being admitted to the ward?
17 A. Yes. That sometimes would have been the case, somebody
18 might have done the observations while somebody took
19 history.
20 Q. In terms of the pain rating, it was a score of 0 to 1.
21 A. Yes.
22 THE CHAIRMAN: Does that scale go up to 10 or 5?
23 A. 10.
24 THE CHAIRMAN: Thank you.
25 A. Yes, as far as I can recall, yes.

1 MR WOLFE: Of course, Raychel by this stage had received
2 a dose of Cyclimorph.
3 A. That's right, yes.
4 Q. And in the comments section, could you translate that
5 for me? I think it's, "Complaint of slight ..."?
6 A. "Central abdominal pain on admission. Colour pale."
7 Q. Yes. So at that stage, that note suggests to me that
8 her observations were normal.
9 A. Yes.
10 Q. And in terms of pain, she was fairly comfortable.
11 A. Yes.
12 Q. The pain may well be controlled by the Cyclimorph, but
13 in any event she wasn't in any distress; is that fair?
14 A. That's right, yes.
15 Q. In terms of your dealings with the parents, she was
16 accompanied by her mother and father; is that correct?
17 A. That's correct.
18 Q. Did you have any direct dealings with them?
19 A. Yes, they were there on admission. I would have taken
20 a history along with Raychel, obtaining information.
21 Q. At that time did Altnagelvin Hospital practice the
22 concept of family-centred care?
23 A. Yes.
24 Q. And the nursing expert retained by the inquiry,
25 Ms Ramsay, said that that's a principle that in terms

1 means parents have greater knowledge of their child than
2 the nurse providing the care, and therefore the parents
3 are to be placed, if you like, in the centre of the
4 care-giving regime.
5 A. Definitely, yes.
6 Q. In practical terms, what did that mean in 2001 in terms
7 of nursing interaction with parents?
8 A. Very much that the parents were kept informed and were
9 involved in, as much as possible, the care of their
10 child.
11 Q. As you've said, you've mentioned Nurse Bryce.
12 A. Yes.
13 Q. And as I understand it, Nurse Noble was in charge of the
14 ward on that night.
15 A. That's correct, yes.
16 Q. And a Nurse Hewitt was also a presence, but as
17 I understand the evidence so far -- and you can comment
18 on this -- Nurse Hewitt was more focused or more
19 dedicated to the infant unit.
20 A. I cannot recall that for definite.
21 Q. Okay. We'll go on to look at the episodic care plan in
22 a moment, but you were responsible for formulating or
23 settling that episodic care plan.
24 A. Yes, that's correct.
25 Q. And was it as a result of that act of putting your name

1 to the episodic care plan that you became her named
2 nurse?
3 A. That was the way it was in 2001.
4 Q. Yes. And again, can you assist the inquiry with
5 this: in practical terms what did the role of named
6 nurse entail on that night?
7 A. The named nurse would have been the nurse who would have
8 been responsible for introducing the child and their
9 family to the ward, the ward layout, explaining the
10 initial plan of care for that child, and also
11 admitting -- you became the named nurse by admitting the
12 child to the ward.
13 THE CHAIRMAN: Is it just pot luck on any evening who the
14 admitting nurse is, whether it's you or
15 Staff Nurse Bryce or Mrs Noble or whoever?
16 A. Yes, it was whoever was available would deal with the
17 admissions when a child came to the ward, yes.
18 MR WOLFE: I notice that you didn't say when you were
19 describing, if you like, the functions of the named
20 nurse that you had sole responsibility for her nursing
21 care.
22 A. No, we worked as part of a team.
23 Q. So although you were the named nurse, she wasn't simply
24 your patient, the care was dispersed through the team?
25 A. Yes. Very much so.

1 Q. And indeed, we can see on the observation sheet in front
2 of us that -- and we'll perhaps come back to this in due
3 course in a bit more detail -- you have signed off on
4 the observations immediately post-operatively.
5 A. Yes.
6 Q. That's the 1.55 and 2.15.
7 A. Yes.
8 Q. It might actually be convenient to just do it now,
9 a little out of sequence. What do those post operative
10 observations tell us about her progress after the
11 surgery?
12 A. That she was comfortable, her observations were stable
13 post surgery.
14 Q. Then to illustrate your point that nursing care wasn't
15 solely provided by you, we can see that Nurse Noble
16 signs all of the -- well, she signs the observations off
17 until 5 o'clock, Nurse Hewitt then does the 7 o'clock,
18 by which stage then it's into the daytime shift.
19 A. Yes.
20 THE CHAIRMAN: On the 1.55 am entry, Ms Patterson, can you
21 read out what's in the comment column for me so that
22 I can make it out?
23 A. "Sleeping, but easily roused. On return to ward. Wound
24 site satisfactory."
25 THE CHAIRMAN: And the next one?

1 A. "Sleepy. Wound site satisfactory, colour pink."
2 THE CHAIRMAN: Thank you.
3 MR WOLFE: In circumstances where a number of nurses could
4 potentially be providing care to a patient, there was
5 obviously a need for good communications between you.
6 A. Yes.
7 Q. I suppose the communications can be both verbal and
8 oral. Was this the main --
9 THE CHAIRMAN: Verbal and oral are the same thing.
10 MR WOLFE: I think they are when I think about it.
11 They could be verbal and written, Ms Patterson.
12 A. Yes.
13 Q. Was this the main written document for exchanging
14 information about a patient?
15 A. In regard to observations, yes. But we also had
16 a nursing care plan, but that would have been updated
17 during our shifts as well. But we communicated verbally
18 throughout the shift.
19 Q. Yes. So as I understand it, this was a contemporaneous
20 and continuing document, so you could look back on it,
21 say, at 2 o'clock, and it would have been written up for
22 the 1 o'clock observations, for example.
23 A. That's correct, yes.
24 Q. Whereas the distinction you draw with the episodic care
25 plan is that it was a document that was written in

1 arrears, it was written at the end of a shift looking
2 back retrospectively?
3 A. That's correct, yes.
4 Q. Just dealing with the episodic care plan, which we could
5 put up on the screen at 020-027-056, please. I think
6 this is the cover sheet of 10 pages. You've told us in
7 your witness statement that you adopted a care plan
8 based on the problem of abdominal pain; is that correct?
9 A. I based it on the problems Raychel had at the time that
10 I was looking after her, yes.
11 Q. Yes, but you didn't compose this plan from scratch.
12 A. No, we used the computerised standard care plans at that
13 time.
14 Q. Does that mean there was a series of care plans on the
15 shelf, if you like, in the computer, which you could
16 lift down, depending upon the nature of the problem?
17 A. And depending on the problems, yes.
18 Q. To what extent do you customise it for the patient in
19 front of you? What input do you put on to it?
20 A. I would select the problem, the problems that the child
21 would have, and on the standard care plan then it would
22 have been the expected outcome and the action points
23 that were recommended on the standard care plan.
24 Q. Let's look at some of those. You say on the front of
25 the care plan that she had been:

1 "Admitted with sudden onset of abdominal pain, seen
2 by the senior house officer in A&E, and bloods taken.
3 Cyclimorph given, IV cannula inserted."
4 And:
5 "On admission to the ward [as you have said earlier]
6 complaining of only slight pain. Fasting for theatre."
7 And then on the right-hand side, these are the
8 actions that you are taking or would wish to take,
9 is that right --
10 A. That's right, yes.
11 Q. -- to deal with that problem?
12 A. Yes. They would have been standard actions on the care
13 plan.
14 Q. In terms of illustrating perhaps this principle of
15 family-centred care, we can see on the right-hand side
16 at the bottom:
17 "Encourage parental participation in care."
18 A. That's correct, yes.
19 Q. If we go over the page, please, to 057. At the bottom
20 of the page, again on the right-hand side, are these
21 further examples of how you might promote the role of
22 the parents in the child's care?
23 A. Yes. And also under the problem of parental anxiety,
24 these would be the action points to help reassure and
25 relieve any anxiety.

1 Q. You've said in your witness statement that the care plan
2 was explained to the parents; is that right?
3 A. The plan of care would have been explained to the
4 parents.
5 Q. Is that a distinction? What was the plan of care and
6 how was it explained to the parents?
7 A. I can't recall exact conversation, but I would believe
8 it would have been that they were aware that Raychel was
9 admitted to the ward and that she was fasting, she would
10 get IV fluids commenced and for theatre whenever the
11 doctor stated she was to go to theatre, and that she
12 would -- the procedure for preparing her for theatre,
13 that she would get a theatre gown on, all jewellery
14 would be removed, and a parent could accompany her to
15 theatre. That would be the information I would normally
16 give to any parents prior to a child going to theatre.
17 As I say, I can't recall exactly the conversation that
18 I would have said to Raychel's parents.
19 Q. Could we just pause at this moment and look at the
20 information the parents received with regards to
21 theatre? I know the chairman's already asked you
22 a quick question in relation to that. Mrs Ferguson has
23 told the inquiry that when she signed the consent form,
24 it was because she was advised that it was
25 a precautionary matter, consent was needed in case

1 Raychel took bad, and in any event her surgery wasn't
2 planned until at least the early hours of the morning.
3 Now, you've explained to the chairman that when
4 Raychel arrived on the ward that night, it wasn't
5 necessarily definite that the surgery would go ahead,
6 the anaesthetist's input was required; is that right?
7 A. Yes.
8 Q. And in terms of the dynamics between a surgeon and
9 anaesthetist, is it ultimately the anaesthetist who has
10 the final word, if you like, in terms of when surgery
11 will take place?
12 A. I couldn't recall that. I mean, that would have been
13 beyond me as to know who made the final decision.
14 Q. In terms of your role as the named nurse, did you have
15 any conversations with the surgeon in terms of anything
16 to do with the planned surgery?
17 A. Not that I can recall, no.
18 Q. Can I maybe push you on this? Would it be typical for
19 the surgeon to talk to you, the named nurse, in respect
20 of why he was thinking that surgery was necessary?
21 A. Not necessarily, no. We wouldn't be involved in any
22 discussion as to -- as far as I can recall.
23 Q. And clearly, surgeons have particular training and
24 expertise. But in this case, you had a child in front
25 of you whose demeanour was alert, not distressed, no

1 great level of pain. Were you surprised that surgery
2 was being planned for that night?
3 A. I cannot recall, but again it would have been the
4 doctor's decision and we would not have been involved in
5 any decision in regard to taking a child to theatre.
6 Q. Okay. Further on that, it doesn't appear that you would
7 expect to be consulted or have that discussed with you;
8 is that fair?
9 A. I do not recall a doctor ever discussing that with me,
10 no.
11 Q. In terms of the process which a surgeon might go through
12 before deciding that surgery is appropriate, at that
13 time the inquiry has heard some evidence that a surgeon
14 such as Mr Makar, who at the time was an SHO, would be
15 expected to make contact with his registrar in order to
16 explain his thinking and to inform the registrar that
17 surgery, particularly at that time of the night, was
18 being considered. Can you assist the inquiry in terms
19 of whether you were aware of that process?
20 A. I was not aware of that.
21 THE CHAIRMAN: So not just whether Mr Makar spoke to
22 Mr Zawislak, but whether he would need to speak to
23 Mr Zawislak?
24 A. I wouldn't have been aware of any process in place
25 there, no.

1 MR WOLFE: Thinking back on it now, can you remember, if you
2 like, when the green light was given and that a decision
3 was made that surgery was definitely happening that
4 night?
5 A. The anaesthetist came to see Raychel on the ward and it
6 was following that the decision was made.
7 Q. And would you have been advised of that decision?
8 A. I cannot recall who advised me, but, yes, I believe
9 I would have been informed, yes.
10 THE CHAIRMAN: Would you have been there when the
11 anaesthetist saw Raychel?
12 A. I cannot recall being at the bedside with Raychel, no,
13 when the anaesthetist had seen her, no.
14 THE CHAIRMAN: In that scenario, whether you remember that
15 particular event, in a typical scenario, would the
16 anaesthetist come up and speak to Raychel or a child and
17 her parents alone, or would the nurse typically be
18 there?
19 A. It could be that the anaesthetist may go and speak to
20 the parents and child.
21 THE CHAIRMAN: I'm sure they could do, but what's typical?
22 What's the norm?
23 A. I cannot recall back then and I'm not based on the ward
24 at the minute, so ...
25 THE CHAIRMAN: That's okay. Thank you.

1 MR WOLFE: It might assist you, Ms Patterson, if I tell you
2 that it's the inquiry's understanding that the parents
3 of Raychel left the hospital, possibly in or around
4 10.30, to return home to gather some things for their
5 child, who it was now clear was going to be in hospital
6 overnight at the very least.
7 A. Yes.
8 Q. Can you remember that happening?
9 A. I can remember phoning the parents to inform them that
10 Raychel was going to theatre.
11 Q. Yes. So in the interim, the anaesthetist had obviously
12 come and examined Raychel?
13 A. Yes.
14 Q. And the inquiry has his notes of that encounter.
15 A. That's right.
16 Q. And piecing the bits and pieces together, you must have
17 been told at that point, hence the reason for your call.
18 A. Yes.
19 Q. Very well. But you can't remember any specific
20 discussion with the anaesthetist or the surgeon?
21 A. No, I cannot recall.
22 Q. Going back to the care plan, within the care plan you
23 anticipated that Raychel's fluid balance would need
24 monitored during her stay in hospital --
25 A. That's correct.

1 Q. -- because at that point in time you would have been
2 aware that Raychel was going to receive intravenous
3 fluids or intravenous fluids had just started.
4 A. That's correct, yes.
5 Q. Just looking at some aspects of that, if I could go to
6 page 059 of the current document. The bottom right-hand
7 corner. One of the issues, if you like, was the need to
8 maintain adequate hydration for Raychel and, on the
9 right-hand side of the page, the nursing tasks are set
10 out in order to achieve that goal; is that a proper way
11 of looking at it?
12 A. That's correct, yes.
13 Q. The nursing task was to:
14 "Check the prescribed fluids, set rate and flow as
15 prescribed, inspect infusion rate hourly and encourage
16 oral fluids and record them."
17 Is it fair to say that that was a plan that was to
18 be put into effect at that time and to be continued
19 throughout Raychel's stay in hospital?
20 A. Yes, that's correct, but then Raychel was fasting at
21 that time, so ...
22 Q. But once she commenced on oral fluids, there was
23 a requirement to monitor that and record?
24 A. That's correct, yes.
25 Q. And equally, I think over a number of pages to 063 of

1 the same document --
2 THE CHAIRMAN: Would you just go to 060 and can you give us
3 059 and 060 together?
4 The section that starts on the bottom left that you
5 were looking at a moment ago, Ms Patterson, is:
6 "Risk of dehydration, IV fluids in situ, maintain
7 adequate hydration."
8 That runs over into the next page, doesn't it?
9 A. Yes.
10 THE CHAIRMAN: Because it's the same heading at the top of
11 the next page.
12 A. Yes.
13 THE CHAIRMAN: The first entry on the right-hand column is
14 "Reduce IV fluids accordingly". In what circumstances
15 in the nursing plan do you reduce the IV fluids
16 accordingly?
17 A. Once the child would be commenced on oral fluids and was
18 drinking well again. And obviously as recommended by
19 the doctor.
20 THE CHAIRMAN: Right. So that depends on what the doctor
21 directs?
22 A. Yes, definitely, yes.
23 THE CHAIRMAN: Thank you. I think you wanted to go to 063,
24 Mr Wolfe.
25 MR WOLFE: Yes. Just on that, "Reducing IV fluids

1 accordingly", that was with a view to what might happen
2 post-operatively, presumably?
3 A. Yes.
4 Q. And so you were at that stage anticipating a future
5 event?
6 A. That's right, yes.
7 Q. 063, please. The issue is:
8 "Post surgery -- at risk of complications."
9 And so you have a list of tasks that are designed to
10 address that, and we've looked at observations and
11 you've set out in prescriptive terms the very regular
12 initial observations and then becoming less regular the
13 further you go in time from the operation; isn't that
14 right?
15 A. That's correct, yes.
16 Q. And then the third entry from the bottom is:
17 "Observe/record urinary output."
18 And again, that's something you would have expected
19 to be carried out throughout the child's stay in
20 hospital.
21 A. Yes, that's correct.
22 Q. All of these bits and pieces of data that were to be
23 gathered, the intravenous fluids, the oral fluids,
24 urinary output -- we could look at the fluid balance
25 chart, but clearly vomit as well. These were all to be

1 recorded on the fluid balance chart; isn't that correct?
2 A. That's correct.
3 Q. Would you understand what the purpose of a fluid balance
4 chart was?
5 A. Yes.
6 Q. What was your understanding of its purpose at that time?
7 A. To record all their urinary output -- all their intake
8 and output.
9 Q. Yes, that was the task that you were performing, but why
10 was that important?
11 A. To measure it up to see that they were getting adequate
12 fluids orally or intravenously and in comparison to
13 their output so that the doctor could review and adjust
14 their IV fluids accordingly.
15 Q. Within the episodic care plan, you didn't enter as
16 a post-surgery risk of complication anything to do with
17 nausea or vomiting. Can I ask you this: children who
18 have appendicectomy surgery, was vomiting common
19 following that or unusual?
20 A. No, I mean children will have vomited following surgery,
21 yes.
22 THE CHAIRMAN: And I think just to broaden Mr Wolfe's
23 question, is that surgery in general rather than just
24 appendicectomies?
25 A. Surgery in general, yes, they could have vomited.

1 THE CHAIRMAN: Because sometimes that's a reaction to
2 anaesthetic?
3 A. That's right, yes.
4 THE CHAIRMAN: Okay.
5 MR WOLFE: Because of the risk that vomiting could occur
6 in the post-surgical setting, should you not, as the
7 nurse planning all of her care throughout her stay in
8 hospital, have formulated a plan for that very
9 circumstance?
10 A. Raychel wasn't vomiting when I was looking after her,
11 and if I was to give Raychel a problem of vomiting, that
12 would have been an actual problem that she didn't have
13 at the time I was looking after her, and because of the
14 limitations of the computerised care plans, if it had
15 been an actual care plan -- an actual problem rather
16 than a potential problem, therefore I didn't give
17 Raychel a problem of vomiting at the time I was looking
18 after her.
19 Q. Could I just put to you a criticism that Sally Ramsay
20 makes, in fairness, directed towards you --
21 MR CAMPBELL: Mr Chairman, before Mr Wolfe moves to the next
22 point, perhaps he could ask the witness to expand upon
23 what she described as the limitations of the
24 computerised care plan.
25 THE CHAIRMAN: I think we're on the same point, Mr Campbell,

1 because if every child that has surgery is at risk of
2 vomiting afterwards, then one would expect that
3 a computerised plan would throw that out on the
4 right-hand column because it throws out plenty of other
5 stuff in the right-hand column, which is not specific to
6 the child. So when Ms Ramsay comes to give evidence,
7 we'll ask her specifically about whether this is as much
8 a problem with the computerised system as it is with
9 anything which is individually done by a nurse in
10 Altnagelvin. I understand the point.
11 MR WOLFE: Thank you, Mr Campbell.
12 Just to allow you the opportunity to respond to
13 Ms Ramsay, she says that:
14 "Considering the frequency of post-operative nausea
15 and vomiting, the failure to record this as a potential
16 or actual problem was an omission of care planning."
17 Do you understand the criticism that's being made?
18 A. Yes, but care plans are updated as an ongoing process.
19 Raychel wasn't vomiting when I was looking after her, so
20 I didn't include it at that time.
21 Q. And just so that we can understand and so that we can
22 put the point to Ms Ramsay when she comes to give
23 evidence, was the structure of the computerised care
24 plan a problem for you in terms of what issues you could
25 address?

1 A. Issues in regard -- for example vomiting, they had to be
2 an actual problem rather than giving it as a potential
3 problem. Also, with the computerised care plan it
4 wasn't just easy to access rather than a handwritten
5 care plan, where you can actually lift the notes and
6 write in as you go along. You had to get into
7 a computer to do so.
8 Q. Yes.
9 THE CHAIRMAN: It's a slightly curious thing, the
10 computerised care plan, isn't it, because it highlights
11 for you a number of things you will typically have to do
12 which are not particular for that patient but which are
13 likely to crop up in any number of patients? For
14 instance, the stuff about communicating with the parents
15 and keeping the parents informed and easing the child's
16 anxiety by involving the parents. I mean, that's all
17 very standard, isn't it?
18 A. That's right, yes.
19 THE CHAIRMAN: So when I look at those entries, those are
20 not specific at all to Raychel, though it is relevant to
21 bear them in mind.
22 A. Yes.
23 THE CHAIRMAN: But then it doesn't include something else
24 which might generally happen, like post-operative
25 vomiting.

1 A. Correct, yes.
2 THE CHAIRMAN: Okay, thank you.
3 MR WOLFE: In terms of nurses coming after you when vomiting
4 is an actual problem, presumably it would be
5 a straightforward task to go into the computerised care
6 plan and to input or type up a plan (a) recognising that
7 vomiting was a current problem and then setting out the
8 steps that might be taken to observe or monitor that
9 problem and what medical input is being considered?
10 A. Yes, you could select the problem of vomiting, yes.
11 Q. And would you expect to see the episodic care plan used
12 in that way if such problems developed that weren't
13 anticipated at the time you were drafting the care plan?
14 A. Yes, because nursing care plans are an ongoing process.
15 Yes, they would be updated.
16 Q. I think I referred to this as a living document, or it
17 should be a living document, when I asked another
18 witness about this. Is that your understanding of how
19 it should be used?
20 A. Yes.
21 Q. I want to move on to the issue of preoperative fluids.
22 Mrs Noble has given an account to the inquiry in which
23 she explains that it was brought to her attention by you
24 that a prescription for fluids had been written for
25 Raychel preoperatively, which provided for the

1 administration of Hartmann's solution.
2 A. Yes.
3 Q. Can you remember that?
4 A. Yes. I didn't recall it in my statement in 2005, but
5 I do believe I did speak to Nurse Noble about that, yes.
6 Q. I just want to pause for a minute and examine how this
7 issue developed. You, as the named nurse, had
8 a responsibility with Staff Nurse Bryce, I understand,
9 to erect the intravenous fluids and get them going;
10 is that right?
11 A. That's correct, yes.
12 Q. And as I understand it from Mr Makar's statement to the
13 inquiry, he actually furnished the ward with a written
14 prescription from the Accident & Emergency department,
15 providing for Hartmann's.
16 A. Yes, he had prescribed Hartmann's.
17 Q. Do you know where that written prescription would have
18 gone?
19 A. I cannot recall, no.
20 Q. Could I push on you this? Is it possible it might have
21 been destroyed once a new prescription was written for
22 Solution No. 18?
23 A. I cannot comment, I cannot recall that at all.
24 Q. But would it be consistent with the train of events that
25 a prescription for Hartmann's ended up in your hands and

1 then you alerted Staff Nurse Noble to the issue.
2 A. Yes.
3 Q. And could I ask you, having received a prescription for
4 Hartmann's from Dr Makar, why did you not simply proceed
5 to erect the fluids in accordance with the prescription
6 you'd been given?
7 A. Because Hartmann's wasn't commonly used on the ward; it
8 was No. 18 Solution that was normally the fluid that was
9 used.
10 Q. Yes, but the doctor, the medical professional who had
11 clearly assessed his patient and written the
12 prescription, believed that Hartmann's was the
13 appropriate fluid preoperatively. Why, as a nurse, did
14 you consider it appropriate to enter into debate about
15 that?
16 A. Well, because No. 18 Solution was the commonly used
17 fluid. I wanted to check with the nurse in charge and
18 also the doctor to -- in regard to the fluids.
19 Q. Was Hartmann's available on the ward?
20 A. There probably was a few bags of Hartmann's available,
21 but it certainly wasn't fluid that was used very often.
22 Q. What was your understanding of why Solution No. 18 was
23 the commonly-used fluid on the ward?
24 A. Just that it was a safe fluid for use in children,
25 medical and surgical children, and it was the fluid that

1 was used from when I started in Altnagelvin
2 in March 1999.
3 Q. Is the corollary of that position that Hartmann's was
4 viewed as somehow dangerous or placing children at risk
5 in terms of your understanding?
6 A. I wouldn't say "dangerous", but I know that whenever
7 a child -- concerns if a child was on Hartmann's, was,
8 in regard to the blood sugar because it didn't contain
9 any dextrose.
10 Q. You'd come back into nursing in Altnagelvin in 1999;
11 isn't that right?
12 A. That's right, yes.
13 Q. Was Solution No. 18 installed as the fluid of choice at
14 that time?
15 A. Well, it was in use, yes, that would have been ...
16 Q. And did somebody explain to you at some point that this
17 was the fluid of choice?
18 A. I cannot recall anybody explaining it to me, but it was
19 standard ward practice.
20 Q. It was just a practice that was introduced to you?
21 A. That's right.
22 Q. And did you question it at all?
23 A. The fluids will have been prescribed by the doctor.
24 Q. Yes.
25 A. It wouldn't have been commenced without being prescribed

1 by the doctor.
2 THE CHAIRMAN: Yes, but what we're just looking at here,
3 Ms Patterson, is this: we assume that you don't often
4 query what a doctor prescribes; would that be right?
5 A. Sorry, can you repeat that?
6 THE CHAIRMAN: Would you often query or challenge what
7 a doctor prescribes?
8 A. If it was outside a normal practice, yes.
9 THE CHAIRMAN: So the reason why you were querying what
10 Mr Makar had done was it was outside normal practice?
11 A. Yes.
12 THE CHAIRMAN: So you raised it with Mrs Noble, who then
13 spoke to Mr Makar?
14 A. Yes.
15 THE CHAIRMAN: And that led to the prescription being
16 changed?
17 A. Yes.
18 THE CHAIRMAN: Okay, thank you.
19 MR WOLFE: Is it fair to say, moving on, that you didn't
20 discuss the issue of the appropriate fluid with the
21 doctor?
22 A. No, I didn't discuss it, no.
23 Q. Did you have any discussion with him at all once the
24 fluid had been changed to Solution No. 18?
25 A. With Dr Makar?

1 Q. Yes.
2 A. No.
3 Q. Dr Makar has given an account to the inquiry about his
4 intentions with regard to fluids and he's explained how
5 he was -- I hesitate to use the words "prevailed upon",
6 but was persuaded that he would use Solution No. 18.
7 And he has explained also that it was his intention that
8 the fluid would be administered in accordance with that
9 prescription for the preoperative period only; do you
10 understand that?
11 A. I wasn't aware of that. It was never passed on to me
12 that it was just for preoperative use only.
13 Q. When you received the prescription -- and we can put the
14 prescription up on the screen, it's 020-021-040. Do you
15 recognise your signature and Nurse Bryce's signature on
16 the right-hand --
17 A. Yes.
18 Q. As the inquiry understands it, fluids post-operatively
19 were established in accordance with this prescription as
20 well.
21 A. That's correct, yes.
22 Q. And we'll go on in a moment just to look at the
23 post-operative situation. But when you received that
24 prescription and went to work in erecting the fluids,
25 what was your understanding of the period during which

1 this fluid would be used at this rate?
2 A. This would be used preoperatively and recommenced
3 post-operatively unless a doctor had prescribed
4 otherwise post-operatively.
5 Q. Can I push you on this? Is that understanding the
6 understanding of a practice that was in place at
7 Altnagelvin at that time?
8 A. Yes. That was standard ward practice.
9 Q. In terms of the preoperative period then, you described
10 earlier in your evidence what you saw as the role of the
11 nurse, which was to ensure, so far as possible,
12 administratively, that the fluids that were connected to
13 the child were consistent with the prescription.
14 A. Yes.
15 Q. And so you checked that the bag was a bag of
16 Solution No. 18, you checked the batch number and
17 recorded it, you set the rate on the -- it's an infusion
18 machine, is that what you'd call it?
19 A. Yes.
20 Q. And then the fluids started.
21 A. Yes.
22 Q. Is that the start and finish of your task?
23 A. No, we recorded the amount hourly.
24 Q. Yes. How was the machine set up to work? Would fluids
25 run continuously at a rate of 80 ml an hour or did the

1 machine have any special facility?
2 A. The pump would have been set to alarm when the set
3 amount of fluid had gone through within the hour for the
4 nurse to come along to reset it again and to check --
5 and to fill up the burette and also to check the IV
6 cannula site.
7 Q. So at the end of an hour, if it was set for an hour, no
8 further fluid could get into the tube?
9 A. Not until it was reset again.
10 Q. Was that a practice that was standard at that time for
11 all children coming into Altnagelvin?
12 A. Yes. That required IV fluids, yes.
13 Q. And in your experience did it apply both during the day
14 and during the night?
15 A. Yes.
16 THE CHAIRMAN: Does that mean that if you set it for 80 ml
17 an hour at, say, 10 o'clock, that it's going to -- the
18 alarm's going to go at almost exactly 11 o'clock for you
19 to come back and reset it.
20 A. Yes.
21 THE CHAIRMAN: And then it'll go off almost exactly at
22 midnight?
23 A. That's right, yes.
24 MR WOLFE: Sir, is that a convenient point? Then we'll move
25 into post-operative fluids.

1 THE CHAIRMAN: Thank you very much. Ms Patterson, we need
2 to take a break to give the stenographer a 10-minute
3 rest. We'll resume at about midday.
4 (11.50 am)
5 (A short break)
6 (12.11 pm)
7 MR WOLFE: Just to go back to one point I dealt with
8 earlier. It's in relation to the evidence that you gave
9 with regard to observing and recording both oral
10 input -- that is oral fluids -- and output, in other
11 words urine. You told the inquiry that you would have
12 expected those observations and recordings to be made
13 throughout the time of Raychel's stay in hospital;
14 is that right?
15 A. Yes.
16 Q. Would you expect nurses to have made some effort to
17 measure what was going in and what was going out?
18 A. Urinary output, we did not measure at that time. We
19 recorded the frequency of the urinary output, but it
20 wasn't measured.
21 THE CHAIRMAN: So it would be just a PU for passed urine?
22 A. Yes.
23 THE CHAIRMAN: And if a parent took a child to the toilet,
24 then how does that end up in the records?
25 A. Usually we would have checked with the parents when

1 we were carrying out observations if they had passed
2 urine in the previous period of time and recorded that
3 then in the fluid balance sheet.
4 MR WOLFE: Mrs Noble gave evidence that it might have been
5 a standard question to ask questions at the hourly fluid
6 check, to pose that question: has there been anything
7 in the past hour, whether in or out?
8 A. Yes.
9 Q. And just to be clear, while it is obviously important to
10 log the first passing of urine after an operation, after
11 surgery, would you continue to observe and record
12 subsequent passages of urine?
13 A. Yes.
14 Q. Raychel went down and had her uneventful surgery and
15 you, as I understand it, were the nurse who went down to
16 the recovery area to fetch her; is that correct?
17 A. Yes, I brought her back from theatre.
18 Q. And I want to ask you about your understanding of the
19 post-operative fluids. I understand the recovery room
20 or area at night-time wasn't available and that
21 a patient was recovered in the actual theatre; is that
22 right?
23 A. Yes.
24 Q. On duty that night in the theatre in terms of the
25 anaesthetists were a Dr Gund, a Dr Jamison and Staff

1 Nurse McGrath. Do you have any recollection of seeing
2 or speaking to any of those people when you went to
3 fetch Raychel?
4 A. Staff Nurse McGrath I would have spoken to.
5 Q. What information, if any, would she have given you?
6 A. I cannot recall the exact conversation that we would
7 have -- that passed between us, but she would have
8 informed me of the findings of the operation, how
9 Raychel's observations were, and in relation to her IV
10 fluids post-operatively.
11 Q. Have you any recollection of what you were told about
12 Raychel's condition and how she'd progressed through
13 surgery?
14 A. I cannot recall exact conversation, but her observations
15 were stable and surgery was uneventful in relation to
16 Raychel's condition.
17 Q. We know that the theatre records, the surgeon's report,
18 stated that this was a mildly congested appendix.
19 A. Yes.
20 Q. Would you have been given that information, do you
21 think?
22 A. Yes, that would have been passed on to me. Again, I
23 cannot recall the exact conversation but, yes, that
24 would have probably been information that would have
25 been passed on.

1 Q. And obviously, every case is different and some appendix
2 operations would be more involved than others. So for
3 example we've heard it said that some children come in
4 and there's lots of inflammation, lots of infection,
5 whereas other children have a much easier time of it
6 in the sense that really there might only be mild
7 congestion and it might have been borderline as to
8 whether surgery was in fact necessary in retrospect.
9 Have you any recollection of whether Raychel fell into
10 the severe and serious category or was it more of a mild
11 operation?
12 A. Everything went uneventful in relation to her surgery.
13 Q. In terms of the post-operative fluids then, did you have
14 a specific discussion with Staff Nurse McGrath
15 in relation to that?
16 A. I cannot recall the exact conversation, but it would
17 have been something that always was discussed, passed
18 over from the theatre staff to the nursing staff
19 in relation to the IV fluids.
20 THE CHAIRMAN: When you're talking here about the
21 post-operative fluids, do you mean the fluids which she
22 has been receiving in recovery or do you mean the fluids
23 she was to receive back on the ward?
24 A. The fluids she was to receive back on the ward.
25 THE CHAIRMAN: Right. So that's what Staff Nurse McGrath

1 talked to you about, what fluids Raychel should receive
2 back on the ward?
3 A. Yes, that would have been -- again, I can't recall the
4 exact conversation, but yes, I would always have checked
5 in relation to the fluids post-operatively.
6 THE CHAIRMAN: So you're asking Staff Nurse McGrath what
7 fluids Raychel is to receive having come out of recovery
8 and when she goes back on to the ward?
9 A. Or it could be that Staff Nurse McGrath told me before I
10 asked her, you know, but, yes, that information would
11 have been passed over.
12 THE CHAIRMAN: Sorry, who do you understand she's getting
13 her information from? It's not her decision, sure it
14 isn't.
15 A. No, no, no.
16 THE CHAIRMAN: So if she's telling you what the fluids are
17 due to be back on the ward, she's getting her
18 information from who?
19 A. The anaesthetist or surgeons.
20 THE CHAIRMAN: Okay. Thank you.
21 MR WOLFE: And can you recall specifically what information
22 she gave you with regards to the fluids that were to be
23 commenced on the ward?
24 A. I can't recall, but it's recorded on her theatre notes,
25 to recommence the IV fluids on the ward.

1 THE CHAIRMAN: Could we look at that?
2 MR WOLFE: Yes. That document is at 020-014-022. If we
3 could highlight the little box at the top, please.
4 First of all, were you given that document to take back
5 to the ward with you?
6 A. Yes, that would go back up with the child's notes, yes.
7 Q. Just assist the inquiry in this way. All of the notes
8 that would have been made during the surgery -- the
9 anaesthetic notes, nursing notes and we have
10 the surgeon's report -- was that all gathered together
11 to be handed to you to be brought back?
12 A. Yes, along with the child's notes, yes.
13 Q. The words used in this chart are:
14 "IV infusion checked."
15 That's the pro forma. And then written on are:
16 "To be recommenced in ward."
17 We know that Raychel was receiving Hartmann's
18 intraoperatively --
19 A. Yes.
20 Q. -- and that Solution No. 18 was given to her when she
21 came back on the ward.
22 A. Yes.
23 Q. How did you know that Solution No. 18 was the fluid to
24 be given as opposed to Hartmann's being recommenced on
25 the ward?

1 A. Because it was the fluid that Raychel had prior to going
2 down to theatre and it was standard ward practice to
3 recommence the IV fluid that she was prescribed
4 pre-operatively to be prescribed post-operatively.
5 Q. But if it was standard ward practice for it to be
6 recommenced post-operatively, why did you and Staff
7 Nurse McGrath even need to have a conversation about it?
8 A. It was always something that was just double-checked.
9 Q. Right. And again, just to be clear, can you say what
10 she said to you?
11 A. No, I cannot recall the exact conversation.
12 Q. She gave evidence to the inquiry --
13 THE CHAIRMAN: Sorry, Mr Wolfe, I don't quite follow this
14 and this is an pretty important point, Ms Patterson.
15 When it says, "IV infusion checked; to be recommenced on
16 ward", it doesn't say there what is to be recommenced on
17 the ward, sure it doesn't.
18 A. No, but that would have been the preoperative fluids.
19 THE CHAIRMAN: You see, that's exactly what Mr Makar says he
20 didn't understand. Mr Makar says -- whether he's right
21 or wrong, and I'm not saying he's necessarily right
22 because he says it -- but he says that's exactly what he
23 didn't expect to happen, that the preoperative fluids
24 would become the post-operative fluids; do you
25 understand?

1 A. Mm-hm.
2 THE CHAIRMAN: Whereas your understanding of "IV infusion
3 checked; to be recommenced on ward" is exactly the
4 opposite: you understand that the preoperative fluids do
5 become the post-operative fluids.
6 A. Yes.
7 THE CHAIRMAN: I'm just checking to see how that message
8 passes along. I'm not for a moment expecting you to
9 remember the exact words which were spoken between you
10 and Staff Nurse McGrath in the early hours of that
11 morning but, whatever it was, you took from it an
12 understanding that this was what was to happen, the
13 pre-op fluids became the post-ops.
14 A. Yes.
15 THE CHAIRMAN: Okay, thank you.
16 MR WOLFE: Mrs McGrath gave evidence last week and she
17 herself recalled being engaged in a conversation
18 involving Jamison, Gund, and herself, and she believed
19 that you possibly arrived at the tail end of that
20 conversation; do you have any recollection of that?
21 A. I cannot recall that, no.
22 THE CHAIRMAN: But this witness would not have been part of
23 that conversation?
24 MR WOLFE: But might have witnessed the tail end of it.
25 You have no recollection?

1 A. No.
2 Q. It's the evidence of Dr Gund, for example, that he would
3 have liked at one point in the transaction to have
4 prescribed Hartmann's solution. Then there was
5 a conversation that followed and he didn't, in the end,
6 prescribe Hartmann's. Had you any awareness of that or
7 knowledge of that?
8 A. No, I was not aware.
9 Q. So when you went back to the ward, you reconnected the
10 fluids, Solution No. 18, at a rate of 80 ml per hour?
11 A. That's correct. That was prescribed preoperatively.
12 Q. Yes. The circumstances in which you wouldn't have taken
13 that step of reconnecting the fluids as they were
14 preoperatively, could you outline the kinds of
15 situations when you wouldn't have done that?
16 A. If the doctor had prescribed otherwise.
17 Q. You mean the doctor in theatre?
18 A. Yes.
19 Q. The doctor in theatre, Dr Gund, as we know, had started
20 to write a prescription and then struck it out. And it
21 was his understanding, he told the inquiry, that the
22 nurses on the ward would obtain medical input -- in
23 other words, they would have Raychel assessed -- before
24 a prescription for the post-operative period would be
25 written. We know that didn't happen, but did that ever

1 happen in other cases that you were aware of?
2 A. I never recall that happening.
3 Q. If an anaesthetist did write a prescription for the
4 post-operative period and if that prescription set out
5 a fluid other than Solution No. 18 -- so for example, if
6 the prescription said Hartmann's -- would nurses
7 typically accept that and apply it or what would be
8 done?
9 A. It would probably have been -- contacted the doctor to
10 query the prescription and to double-check is that
11 definitely what fluid they want to prescribe going by
12 standard ward practice that it was No. 18 Solution.
13 THE CHAIRMAN: Similar to what had happened earlier in the
14 evening?
15 A. That's right, yes.
16 MR WOLFE: In Raychel's situation, if we can call it that,
17 where you have taken Raychel back to the ward,
18 reconnected her to the fluids as they were
19 preoperatively, how long or in what circumstances would
20 those fluids stay in place and then be revised or
21 reviewed?
22 A. The doctor would -- until the doctor would prescribe
23 alternative fluids.
24 Q. The next opportunity to do that on an overnight theatre
25 situation would be at the ward round; is that right?

1 A. Yes, probably, unless the doctor had reviewed her in
2 between times.
3 Q. I suppose the bag of fluids could run out in the interim
4 and that would afford another opportunity to review.
5 A. That's right, yes.
6 Q. In terms of how well-known this practice was, this
7 practice of simply recommencing the fluids on the
8 preoperative regime post-operatively, was that known to
9 the surgeons, the surgical team, so far as you're aware?
10 A. I would not have been aware. I would have thought they
11 would have been aware, but I would not be aware of that.
12 Q. You've probably never had a conversation with them to --
13 A. That's right.
14 Q. -- to test their knowledge.
15 A. Yes.
16 Q. That's probably fair to say.
17 A. Yes.
18 Q. When it comes to the ward round, have you attended ward
19 rounds with doctors?
20 A. Yes, I would have, yes.
21 Q. As we understand it at the inquiry, one of the functions
22 of the ward round is to examine the fluids that
23 a patient might be receiving. And at that time, would
24 there be an opportunity to understand that the patient
25 is receiving the same fluid at the same rate

1 post-operatively as had been in place preoperatively?
2 A. Yes, the doctor would have reviewed the fluids on the
3 ward round, yes.
4 THE CHAIRMAN: And you have seen that happen?
5 A. Yes.
6 THE CHAIRMAN: Is that a fairly standard part of a ward
7 round?
8 A. Yes, it would be, yes.
9 MR WOLFE: Looking back at this practice now, it's not
10 a practice that happens anymore; is that correct?
11 A. That's correct, yes.
12 Q. Dr Makar, in explaining how he simply intended that the
13 fluids would be used preoperatively, has explained that
14 he wouldn't have written a prescription for
15 post-operative fluids until he knew what the situation
16 was post-operatively because it's a completely different
17 context or different environment and the child may have
18 different fluid needs post-operatively as compared to
19 the preoperative phase; do you understand that?
20 A. As I say, it was standard ward practice to recommence
21 the IV fluids post-operatively that were prescribed
22 preoperatively, so ...
23 Q. Yes. I'm not saying you were responsible for the
24 practice, but do you understand the criticism of it that
25 Dr Makar has advanced?

1 A. Yes, but I don't recall a change being made to
2 prescriptions. It was always the preoperative fluids
3 that were recommenced.
4 Q. In this case and from what you've described, it wasn't
5 an untypical scenario. Raychel received the same rate
6 of fluid post-operatively: not just the same type of
7 fluid, but the same rate of fluid. Some of the experts
8 who have looked at this have said that Raychel's fluid
9 preoperatively was prescribed at too high a rate. It
10 should have been 65 ml per hour as opposed to 80; do you
11 understand that?
12 A. Yes, it was the doctor's responsibility to calculate the
13 rate of IV fluids.
14 Q. Of course. And post-operatively, a number of the
15 experts have said that the rate should be reduced
16 further again, so the starting point should be 65 and
17 then you should reduce that by a further 20 per cent or
18 so, bringing it down to something in the region of
19 52/53 ml per hour. Can I ask you this: as a nurse,
20 would you have been able to calculate standard
21 maintenance rates for intravenous fluids?
22 A. At that time, no, we wouldn't have calculated the rate
23 of IV fluid. That was the doctor's responsibility.
24 THE CHAIRMAN: Sorry, did you have an idea of what the rate
25 should be, without you necessarily doing the calculation

1 did you have a calculation of what the rate would be?
2 A. I didn't consider it to be an excessive amount of fluid
3 that Raychel was receiving.
4 THE CHAIRMAN: Do you think that you would spot if a child
5 was getting too much fluid or too little fluid?
6 A. Yes.
7 THE CHAIRMAN: But as long as it seems roughly right, you
8 leave it?
9 A. That's correct, yes.
10 THE CHAIRMAN: Did you know that there's a formula called
11 the Holliday-Segar formula? Were you aware of that?
12 A. I wasn't aware of that.
13 THE CHAIRMAN: Okay, thank you.
14 MR WOLFE: Sir, can I say this generally. There are
15 a number of perspectives on whether nurses should be
16 able to calculate fluids. For example, Ms Chapman, who
17 has written a generally sympathetic report in relation
18 to the nursing care, said at 095-019-084 that she would
19 have expected nurses to calculate full fluid
20 requirements for a child based on their weight, whereas
21 Sally Ramsay has produced a report saying that she
22 wouldn't expect nurses to recalculate fluids, but she
23 would expect an experienced nurse to perhaps know when
24 too much or too little is given and to make a report to
25 the prescriber.

1 At your level of experience in 2001, Ms Patterson,
2 are you telling the inquiry that you would only have
3 realised that a fluid rate was wrong if it was quite
4 extreme?
5 A. Yes, if it was -- yes.
6 Q. Tell me this: did you ever at that time see fluids being
7 reduced in their rate in the post-operative situation?
8 A. No, I cannot recall that happening.
9 Q. Had you ever been taught that fluids post-operatively
10 should be reduced in their rate?
11 A. I cannot recall that, no.
12 Q. What is the situation now, as you understand it, or the
13 last time you worked in paediatrics?
14 A. I wouldn't like to comment on that because I haven't
15 been working on the ward since 2005.
16 Q. In 2005, had the situation changed in that rates were
17 reduced post-operatively?
18 A. I don't feel I can comment on that.
19 Q. Is that because you can't recall?
20 A. I can't recall, yes.
21 Q. As we saw earlier, when Raychel returned to the ward,
22 you carried out post-operative observations; is that
23 right?
24 A. That's right, yes.
25 Q. And Raychel had, in your experience of dealing with her,

1 a comfortable post-operative night?
2 A. Yes.
3 Q. Would you have anticipated her progress to have
4 continued to be smooth?
5 A. Yes.
6 Q. There was no cause for alarm?
7 A. None.
8 Q. Raychel's return to the ward was timed at about 1.50;
9 is that correct?
10 A. Yes.
11 Q. I wonder if could you help us on this: Raychel's mother
12 and father expected her to have returned to the ward
13 much quicker. She had gone down to theatre at or about
14 11/11.20 and was only back at the ward, as we say, about
15 2 o'clock. They became alarmed and worried at what they
16 perceived to have been a delay in her returning. They
17 had been told that Raychel would only be away for about
18 an hour. Did you tell the parents what time they might
19 expect Raychel to return to the ward?
20 A. No, I cannot recall telling the parents, no.
21 THE CHAIRMAN: At the earlier stage when you are keeping the
22 parents informed about what's likely to happen over the
23 next few hours, would that have been something that you
24 would have done with them after Raychel came on to the
25 ward and then after it was confirmed that there was to

1 be an operation?
2 A. Not necessarily I've told them at that time ... I mean,
3 unless they had asked specifically, I don't think that
4 would have ever been something I would have said at that
5 time.
6 THE CHAIRMAN: Is that not part of the role of the nurses --
7 and according to the care plan -- to keep the parents
8 informed?
9 A. Yes, I would have kept the parents informed.
10 THE CHAIRMAN: Would part of that involve telling the
11 parents, for instance, that Raychel's now going up to
12 theatre and giving them even a rough idea of how long
13 that might take? That sounds pretty normal, no?
14 A. But at that time we didn't know Raychel was going to
15 theatre that night.
16 THE CHAIRMAN: Yes. But later on when the position changed
17 and it did become definite, then would it have been
18 fairly standard at that later stage to speak to the
19 parents and say, "Raychel is now going to theatre and
20 she's going to go in 10 minutes", or, "We're going to
21 take her up now", or whatever? That would be fairly
22 standard, would it not?
23 A. Certainly at the time of going to theatre it would be
24 something that the parents would be informed about, yes.
25 THE CHAIRMAN: And without ever guaranteeing any parents

1 that their child will be back in 30 minutes, 1 hour,
2 2 hours or whatever, would it be normal to give the
3 parents an idea of how long their child might be away
4 from the ward for?
5 A. It's very difficult to put an exact time on any child
6 going to --
7 THE CHAIRMAN: Of course it is.
8 A. The length of time they would be away, but I wouldn't
9 have told the parents a hour. To me, an hour wouldn't
10 be long enough.
11 THE CHAIRMAN: Even with things going smoothly, that
12 wouldn't be long enough?
13 A. No.
14 THE CHAIRMAN: Because she has to be anaesthetised, then the
15 operation, then recovery?
16 A. That's right.
17 THE CHAIRMAN: So even though the operation won't take
18 an hour, the before and after will extend it beyond
19 an hour?
20 A. Certainly. Certainly, yes.
21 THE CHAIRMAN: Okay, thank you.
22 MR WOLFE: In your witness statement for the inquiry, you
23 say that, at or about 7.05 on 8 June, Raychel was
24 complaining of abdominal pain and you administered
25 diclofenac, which is an anti-inflammatory painkiller,

1 isn't it?
2 A. Yes.
3 Q. And you administered Flagyl, which is an antibiotic?
4 A. Yes.
5 Q. In terms of her abdominal pain at that time, I don't
6 think that's reflected in the observations. Is there
7 any reason why it wasn't?
8 A. Observations had been carried out quite recent to that,
9 so I didn't record it in at that time.
10 Q. To what extent was she in pain?
11 A. From what I can recall, it would have been slight
12 abdominal pain when she wakened up at that time and that
13 would have been quite normal post surgery,
14 post-appendicectomy.
15 Q. Should you have recorded it in the notes that she was
16 experiencing pain?
17 A. It certainly could have been recorded, yes.
18 Q. At or about 8 o'clock, the next shift started and there
19 was a handover of care. We understand that Nurse Noble
20 handed over care to the next shift of nurses.
21 A. Yes.
22 Q. Did you participate in that in any way?
23 A. No.
24 Q. You carried out some observations at or about 8 o'clock;
25 is that right?

1 A. That morning at 8 o'clock -- I reset her drip, her IV
2 fluids, at 8 o'clock that morning, yes.
3 Q. You reset her drip as opposed to observations?
4 A. Yes.
5 Q. I think that's a more accurate, of course. Could
6 we have up on screen, please, 020-018-037? This is the
7 fluid balance sheet for 8 June, Ms Patterson; do you
8 recognise it?
9 A. That's right, yes.
10 Q. The first entry is at 8 o'clock. That's designed to
11 reflect the fluid that had been infused in the period
12 between 7 am and 8 am; is that right?
13 A. That's right, yes.
14 Q. And we see your signature on the right-hand side;
15 is that right?
16 A. That's right, yes.
17 Q. Indeed, just for completeness, as I understand it, your
18 signature appears one other time on that sheet, towards
19 the end of the day at midnight.
20 A. At midnight, yes.
21 Q. At the time or between that period, 8 and 9, the word
22 "vomit" is entered; do you see that?
23 A. Yes.
24 Q. Is that entry made by you?
25 A. No, no, I was unaware that Raychel had vomited prior to

1 going off duty that morning.
2 Q. So when you went into the room, which was room I, where
3 Raychel was cared for --
4 A. Yes.
5 Q. -- in terms of doing the work that you had to do in
6 order to complete this form at this time, was that
7 simply to look at the fluid pump?
8 A. Yes, and her IV cannula and reset the pump again for the
9 next hour.
10 Q. And you would have signed off and then left the room?
11 A. Yes; unless there was anything else that was required to
12 do, yes.
13 Q. Can you remember Raychel's condition at that hour when
14 you went in?
15 A. Before I went off duty, I helped Raychel sit up in bed
16 and her dad was there at that time, and I told Raychel
17 and her dad she was doing very well.
18 Q. And there was no complaint of nausea at that point?
19 A. No. I cannot recall.
20 Q. And so far as you're aware, she hadn't vomited?
21 A. I wasn't aware that she had vomited prior to -- I was
22 going off duty.
23 Q. You can't help us any further in relation to this vomit?
24 A. No, I was unaware of that vomit.
25 Q. I'm conscious that you weren't the reporter of this

1 vomit, but if you had observed the vomit what would have
2 been the appropriate steps to take at that point?
3 A. I think I probably would have informed a doctor when
4 they came to do the ward round.
5 Q. And record it?
6 A. And record it, of course. Yes, record it.
7 THE CHAIRMAN: In the way that it's recorded there, just
8 "vomit" or "large vomit" or "vomit plus plus" or
9 whatever?
10 A. Normally I would try and record whether it's a small,
11 medium or large vomit.
12 THE CHAIRMAN: How would you enter a small vomit? What
13 would you write?
14 A. I would write "small vomit".
15 MR WOLFE: That is your entry at the bottom, is it, the last
16 vomit?
17 A. At 11 o'clock, yes, "Small coffee-ground vomit", yes.
18 THE CHAIRMAN: So you would write "small vomit" for that, or
19 "large vomit" if it was a large vomit? If you came
20 along to look at these notes and it said at 1 o'clock
21 and then at 3 o'clock it was vomit plus plus, how do you
22 interpret that? Because that's something you might have
23 to do, isn't it, you might have to interpret that?
24 A. Yes, to me that would have been indicating a larger
25 vomit.

1 THE CHAIRMAN: Right. So if you had -- I know you weren't
2 much involved with Raychel's care on the Friday night,
3 but if you had been looking through her records to see
4 how she had been during the day, you would have seen
5 a vomit at 8 am and then what you would have regarded as
6 three large vomits, one which is described as "large",
7 and two which are described as "vomit plus plus"?
8 A. Yes.
9 THE CHAIRMAN: Thank you.
10 MR WOLFE: In terms of the use of the plus symbol, was there
11 any teaching around that or instruction or even practice
12 on the ward? How do people know what they were
13 conveying with the use of that symbol?
14 A. I can't recall any specific teaching on that, no.
15 Q. You obviously didn't use the symbol; you preferred the
16 language.
17 A. I tended to use, yes, small, medium or large, yes.
18 Q. To the extent that the inquiry might have heard evidence
19 that "plus plus" connoted a small to medium vomit, what
20 would you say?
21 A. That's not how I would have envisaged plus plus.
22 Q. We talked earlier about the use of the episodic care
23 plan and how, whenever you came to formulate that at or
24 about 10 o'clock the previous night, you didn't refer to
25 post-operative nausea or vomit as a problem, because it

1 wasn't, it wasn't a problem that you could foresee at
2 that point or did foresee. Whereas quite plainly, by
3 mid-afternoon on this day, there were four vomits
4 recorded. If you had been on duty in a situation where
5 four vomits had been recorded -- we don't necessarily
6 need to think of Raychel's specific case for the
7 purposes of this question, but in terms of your general
8 nursing practice, if you see four vomits in the space of
9 seven hours or so, first of all in terms of the care
10 plan, would you be doing anything to revise or amend the
11 care plan to take into account this development?
12 A. It's difficult to comment on a situation that I'm not
13 actually there in.
14 Q. But I'm trying to take it away from the specifics of
15 Raychel's case to help you. Imagine this as a scenario
16 you were being tested upon as a student nurse or a young
17 nurse. The question is: you've got an episodic care
18 plan that doesn't refer to nausea or vomiting and you're
19 now in the first post-operative day and you've got four
20 vomits in reasonably quick succession; what would you do
21 in terms of care planning?
22 A. I would give a problem for vomiting.
23 Q. Yes. What, on the action side of the line, would you be
24 writing up as a nurse in terms of the plan?
25 A. Recording all vomits, informing the doctor and I suppose

1 reassuring the child and family.
2 Q. Would you be having any thoughts about fluids, any plans
3 in relation to the fluids that the child was getting?
4 A. I think by informing the doctor, then it would be the
5 doctor's decision in regard to the fluids.
6 Q. What about anti-emetics?
7 A. Yes, again that would be by informing the doctor, then
8 the doctor would make the decision in regard to the
9 anti-emetics.
10 THE CHAIRMAN: What would you tell the doctor? There seems
11 to be a bit of a gap here potentially about what the
12 doctors actually knew when they came along. If you were
13 contacting the doctor in this situation, first of all
14 can I take it that you would like to see him on the ward
15 when he arrives so that you can explain to him with the
16 child there and the parents there what the problem is?
17 A. Yes, again it's difficult to comment on this exact
18 situation, when I wasn't there.
19 THE CHAIRMAN: Yes, but if you're sufficiently concerned
20 about a child's progress that you call a doctor, do you
21 prefer then to talk to the doctor at the bedside with
22 the parents there to explain what your concern is and
23 then that helps the doctor or gives the doctor a steer
24 on what he's looking at or what he's looking for?
25 A. Yes, that would be ideal, yes, that you would speak to

1 them, yes.
2 THE CHAIRMAN: Or if the doctor came along and you weren't
3 immediately available, would you then want to talk to
4 the doctor after the doctor has seen the child?
5 A. I would certainly want to make sure the doctor was
6 aware.
7 THE CHAIRMAN: Right. So even if you don't see him before
8 he sees the child or even if you can't be there with him
9 seeing the child, you want to speak to him afterwards to
10 make sure that he's aware of your perspective on the
11 problem?
12 A. Yes. I would have had concerns to contact him, so
13 therefore I would have wanted to pass on those concerns
14 to the doctor.
15 THE CHAIRMAN: Would you necessarily be able to express your
16 concerns when you're bleeping or phoning the doctor to
17 bring the doctor down, or do you just do it by a bleep?
18 A. You can bleep the doctor, yes.
19 THE CHAIRMAN: So if you bleep the doctor, that means you're
20 not explaining to the doctor what the problem is, you're
21 bleeping the doctor to ask the doctor to come down?
22 A. Yes.
23 THE CHAIRMAN: So if the doctor responds to a bleep, the
24 doctor arrives on the ward, uninformed about the
25 problem?

1 A. Yes. You may briefly have told him on the phone. If
2 they had phoned before they came to the ward, you may
3 briefly have told him on the phone.
4 THE CHAIRMAN: Yes, you may briefly have told them, but you
5 are going to fill them in on more detail when they come
6 down.
7 A. I suppose it's hard just to generalise situations and an
8 individual situation and --
9 THE CHAIRMAN: I understand that, but there's some point
10 whether before the doctor sees the child or when the
11 doctor is seeing the child or after the doctor sees the
12 child, when you want to make sure that the doctor knows
13 what your concerns are. You also want to know from the
14 doctor what's to happen.
15 A. That's right, yes.
16 THE CHAIRMAN: So that conversation becomes particularly
17 important?
18 A. Yes.
19 THE CHAIRMAN: Thank you.
20 MR WOLFE: Can I just ask you specifically, Ms Patterson,
21 about the trigger for getting a doctor to come to
22 review? Let me put it to you from this perspective:
23 Mr Orr is an expert surgeon who the Trust, through their
24 legal advisers, have retained and he's provided a report
25 which says that the surgical team should have reviewed

1 Raychel after her two plus vomits -- that's the one at
2 10 o'clock, I should say, and the one at 1300 hours. So
3 steps should have been put in place to ensure that
4 Raychel was reviewed by lunchtime on that day. In terms
5 of what you would have done, had you been on duty, if
6 Raychel had vomited three times between 8 o'clock and
7 1 o'clock, would you have been getting a doctor?
8 A. Again, it's difficult to comment on a situation where
9 I actually wasn't there. My knowledge now has changed
10 a lot since 2001 as well.
11 Q. Let me push you on that if I can. Post-operative
12 vomiting, particularly large vomits -- and there's at
13 least one recorded here as large regardless of your view
14 of what plus plus means. That would be very
15 uncomfortable for a child.
16 A. Yes.
17 Q. And as a nurse you would be wanting, as per the care
18 plan, to reduce and perhaps remove that discomfort.
19 A. That's right, yes.
20 Q. So how long would you let the vomiting go before you
21 asked for a doctor's advice?
22 A. It would very much depend on the individual child and
23 the child's condition, but yes, certainly you wouldn't
24 want a child to be vomiting over a period of time if you
25 could get the doctor to administer an anti-emetic to

1 prevent the vomiting.
2 Q. Is Mr Orr wrong to suggest that it should be by
3 lunchtime?
4 A. No, certainly I mean if the child has been vomiting
5 in the morning time, yes, I would agree that an
6 anti-emetic may have helped.
7 Q. In terms of ward rounds in Altnagelvin Hospital, would
8 you have an experience of being on duty when they were
9 being conducted by the surgical team?
10 A. Yes.
11 Q. In terms of the personnel who would attend at those,
12 I suppose that would vary: sometimes you might have the
13 consultant in attendance, sometimes the registrar,
14 sometimes just the SHO. Am I right in thinking --
15 A. Yes. From what I can recall back, yes.
16 Q. In terms of the more common or the most common position,
17 the everyday position -- well, obviously there might be
18 exceptions -- what was the everyday position?
19 A. As far as I can recall, an SHO and registrar maybe or
20 one or other.
21 Q. One or other?
22 A. Yes ...
23 THE CHAIRMAN: Did that depend on whether it was paediatric
24 or surgical?
25 A. Oh yes, certainly. Sorry, I was talking about surgical

1 patients, yes, sorry.
2 MR WOLFE: Surgical was the question I asked you.
3 A. Surgical, yes.
4 Q. In terms of the conduct of the ward round by a surgeon
5 or a member of the surgical team, what are the kinds of
6 things that you would expect the doctor attending to do?
7 What would his checklist be? Presumably, checking the
8 wound.
9 A. Yes. And checking the wound, pain, medication, IV
10 fluids, commencing on oral fluids, passing urine, any
11 vomiting that would have occurred. They would have
12 reviewed the fluid balance sheet.
13 Q. You would have expected them to?
14 A. Yes, yes.
15 Q. And I think you reflected earlier when I asked you about
16 electrolyte testing being conducted. If we move my
17 question across to the paediatric medical side,
18 do you have a recollection of when or how often
19 electrolytes were being done at that time on the
20 paediatric medical side? Was it daily, was it more
21 often than that?
22 A. If a child was on IV fluids, it would probably have been
23 daily, but I wouldn't just want to say any more than
24 that.
25 Q. Is that because you don't have a clear memory?

1 A. Because I don't have a clear mind, yes.
2 Q. You next came on duty on the evening of 8 June; isn't
3 that right?
4 A. Yes.
5 Q. And that was at about 7.45 pm.
6 A. Yes.
7 Q. And you worked through until the next morning. In other
8 words, you did a night shift.
9 A. That's right, yes.
10 Q. And you've told us in your witness statement that, upon
11 returning to duty, you were allocated to work in the
12 infant unit, caring for infants up to six months of age.
13 A. Yes.
14 Q. So you weren't caring for Raychel?
15 A. Yes.
16 Q. I wonder, could you just help orientate us in terms of
17 where the infant unit is? If I could put the plan up,
18 please, it's 316-016b-001. Just take a moment to
19 orientate yourself. We are told -- and maybe you can
20 confirm for us -- do you see on the right-hand side?
21 A. Yes.
22 Q. You see an arrow pointing to room I.
23 A. Yes.
24 Q. That's where Raychel was cared for; is that correct?
25 A. That's right, yes.

1 Q. And directly across from that, it's not particularly
2 highlighted, but directly across from her room would
3 have been the nursing station or reception area, it has
4 also been called.
5 A. Yes, that's right.
6 Q. Where was the infant unit at that time?
7 A. The infant unit would have been just down below
8 room I on the right-hand side.
9 Q. So further down the page, if you follow my finger?
10 A. Yes.
11 Q. Is it the two rooms next to room I?
12 A. No, it wouldn't have been next to room I. Room G and H
13 would have been the infant unit.
14 Q. Room G and H?
15 THE CHAIRMAN: It's the two rooms below I and G, in
16 particular, is quite a bit bigger, is it?
17 A. Yes.
18 THE CHAIRMAN: H is about the same size and G is quite a lot
19 bigger.
20 A. G would have been the main infant unit. It wouldn't
21 always have been used unless --
22 MR WOLFE: They were separate rooms, were they?
23 A. Yes.
24 Q. But generally, unless you were very busy, G was the room
25 that was used?

1 A. Was the main one, yes.
2 Q. Just if we could zoom out again, please. "Sister's
3 office" is labelled there on the other side of the
4 premises.
5 A. Yes.
6 Q. Do you see that?
7 A. Yes.
8 Q. Does that accord with your memory of the time?
9 A. Yes, in 2001, yes.
10 Q. When you reported for duty on that night and were
11 allocated the infant unit, tell me, was that unusual
12 in the sense that on the previous night you were one of
13 the nurses with, if you like, closest contact with
14 Raychel and were her named nurse?
15 A. No, it was the nurse in charge on day duty, a senior
16 nurse on day duty who would have allocated the staff for
17 the next shift. So, no, it wouldn't have been unusual.
18 It depended very much on the number of patients on the
19 ward, the skill mix and experience of the nurses as
20 well.
21 Q. You've told us in your witness statement that you didn't
22 attend the handover that was being given in respect of
23 patients such as Raychel.
24 A. Yes, that's right, because the infant unit -- yes, it's
25 on the same floor as the main ward, but it's staffed

1 separately so there would have been a separate handover
2 for the patients in the infant unit. So I wouldn't have
3 been part of the handover on the main ward that night.
4 Q. Can I ask you this: although you weren't at the
5 handover, had you any knowledge or any sense of the fact
6 that Raychel was still a patient and what condition she
7 was in at that time?
8 A. No, I wouldn't have been aware of that. No, I wouldn't.
9 Q. We know from the records that within an hour of the
10 handover taking place, Raychel had suffered
11 coffee-ground vomits. She was also reporting to your
12 nurse colleagues, that is Noble and Gilchrist, that she
13 had a sore head. And ultimately, a Dr Curran was called
14 in to prescribe an anti-emetic. First of all, at any
15 point in the evening were you apprised of her condition?
16 A. No. As I wasn't working on that area, on the main ward,
17 no, I wouldn't have been. It wouldn't have been normal
18 for me to have been aware of the patients out on the
19 main ward.
20 Q. If I can pre-empt the evidence that might be given by
21 Staff Nurse Roulston: during the day, she had quite
22 a lot to do with the infant unit, but was helping out to
23 cover breaks in the main ward. Was that expected of you
24 on the evening shift?
25 A. No, I was allocated to work in the infant unit so, no, I

1 wasn't on hand to relieve breaks on the main ward that
2 night.
3 Q. You tell us that when you were walking through the main
4 ward at some point, you had some contact with Raychel's
5 father; is that right?
6 A. Yes.
7 Q. We have the plan up in front of us. Can you say from
8 your recollection where you had that interaction with
9 him?
10 A. I cannot recall for definite, but it probably was
11 outside room I and it was on the corridor. I was
12 obviously walking through the ward to get something and
13 Raychel's dad had a vomit bowl, which I accepted off
14 him.
15 Q. Right. So he had a vomit bowl and he handed it to you?
16 A. Yes.
17 Q. You've recorded, if we can put it up again 020-018-037
18 -- just to be clear, at 2300 hours, is that your
19 handwriting?
20 A. That's right, yes.
21 Q. "Small coffee-ground vomit."
22 A. Yes.
23 Q. When you say it was a coffee-ground vomit, could you
24 describe it for us?
25 A. It was brown in colour.

1 Q. You say small.
2 A. Yes. Probably just about covering the bottom of the
3 vomit bowl.
4 Q. When you say a vomit bowl, it's one of those cardboard
5 kidney-type trays?
6 A. Yes.
7 Q. And you tell us also that you reported this episode to
8 your nursing colleagues.
9 A. Yes.
10 Q. There were three of them on duty that night, as we
11 understand it, plus an auxiliary.
12 A. Yes.
13 Q. The auxiliary was Lynch.
14 A. Yes.
15 Q. The nurse in charge was Nurse Noble and then we have
16 Gilchrist and Bryce.
17 A. That's right.
18 Q. Can you remember, doing your best, which of those nurses
19 you reported to?
20 A. I cannot recall, no, which nurse I reported it to.
21 Q. Can you remember what you said?
22 A. Not exactly, no, but I would have told them that she had
23 had a coffee-ground vomit and the size of it.
24 THE CHAIRMAN: Did you go to see Raychel? You took the bowl
25 away and you made the entry on her chart. Was that

1 chart at the bottom of her bed?
2 A. The chart would have been at the bottom of her bed.
3 THE CHAIRMAN: As best you can, when you were given the
4 bowl, did you take it away and dispose of it and then go
5 back to the bed?
6 A. Yes, I would have disposed of the bowl.
7 THE CHAIRMAN: And then you went back to the bed?
8 A. Yes, and I recorded it in her fluid balance chart.
9 THE CHAIRMAN: Apart from recording it, did you look at
10 Raychel or ask her father how she was?
11 A. I can't recall any conversation, and I don't recall
12 anything that caused me concern in regard to Raychel at
13 that time.
14 THE CHAIRMAN: Well, would it not be a cause of concern that
15 a girl who you might normally have expected to be off IV
16 fluids by 11 o'clock at night, almost 24 hours after her
17 operation was still on IV fluids, which you would have
18 seen at her bedside, and had vomited again and, by
19 making that entry to the chart, you would have seen
20 a series of vomits through the day? Would that not be
21 a cause of concern?
22 A. That's why I reported it to the nurse on the ward who
23 was looking after Raychel that night.
24 THE CHAIRMAN: And then you left, so in essence you did what
25 you had to do and then left it to the nurses who were

1 looking after Raychel to take it from there?
2 A. Yes, because I had responsibility for the babies that
3 I was looking after in the infant unit that night.
4 THE CHAIRMAN: So you had to get back to it?
5 A. I had to get back to them.
6 MR QUINN: Mr Chairman, one point of clarification if I may.
7 My recollection is that the charts were kept in the
8 sister's office. That might mean the computerised
9 record was in the computer in the sister's office, but
10 I certainly have a recall of other witnesses saying that
11 the charts were kept at the sister's office and that's
12 why we were identifying what the recollection was --
13 THE CHAIRMAN: Yes. Can you help us with that?
14 A. Yes, the nursing care plan charts were kept in sister's
15 office and the medical notes -- sorry, not sister's
16 office, in the office that was -- the nurses' station.
17 The fluid balance sheet would have been at the bottom of
18 Raychel's bed.
19 MR WOLFE: That was one thing I was going to ask of you. In
20 terms of what was kept at the bed, I think an impression
21 might have formed -- certainly might have formed in my
22 mind -- that all of the notes that we see in what we
23 call file 20 might have been at the bed, but that's not
24 right from what I can work out now. What was at the
25 bed?

1 A. No, at the bottom of the bed would have been the
2 observation sheet and the fluid balance sheet, and that
3 would have been --
4 Q. What about the drug kardex?
5 A. Sorry, the drug kardex, yes, that would have been at the
6 bottom of the bed.
7 Q. So in answer to the chairman, you said that when you
8 made your entry you would have seen the other entries
9 perhaps at that time for the first time?
10 A. Yes, that would have been the first time, yes.
11 Q. And you would have appreciated that one hour before you
12 were making your entry, Raychel had three small vomits
13 and then, an hour before that, she had vomited "coffee
14 grounds plus plus", and you would have interpreted that
15 as a large vomit.
16 A. Yes.
17 Q. And then you would have seen the other vomits during the
18 day.
19 A. Yes.
20 Q. And that was a concern for you and that's why you
21 reported it to a nursing colleague?
22 A. As I wasn't looking after Raychel that night, I reported
23 it to ...
24 THE CHAIRMAN: Was the type of vomit that had been given to
25 you a concern, the coffee-ground vomit?

1 A. Well, I mean, children did vomit coffee grounds on
2 occasions.
3 THE CHAIRMAN: I've got the impression -- and please correct
4 me if this is wrong -- that it indicates a more alarming
5 type of vomit.
6 A. A coffee-ground vomit could have occurred maybe with
7 a forceful vomit or vomiting over a period of time.
8 THE CHAIRMAN: That's rather the point, isn't it? If it's
9 vomiting over a period of time, that's a bit more
10 alarming than if it's a one-off.
11 A. Yes.
12 MR QUINN: Mr Chairman, I just want to know through
13 yourself, sir, precisely what was kept at the bed. For
14 example, the clinical notes that appear at 020-007-013,
15 which is where one would assume, from my point of view,
16 that a doctor would make a note, for example, when they
17 come to give any other intravenous medication. So could
18 we ask if that note was kept at the bedside perhaps?
19 Because that is a note where -- you see there's three
20 lines of the 8th. One would assume that a doctor coming
21 along later in the day to give other medication would
22 write up that note or observe on that note or perhaps
23 enter a vomit, as Dr Curran and Dr Devlin might have.
24 THE CHAIRMAN: Can you help with that?
25 A. As far as I recall, no, that wouldn't have been kept

1 at the bottom of the bed; that was kept on a trolley
2 with all the other patients' notes.
3 THE CHAIRMAN: Okay. To get a picture of it: the records
4 which are at a child's bed -- and we're not just talking
5 about Raychel, we're talking about standard -- you'd
6 have the hourly observation record, you'd have the fluid
7 balance chart and you'd have the drug kardex; is that
8 right?
9 A. Yes.
10 THE CHAIRMAN: Anything else?
11 A. Just their observation chats and their fluid balance
12 charts and their medicine kardex as far as I can recall.
13 THE CHAIRMAN: So the other notes are then kept at the
14 nursing station, which happens to be just outside
15 room I?
16 A. That's right, yes.
17 THE CHAIRMAN: So when a doctor's called down to the ward to
18 see a child, whatever room that child is in, that means
19 the doctor will have some information available at the
20 bedside --
21 A. That's right.
22 THE CHAIRMAN: -- but if the doctor wants to see what other
23 doctors have been writing about that patient or what's
24 in that patient's history, the doctor has to pick those
25 up from the nursing station; is that right?

1 A. That's right, yes.
2 THE CHAIRMAN: On a typical visit, if there is such a thing
3 as a typical visit, would you expect a doctor to grab
4 those notes, like this note that's on the chart in front
5 of you, at the nursing station and then bring it to the
6 bedside and look at it in conjunction with the sheets
7 which are at the child's bedside?
8 A. They may have done or they may have got the notes
9 afterwards and written in after they had seen the child.
10 THE CHAIRMAN: Okay.
11 MR WOLFE: Could you put the previous document back on
12 screen again, please, 020-018-037?
13 MR STITT: May I intervene? I appreciate the point was
14 raised by Mr Quinn and not by Mr Wolfe, but it's not my
15 understanding that there's any criticism of this
16 procedure whereby the clinical notes -- and by "clinical
17 notes", I mean the doctor's notes -- are kept at the
18 nursing station and were there to be picked up. I'm
19 assuming it's accepted that that was standard practice
20 and is not being criticised. If it is being, then of
21 course we will look into it, but it's my understanding
22 that that is standard practice.
23 MR WOLFE: I think my friend's understanding is correct.
24 I'm not aware of any criticism on any of the expert
25 materials that we have obtained which points an

1 accusatory finger at that. It may well be that people
2 have proceeded or experts have proceeded on a
3 misunderstanding of what was available. I don't know.
4 THE CHAIRMAN: Let me just ask this: do you understand why
5 the records are split? Do you understand why some of
6 a child's records are at the child's bedside and some
7 are at the nursing station? Why is that? Sorry, I'm
8 really saying: if you want to keep things as easy as
9 possible for the doctors and, for that matter, the
10 nurses, why didn't you keep them all together?
11 A. I suppose there would be issues around confidentiality
12 as well if there are medical notes at the bottom of
13 a child's bed: could somebody come and lift them and
14 access them?
15 MR STITT: Obviously immediate family are one category of
16 visitor. There could be other friends of the family who
17 might be there when the family aren't there who could
18 have access to confidential medical notes from a doctor,
19 and there might be -- and I'm not suggesting for one
20 second that the cleaning staff are going to be
21 interested in clinical notes, but in theory they could
22 be. Say for instance you had a cleaner who lived in the
23 same part as a patient ...
24 THE CHAIRMAN: Thank you.
25 MR WOLFE: Just looking at this document again, you say you

1 acted on the vomit by reporting it and recording it.
2 A. Yes.
3 Q. You went into Raychel's room in order to record it --
4 A. Yes.
5 Q. -- and can you recall her condition at that point?
6 A. I cannot recall what Raychel was doing at that time, no.
7 THE CHAIRMAN: Do you remember if she was awake or asleep?
8 A. I cannot recall.
9 MR WOLFE: Did you examine her?
10 A. No. I cannot recall that I did, no.
11 Q. You would then, upon recording it, have seen this other
12 list of vomits?
13 A. Yes.
14 Q. At this stage, I think you've told us already, but you
15 weren't aware that Dr Curran had attended?
16 A. No, I wouldn't have been aware of that. Again, because
17 I wasn't working on the main ward.
18 Q. And that wasn't brought to your attention when you
19 reported the vomit to your colleague?
20 A. Not that I can recall, no.
21 Q. When you saw this list of vomits within a comparatively
22 short space of time, did you give any consideration to
23 whether you should be expressing detailed concerns to
24 your colleague about this child's apparent condition?
25 A. Because I wasn't working on the main ward, I reported it

1 to the nurses on the main ward and it wouldn't have been
2 my responsibility to contact a doctor or ...
3 THE CHAIRMAN: Let me ask it in a slightly different
4 way: this was a girl who you had been involved in caring
5 for the night before and the expected progress that she
6 was going to make was that she might be off fluids
7 entirely by Friday night; isn't that right?
8 A. Yes.
9 THE CHAIRMAN: And you went to see her, you happen to go and
10 see her because of the vomit which Mr Ferguson gave you,
11 and you looked at the chart and you saw regular vomiting
12 or repeated vomiting. When you reported it to whichever
13 colleague it was, did you not say, "What's going wrong
14 with Raychel?". Would that be a normal thing to say?
15 A. I cannot recall that I did, but ...
16 THE CHAIRMAN: Okay.
17 MR WOLFE: When you look at the chart as it appears in front
18 of you -- and this is a difficult exercise because all
19 sorts of information is probably going through your
20 head, all kinds of thoughts -- but was what appears on
21 this chart an unusual state of affairs for you? Put it
22 another way, a state of affairs that ought to have
23 raised concerns for somebody?
24 A. Well, children did vomit post-operatively and some
25 children vomited longer than others. So yes, I think it

1 was something you would have wanted to make a doctor
2 aware of, yes.
3 Q. And if you had been making the doctor aware of this
4 scenario, this patient, what would you have been wanting
5 to say, what would you been telling them?
6 A. You'd be reporting the vomiting, that the child had been
7 vomiting over a period of time, and the frequency of the
8 vomits and the fact that she'd been vomiting
9 coffee-ground vomits.
10 Q. If you had a young doctor in front of you, would you be
11 suggesting any course of action?
12 A. Again, it's difficult to comment on a situation
13 I actually wasn't involved in.
14 THE CHAIRMAN: Okay.
15 MR WOLFE: That might be a convenient moment to break at
16 this point.
17 THE CHAIRMAN: It has been a long morning for you,
18 Ms Patterson. We'll break now and resume at 2.15. It
19 won't take that much longer for your evidence to be
20 finished. Okay?
21 I should say then we'll start with Nurse Bryce after
22 that and I'll sit today until 4.45.
23 MR STITT: Mr Chairman, on Wednesday last, in an exchange
24 with Mr Lavery, he indicated to you -- this is on
25 a different issue obviously, if you don't mind me making

1 this point now.
2 THE CHAIRMAN: Let's let Ms Patterson out of the witness box
3 if we are going to go on to something different.
4 MR STITT: It was indicated by Mr Lavery that Dr Fulton, who
5 was the medical director, had indicated that he wished
6 to put in a statement to correct an error that had
7 occurred in his original statement -- I don't know if
8 you recall that -- as to the identities of those persons
9 at the meeting on 12 June and whether or not they
10 specifically said something.
11 THE CHAIRMAN: Yes.
12 MR STITT: You indicated that if such a statement was going
13 to be put in, you would like it by today.
14 THE CHAIRMAN: Yes.
15 MR STITT: I have handed in a signed statement with four
16 appendices, being the four pages from the original
17 record to which he refers in his statement. And we will
18 leave that with you, sir, and you can decide which way
19 to deal with it.
20 THE CHAIRMAN: Okay. I'll look at it over lunch and, unless
21 there's something untoward, I'll circulate it this
22 afternoon. Okay? We'll resume at 2.15. Thank you.
23 (1.25 pm)
24 (The Short Adjournment)
25 (2.15 pm)

1 MR STITT: Mr Chairman, there's one small matter which I'd
2 like to deal with if I may.
3 On Friday, sir, you may recall I had made
4 a submission in relation to ...
5 THE CHAIRMAN: Privilege?
6 MR STITT: In relation to the patient advocate's note. We
7 know the points. You at one point asked me, sir, to
8 confirm whether there was any other note made of that
9 meeting, and I've done that and no other note was made
10 of that meeting.
11 THE CHAIRMAN: I don't want to prolong this now because I'd
12 like to get Ms Patterson away from the witness box.
13 There was, during the earlier debate about that meeting,
14 some suggestion -- I think from the Trust side -- that
15 it didn't necessarily accept that the note was
16 a complete record. We heard some evidence on Friday
17 from Ms Millar about that and I think there's to be
18 a suggestion that there was some more said. Perhaps it
19 might be in terms of there was an apology made and
20 sympathy expressed at the start of the meeting, which
21 isn't entirely recorded.
22 MR STITT: That's the nature of it, yes.
23 THE CHAIRMAN: If that's the nature of it, I've got that
24 point. But what I wanted to check was that that is the
25 extent of the disagreement about it because -- we've

1 checked this over the weekend -- Ms Burnside, the
2 chief executive, made a statement, which I don't need to
3 bring up -- and I'm not sure it's even on screen yet --
4 098-267-724. She says in that:
5 "It is my judgment that this note is not a full
6 account of the content or an adequate reflection of the
7 atmosphere of the meeting."
8 Setting aside the point about atmosphere, which
9 might be difficult to convey in a minute or a record
10 anyway. When Ms Burnside says that:
11 "... this not is not a full account of the content
12 of the meeting."
13 If she's saying anything beyond that there was an
14 expression of sympathy and regret or whatever it is
15 along those lines, I'd like to know what that is,
16 Mr Stitt.
17 MR STITT: Yes. I had read that statement. It then goes on
18 to get into what one would take as expressions of
19 sympathy in the same paragraph.
20 THE CHAIRMAN: Yes, it does.
21 MR STITT: In fact, having already spoken to Ms Burnside
22 this morning on this specific issue about the note,
23 I will have her contacted again this afternoon just to
24 confirm and complete that point.
25 THE CHAIRMAN: Subject to whatever Ms Burnside comes back to

1 you with, your understanding is that the extent to which
2 there are reservations about the note are that it
3 doesn't expressly record the fact that the hospital's or
4 Trust's sympathy and sorrow is extended, and the note
5 perhaps inevitably doesn't convey what the Trust
6 believes is the atmosphere of the meeting; is this
7 right?
8 MR STITT: That's my understanding and I'll formally confirm
9 that.
10 THE CHAIRMAN: Thank you very much indeed.
11 MR WOLFE: Ms Patterson, you told us that when you were
12 handed the 11 o'clock vomit dish by the father, you
13 reported that to a colleague after making a note
14 in relation to it.
15 A. Yes.
16 Q. The colleague that you reported it to, was she standing
17 at or about the nursing station?
18 A. I cannot recall where she was standing. I would have
19 disposed of the vomit bowl and I would have recorded it
20 in the fluid balance sheet and then spoken to her, but
21 I don't know where she was ...
22 Q. In reporting the matter to your colleague, was it your
23 impression that the fact of this further vomit was new
24 information that you were giving her? In other words,
25 she wasn't aware of the vomit?

1 A. Of the vomit that I had collected?
2 Q. Yes.
3 A. No, she wouldn't have been aware at that time;
4 I informed her of the vomit.
5 Q. You wouldn't have know this, but the plan was to
6 continue to monitor and observe Raychel. The doctor had
7 been at or about 11 o'clock and had prescribed an
8 anti-emetic.
9 Reporting this further vomit to your nursing
10 colleague, did you understand that she was going to take
11 any follow-up action in light of your report?
12 A. That wasn't discussed.
13 Q. I get the impression this was a very brief conversation
14 in passing, "That child has vomited a small vomit of
15 coffee grounds", and then you're off; is that the
16 flavour of it?
17 A. I can't recall the full conversation, no. But yes,
18 I would have reported that vomit.
19 Q. Yes, but given the limitations of your memory, would
20 I be right in trying to interpret your evidence as
21 saying that really this was a very brief conversation?
22 A. Yes.
23 Q. Do you look back at the conversation now with any regret
24 in terms of whether this was a missed opportunity to
25 take rather more aggressive action in relation to

1 Raychel's needs at that point?
2 A. The fact that I was working in the infant unit that
3 night -- I felt it was my duty to report that vomit to
4 the nurses on the ward.
5 THE CHAIRMAN: Can I ask you just on this: can you remember
6 how Mr Ferguson was?
7 A. I can't recall him expressing any concerns to me at that
8 time.
9 THE CHAIRMAN: From my end, I'm trying to put myself in his
10 position and I'm wondering, could I have been anything
11 other than very worried about the fact that my daughter
12 had received, for the second time, an anti-emetic and
13 was still being sick and this was added to the number of
14 vomits that there had been during the day, and by the
15 time Friday night came at about 11 o'clock, she was
16 still on the IV fluid, that he might have hoped that she
17 would be off, or at least it would be reduced. So I'd
18 be surprised if he wasn't at least a bit worried about
19 her.
20 A. I cannot recall him saying anything to me in regard to
21 that.
22 THE CHAIRMAN: Okay.
23 MR WOLFE: We looked earlier --
24 MR QUINN: Just on that point, it's clear from Mr Ferguson's
25 statement that he was extremely concerned at this time

1 of night. In fact, he phoned his wife at some time just
2 before this and expressed concern that the nurses
3 weren't listening to him. He will say that when he
4 handed the bowl to the nurse, he did express concerns to
5 this particular nurse.
6 THE CHAIRMAN: It seems the natural thing to have done.
7 MR QUINN: Yes, and he said he did do it.
8 THE CHAIRMAN: I'm wondering, Ms Patterson, when you give
9 this evidence, are you saying that you don't remember
10 what he said rather than remembering that he wasn't
11 worried? Do you know the difference?
12 A. Yes, I don't remember what he said, or I don't remember
13 him expressing anything to me, yes.
14 MR WOLFE: You saw Raychel again at 12 midnight.
15 A. Yes.
16 Q. We saw it earlier when we had the fluid balance chart
17 up -- we needn't put it up again. The purpose of seeing
18 her at that point was to record the fluids that had gone
19 in in the previous hour.
20 A. Yes.
21 Q. Why were you allocated that task when, as you have been
22 describing, you were primarily based in the infant unit?
23 A. I obviously was going through the main ward for some
24 reason and Raychel's drip was alarming, so I went to
25 reset it for the hour again as I walked through the

1 ward.
2 Q. This was for midnight, as we understand.
3 A. Yes.
4 Q. Any recollection of seeing her parents at that point?
5 A. No, I cannot recall.
6 Q. Do you think they were there or weren't there?
7 A. I couldn't comment on that.
8 Q. You couldn't comment?
9 A. No.
10 Q. Had you any concerns at that point when you saw Raychel
11 at that time?
12 A. No, I can't remember anything that concerned me with
13 regard to her behaviour at that time.
14 Q. Do you think she was asleep?
15 A. I presume because I didn't note anything different in
16 regard to her behaviour that, yes, she was asleep.
17 Q. You say in your witness statement that after that point
18 you didn't have any further contact with Raychel, but
19 you saw her parents at 3 o'clock.
20 A. Just as they returned to the ward, I was in the infant
21 unit and I saw them return to the ward around that time.
22 Q. Am I right in interpreting your evidence in your witness
23 statement as saying that you had no involvement in
24 Raychel's care at the point of her seizure and
25 thereafter?

1 A. That's right, I was in the infant unit.
2 Q. Were you aware that really things had taken a very
3 difficult and unusual course for Raychel by mid-morning?
4 A. I probably would have been aware, yes.
5 Q. How did you discover that Raychel had passed away?
6 A. I cannot recall when or who informed me. I was off duty
7 after that and returned on duty a few nights -- on the
8 Monday night. But I was aware a few days later of
9 Raychel's passing.
10 Q. Would that have been through a formal communication from
11 the Trust or would it have been through, if you like,
12 informal discussions from your nursing colleagues?
13 A. I wasn't on duty again until that Monday, until the
14 Monday night.
15 Q. That was Monday the 11th, I think.
16 A. Yes.
17 Q. So on that night you would have learnt this awful news
18 from your nursing colleagues?
19 A. Yes.
20 Q. Can you remember the sense of emotion or feeling at that
21 time?
22 A. Yes, it was a shock and very sad. It was a very
23 distressing time for the family.
24 THE CHAIRMAN: Just before we get there, on the Saturday
25 morning your shift would have finished at about 8 am,

1 would it?
2 A. Yes.
3 THE CHAIRMAN: And by that time Raychel was in terrible
4 trouble.
5 A. Yes.
6 THE CHAIRMAN: Do you remember seeing her parents coming
7 back into the ward sometime after 3? Do you remember,
8 as your shift finished, being told or brought up-to-date
9 about just how disastrous the position was?
10 A. Yes, I would have been aware, yes.
11 THE CHAIRMAN: Thank you.
12 MR WOLFE: You tell us in your witness statement that you
13 became aware that an incident review meeting was planned
14 for the Tuesday, 12 June 2001, and this is the meeting
15 that was convened by Dr Fulton.
16 A. Yes. That's right.
17 Q. And you've told us that you were unable to attend that
18 meeting because you had previously allocated shifts,
19 night duty.
20 A. Yes, that's right.
21 Q. Were you invited to attend the meeting?
22 A. I was aware the meeting was taking place, yes.
23 I presume I was invited to attend, yes.
24 Q. The meeting, as I understand it, commenced at 4 o'clock
25 in the afternoon and you've explained your inability to

1 attend because of previously allocated work shifts, that
2 is the night duty which was presumably due to commence
3 at or about 7.30/8 o'clock.
4 A. Yes, I was working on the Monday night, the previous
5 night.
6 Q. Yes. But the meeting was on the Tuesday, isn't that
7 right?
8 A. Yes.
9 Q. And you say you couldn't attend that because you were
10 due to commence a night shift.
11 A. Yes, I was due to attend -- I'm not sure if I was on
12 night duty on the Tuesday night as well.
13 Q. I have difficulty following your reasoning as to why you
14 couldn't attend the meeting.
15 A. I know that I was on night duty on the Monday night,
16 I may have had family commitments as well on the
17 Tuesday. I cannot recall exactly why.
18 Q. Obviously, as Raychel's named nurse, as the person who
19 had dealings, if you like, with her post-operative fluid
20 arrangements, it was right and proper that you were
21 invited to attend this meeting. Was there a reluctance
22 to your part to attend the meeting?
23 A. No, no there wouldn't be. I cannot say for definite if
24 I received an invite. I do not recall that for
25 definite. But I know I was aware of the meeting taking

1 place.
2 Q. As it happens, you weren't ever asked to provide
3 a statement to your employer in relation to your
4 involvement with Raychel's care; is that correct?
5 A. Yes, that's correct, yes.
6 Q. You didn't ever provide a statement?
7 A. No, not until 2005.
8 Q. And that was for the purposes of the inquiry.
9 A. Yes.
10 Q. The shock of Raychel's death that you've described must
11 have been clear to you from conversations with your
12 nursing colleagues; is that right?
13 A. Yes.
14 Q. Is it fair to say that you and your nursing colleagues
15 would have discussed how Raychel's death occurred and,
16 if that's right, did you participate in such
17 discussions?
18 A. I suppose the death of any child is extremely
19 distressing and, yes, that would have been something we
20 probably would have discussed together. I cannot recall
21 exact conversations with nursing staff or who with, but
22 yes.
23 Q. The inquiry's heard some evidence from some nurses and
24 they've frankly accepted that, at a fairly early stage
25 in this aftermath, a number of things were acknowledged

1 on the part of staff who had cared for Raychel or who
2 had some involvement in her care. There was an
3 acknowledgment that Raychel had received an excessive
4 rate of fluid. There was an acknowledgment that her
5 electrolytes ought to have been assessed in
6 circumstances where the vomiting was regarded as having
7 been severe. There was also an acknowledgment that the
8 fluids that Raychel received were inappropriate, albeit
9 there was an element of finger-pointing towards the
10 Royal Hospital because they seemed to know something
11 about these fluids which hadn't been disseminated to the
12 rest of the world, if you like.
13 It's a bit of a long introduction, Ms Patterson, but
14 can I ask you this: in your discussions with your
15 colleagues at that time, did you gain an understanding
16 of what it was about Raychel's care that might have led
17 to her seizure and death?
18 A. It's very hard to comment on that now. I do remember
19 hearing it was because of a low sodium that Raychel had
20 passed away. I do not recall specifically because of
21 wrong fluids or too much fluid being the reason for her
22 death. I do know that after her death No. 18 Solution
23 was no longer used for surgical children.
24 Q. You've also said in your statement that, after her
25 death, there was greater attention paid to urea and

1 electrolyte assessment.
2 A. That's right, yes.
3 THE CHAIRMAN: In what way?
4 A. That they were checked either preoperatively or
5 intraoperatively and then within 12 hours
6 post-operatively.
7 THE CHAIRMAN: Thank you.
8 A. And also the doctor was -- the anaesthetist was
9 responsible for prescribing the fluids in the first
10 12 hours post-operatively as well.
11 MR WOLFE: Did you get a sense from those who you were
12 talking to at that time that it was understood that
13 there had been a failure to measure her electrolytes in
14 a timely way?
15 A. It would have been more that No. 18 Solution was the
16 problem rather than anything else that I can recall.
17 Q. Was there any discussion with you about the extent of
18 Raychel's vomiting and whether nursing and medical staff
19 should have picked up the fact that this was
20 contributing to Raychel's difficulties?
21 A. I can't recall any discussion with me in regard to that.
22 THE CHAIRMAN: I've heard a number of witnesses say that the
23 reason Solution No. 18 was used rather than Hartmann's
24 was because Hartmann's didn't have glucose, where
25 Solution No. 18 did. Was that your understanding?

1 A. Yes, that's right.
2 THE CHAIRMAN: Well, since Solution No. 18 was discontinued
3 and since Hartmann's stopped [sic], how are children's
4 glucose levels maintained?
5 A. There's 3 per cent dextrose added to the Hartmann's now.
6 THE CHAIRMAN: So it's Hartmann's with 3 per cent dextrose
7 added?
8 A. Yes. I hope I'm right in saying 3 per cent, but there's
9 dextrose added to it, yes.
10 THE CHAIRMAN: Okay.
11 MR WOLFE: What do you think you have learnt as a result of
12 Raychel's death?
13 A. Certainly in regard to fluid management and the risks of
14 hyponatraemia and the dangers of hyponatraemia occurring
15 and the importance of electrolyte checks.
16 Q. There was a meeting with Raychel's family that took
17 place in September 2001.
18 A. Yes.
19 Q. Were you aware that that meeting was taking place?
20 A. I was aware the meeting took place. I don't think
21 I knew about it beforehand.
22 Q. You weren't invited to attend?
23 A. No, I wasn't invited to attend that meeting.
24 Q. Is there anything else you wish to say, Ms Patterson,
25 before we finish your evidence?

1 A. No, I don't think so.
2 THE CHAIRMAN: Can I just ask you one more
3 question: Altnagelvin Hospital very quickly changed its
4 own practices, but a year or two later the department
5 issued hyponatraemia guidelines. Did you learn anything
6 from those guidelines which you hadn't already picked up
7 from Altnagelvin's internal improvements in its
8 procedures? And can you remember when the guidelines
9 came out -- well, first of all, do you remember the
10 guidelines coming out?
11 A. Yes.
12 THE CHAIRMAN: Were you trained in them when they came out?
13 A. I was made aware of them, yes. Dr Geoff Nesbitt had
14 a training session.
15 THE CHAIRMAN: Right. And you went to that?
16 A. I wasn't able to attend that, but I got feedback from
17 that.
18 THE CHAIRMAN: Did that add to anything which you'd already
19 learnt?
20 A. No. As far as I can recall, the changes had been in
21 place in Altnagelvin prior to the guidelines.
22 THE CHAIRMAN: So in a way, because of the disaster with
23 Raychel, Altnagelvin was the first hospital to put
24 things right?
25 A. Yes.

1 THE CHAIRMAN: And then the guidelines came out to be spread
2 around Northern Ireland?
3 A. Yes.
4 THE CHAIRMAN: Okay. Thank you.
5 MR WOLFE: Sir, I have no further questions, but I'll just
6 look around the room --
7 MR QUINN: I have just one question I want to refer to.
8 I wonder could we have up on screen WS048/1? Page
9 number 4, please. I just want to read out and ask
10 a question through yourself, sir. The second paragraph:
11 "However, when walking through the main ward her dad
12 gave me a vomit bowl with a small coffee-ground vomit.
13 I reported this to the nursing staff caring for Raychel
14 that night. At 12 midnight, I reset the IV pump and
15 checked her IV site. If I had seen anything to concern
16 me at that stage, I would have mentioned it to the
17 nursing staff caring for Raychel."
18 I just want to ask: was there nothing that the nurse
19 saw that would concern her at that stage that would have
20 caused her to make any sort of report to the nursing
21 staff? I'm aware of the word "concern" because -- I've
22 pointed this out to the inquiry before -- there seems to
23 be a theme running through this inquiry that the
24 nurses -- none of them -- have anything to concern them
25 about Raychel, and I just want to ask this witness: was

1 there nothing at all that would have concerned her given
2 what I have just read out about the coffee-ground vomit
3 and the points you have made, sir, that is that there's
4 already an entry on the record about "vomiting coffee
5 grounds" and "3x vomiting". Why would you say there's
6 nothing to concern her?
7 THE CHAIRMAN: If I ask you maybe the same question. What
8 would it have taken to concern you, Ms Patterson, at
9 11 o'clock or 12 o'clock?
10 A. Well, she vomited at 11 o'clock and that is when
11 I reported that vomit.
12 THE CHAIRMAN: Right, so you did mention that to the nursing
13 staff.
14 A. Yes.
15 THE CHAIRMAN: So it's at midnight then.
16 A. It's at midnight. If Raychel hadn't been settled at
17 that time of the night, that would have caused me
18 concern.
19 THE CHAIRMAN: Okay. I think that's as far as we'll take
20 it, Mr Quinn.
21 Mr Lavery, have you anything from the Trust's
22 perspective? Mr Campbell, have you anything?
23 Ms Patterson, that's the end of your evidence.
24 Thank you very much for coming today and helping us.
25 You're now free to leave.

1 (The witness withdrew)
2 MR WOLFE: Sir, the next witness we have planned for today
3 is Ms Fiona Bryce.
4 MS FIONA BRYCE (called)
5 Questions from MR WOLFE
6 MR WOLFE: Good afternoon, Mrs Bryce. Could I start by
7 asking you about the witness statements that you've so
8 far provided to the inquiry? As I understand it,
9 you have provided a witness statement of 30 June 2005 --
10 A. That's correct.
11 Q. -- and a second witness statement on 22 June 2012.
12 A. That's correct.
13 Q. Would you care to adopt those witness statements as part
14 of your evidence to the inquiry?
15 A. That's correct.
16 THE CHAIRMAN: Do you understand what that means? That
17 means we'll take those statements as the starting point
18 for your oral evidence and there's nothing in them that
19 you want to correct or change at this point?
20 A. No.
21 THE CHAIRMAN: Okay, thank you. Some witnesses have, since
22 making their written statements, come across other
23 information which has led them to say, "I've got a time
24 wrong", or something like that, but you're okay with
25 your statement as it stands?

1 A. Yes.
2 THE CHAIRMAN: Thank you.
3 MR WOLFE: It is the case, Mrs Bryce, that in terms of
4 putting your recollections in writing, you have only
5 ever provided witness statements to this inquiry so
6 that, for example, you haven't previously provided
7 a statement to your employer, the Trust, in relation to
8 Raychel's case?
9 A. No, just to the inquiry, the statements that I have
10 provided.
11 Q. And you didn't give evidence at the inquest into
12 Raychel's death?
13 A. No.
14 Q. And you weren't caused to make a statement by the PSNI
15 as part of their investigation?
16 A. No.
17 Q. You're now currently employed as a staff nurse in the
18 paediatric day care unit at Altnagelvin; is that right?
19 A. That's correct.
20 Q. Whereas at the time of Raychel's treatment in the
21 Altnagelvin you were employed as a grade D staff nurse.
22 A. Correct.
23 Q. Perhaps it'd be helpful if we could look at your CV
24 briefly. It's at WS054/1 at page 1. We can see that
25 you qualified as staff nurse in 1980, so that by the

1 time you were caring for Raychel you were 20-and-a-bit
2 years post qualified.
3 A. Yes, I did have time out.
4 Q. Was your training provided in the Royal Belfast Hospital
5 For Sick Children?
6 A. It was.
7 Q. You obtained a qualification as a sick children's nurse;
8 is that correct?
9 A. Correct.
10 Q. After a few months spent working in the Royal, you
11 obtained employment at Altnagelvin in the Special Care
12 Baby Unit --
13 A. Yes.
14 Q. -- where you worked until 1982 before taking a break of
15 service for approximately eight years; is that correct?
16 A. Yes.
17 Q. Then through the 1990s, your service as a nurse was --
18 I don't mean this pejoratively at all, but it was
19 sporadic. You were part-time, sometimes a bank nurse.
20 A. That's right.
21 Q. And in addition, you had some employment -- as
22 I understand it, part-time employment -- as a lecturer.
23 A. Yes. That's correct.
24 Q. In what field were you lecturing?
25 A. It was with the North Western Institute of Higher

1 Education in childcare.
2 Q. Were you lecturing as a nurse professional to trainee
3 nurses?
4 A. No. I was working as just somebody who had experience
5 working with children. I wasn't a qualified teacher or
6 tutor.
7 Q. At or about June 2001, what was your employment
8 commitment in terms of time to Altnagelvin?
9 A. At that time, I had between one and two nights of night
10 duty every week.
11 Q. And in terms of the arrangements that were in place to
12 give you an understanding of how a nurse was supposed to
13 work within the Altnagelvin setting, did you have
14 induction processes or any form of information given to
15 you in terms of how nurses were supposed to conduct
16 themselves?
17 A. When I started, that would have been carried out by
18 whoever was on charge that night, the night when I began
19 my work, but I did do a back-to-nursing course before
20 I went back after my break of service.
21 THE CHAIRMAN: Sorry, when would that have been? Would that
22 have been in 2000?
23 A. I did my back-to-nursing course --
24 THE CHAIRMAN: Or was that 1991 after you --
25 MR WOLFE: It was January --

1 A. I did it in 1991.
2 THE CHAIRMAN: Okay, thank you.
3 MR WOLFE: What did that entail?
4 A. Because I had had a break of service for eight years, it
5 was just a reintroduction into nursing, back into the
6 nursing profession again. It was general.
7 Q. Re-acquainting you with some of the --
8 A. Yes, a reintroduction.
9 Q. Was it clinical reintroduction or, in the sense of
10 nursing, clinical or was it more to do with professional
11 obligations and what have you?
12 A. A combination.
13 Q. Was that specifically in the field of paediatric
14 nursing?
15 A. Yes. Well, bachelor's of course wasn't just
16 specifically to paediatrics, but I was a paediatric
17 nurse during that course.
18 Q. By June 2001, to what extent had you gained experience
19 with regard to the needs of children who had gone
20 through surgery or who were about to go through surgery?
21 A. Well, I had been working -- following the
22 back-to-nursing course, I had been working fairly
23 consistently, every two to three -- usually two nights
24 a week, apart from a couple of months in the summertime.
25 So I had been working on the ward for a fair bit of time

1 by the time of 2001 and I had a fair bit of experience.
2 Q. Presumably, given how common appendix problems are for
3 children, you had nursed children who had undergone
4 appendicectomy.
5 A. Correct.
6 Q. And with such children, there obviously isn't an
7 identical case, one after the other, every case is
8 different, but generally speaking, in the absence of
9 intraoperative problems, how would you expect a child to
10 progress after surgery?
11 A. To recover?
12 Q. To recover to the point at which they might be
13 discharged from hospital. What is a typical, if there
14 is such a thing, post-operative phase?
15 A. Well, every child is different, but we would -- my
16 experience in working, they would have recovered
17 extremely well, having had surgery, and would be
18 discharged within a day or two, and with further
19 recovery at home.
20 Q. So in a case without problems, it would be surgery,
21 you'd perhaps expect in many cases, perhaps, some
22 element of post-operative vomiting?
23 A. Absolutely, yes. That was fairly common.
24 Q. Yes. Relatively easily managed?
25 A. Yes.

1 Q. Using anti-emetics or do sometimes cases settle without
2 the need for anti-emetics?
3 A. Yes, yes.
4 Q. Sorry, both?
5 A. Sometimes they need anti-emetics and sometimes they
6 recover, they're fine. It doesn't take anything.
7 Q. And generally, you'd be looking to discharge a patient,
8 all things being equal, in the second post-operative
9 day?
10 A. Probably.
11 Q. So one full day of recovery in hospital and then perhaps
12 released the next day?
13 A. Yes.
14 Q. At that time, and we're using 2001 as our baseline, had
15 you heard of the term hyponatraemia?
16 A. No, I had not.
17 Q. So you hadn't --
18 A. I hadn't heard of the word.
19 Q. You hadn't heard of the word, that's very clear.
20 Had you heard of low sodium as being a problem that
21 had to be nursed or cared for?
22 A. Low sodium ...
23 Q. As opposed to using, if you like, the big technical term
24 hyponatraemia, which you say you hadn't encountered.
25 Low sodium or electrolyte problems.

1 A. Yes.
2 Q. Were they issues that you'd encountered?
3 A. With an electrolyte imbalance, maybe children who had
4 attended hospital with vomiting and diarrhoea, then
5 we would have been very conscious that their electrolyte
6 balance would obviously be put out a bit.
7 THE CHAIRMAN: So how would you treat them?
8 A. How would they have been treated? Well, they would have
9 been put on to intravenous fluids, unable to take
10 anything orally, it would have been on to intravenous.
11 THE CHAIRMAN: What fluid would that have been?
12 A. It would have been Solution No. 18.
13 THE CHAIRMAN: Right. How would their sodium levels be
14 restored?
15 A. Solution No. 18 appeared to be able to restore their
16 sodium okay.
17 THE CHAIRMAN: Okay.
18 MR WOLFE: Had you any experience at that time of other
19 fluids being used to replace gastric losses in cases
20 such as gastroenteritis patients?
21 A. No, Solution No. 18 would have been the fluid of choice
22 at that time.
23 Q. You would be aware of other fluids that were available
24 at that time.
25 A. Yes, I would have been, yes.

1 Q. Would you have been aware of Hartmann's, for example?
2 A. I can't ever recall Hartmann's being used because it's
3 children I work with, so I never recall Hartmann's being
4 used.
5 Q. Would you have been aware of the difference in
6 composition between the two fluids?
7 A. No. I just know there was glucose in the
8 Solution No. 18, or dextrose, and there wasn't that in
9 a lot of the other fluids and children needed glucose.
10 Q. Children who are suffering vomit and diarrhoea need
11 those gastric losses replaced, don't they?
12 A. They do.
13 Q. And you're saying that those gastric losses were
14 replaced by a low-sodium fluid such as Solution No. 18?
15 A. Yes.
16 Q. Could you be mistaken in your recollection, Mrs Bryce?
17 The inquiry has heard evidence that Solution No. 18
18 might be used in combination with a higher sodium fluid
19 in circumstances of gastroenteritis, for example.
20 A. My experience was that Solution No. 18 was an adequate
21 solution for children and, in my experience, it was
22 enough -- I have never experienced a child reacted like
23 Raychel. My experience was that Solution No. 18 was
24 absolutely fine to replace the sodium.
25 THE CHAIRMAN: Can you illustrate this? Again, I'm sure all

1 the cases are different, but for how long might a child
2 have been on IV fluids for vomiting and diarrhoea.
3 A. With gastro children?
4 THE CHAIRMAN: Yes.
5 A. I can't recall how long they would have been on for, no.
6 I can't -- are you talking about how many days?
7 THE CHAIRMAN: Yes.
8 A. No, I can't answer that question.
9 THE CHAIRMAN: Thank you.
10 MR WOLFE: In terms of the education that you had received
11 in qualifying to become a nurse, were you educated
12 in relation to issues around the maintenance of fluid
13 balance in children?
14 A. I can't recall all my training. It's a long time ago,
15 I'm sorry. I can't recall exactly what we would have
16 been taught.
17 Q. Well, can I ask you this: Sally Ramsay, who has provided
18 the inquiry with her views on issues raised by Raychel's
19 case, has said that, at a minimum, she would expect
20 a registered nurse such as yourself to be aware that
21 fluid lost from vomiting, if not replaced intravenously,
22 can result in dehydration and electrolyte imbalance. As
23 a statement of principle, if you like, is she correct or
24 accurate to have that expectation of nurses caring for
25 children?

1 A. Yes. I was aware that if a child was vomiting and had
2 losses, they needed to be replaced, and my understanding
3 was that they were being replaced with the use of the
4 Solution No. 18 to replace the losses.
5 Q. In cases where a child has been vomiting for -- let's
6 call it a prolonged period of time -- what would you say
7 was the nurse's obligation in that situation? What
8 would you expect of yourself if you're witnessing
9 a child vomiting on a prolonged basis?
10 A. Again, I felt that a child -- if a child was on
11 intravenous fluids, that that would be replacing the
12 losses for the child -- enough for the child to recover
13 or to replace the losses.
14 Q. Right. So if a child's vomiting in front of you and has
15 been vomiting several times over a period of a few hours
16 and the child is hooked up to an intravenous drip, you
17 would have no obligations and no concerns in that
18 setting?
19 A. My concerns would be the losses, but when the IV fluids
20 were running, that was compensating, that was making up
21 for their losses, and that was my understanding.
22 Q. Right. So in that setting you wouldn't --
23 THE CHAIRMAN: You'd expect things to come right?
24 A. Yes.
25 THE CHAIRMAN: If you've got a vomiting child on IV fluid,

1 you expect things to come right, how? How will they
2 come right?
3 A. Well, eventually the child would stop vomiting and
4 having the fluids running, it would -- my experience was
5 that as long as there was IV fluids running, they
6 usually ... They always settled down, had been my
7 previous experience.
8 THE CHAIRMAN: Thank you.
9 MR WOLFE: By what? How could they settle down? Is there
10 a need for medical input in this situation? How is the
11 vomiting going to settle down in this situation?
12 A. You would have called a doctor, who would have
13 prescribed an anti-emetic as well to help her settle
14 down, to try and stop the vomiting, to try and get it
15 stopped.
16 Q. Right. Let's look at this again. You have a nurse on
17 duty with a child in receipt of fluids and a child who
18 is vomiting.
19 A. Yes.
20 Q. How do you bring the vomiting to an end?
21 A. You request a doctor, who would come and see the child
22 and assess the child and order what had to be ordered,
23 which could have been an anti-emetic, and do what they
24 had to do. So we would -- it's a doctor's
25 responsibility to make that decision.

1 Q. Is it the nursing responsibility to bring to the
2 doctor's attention all of the vomiting that has taken
3 place?
4 A. Yes, we record it and you would tell the doctor.
5 Q. Have you heard of electrolyte testing?
6 A. Yes.
7 Q. And are you aware of the circumstances in which
8 electrolyte testing might be useful?
9 A. Yes.
10 Q. Were you aware of that in 2001?
11 A. Yes.
12 Q. And what purpose might be served by the use of
13 electrolyte testing?
14 A. Well, that would check the child's electrolyte -- how
15 the child's blood -- electrolytes were in her blood ...
16 Q. Yes. And what if the electrolytes were low? Would
17 you have any understanding of what should be done?
18 A. Absolutely, yes. The doctor would then make a decision
19 or change or decide what to do with the fluid or with
20 the child.
21 Q. Yes. It's your understanding that in all cases like
22 that, the appropriate course would have been to use
23 Solution No. 18?
24 A. In my experience, Solution No. 18 was the fluid of
25 choice.

1 THE CHAIRMAN: It's not something that is your fault, I'm
2 just trying to understand it. Do you understand why it
3 was that the medical patients appear to have had blood
4 testing done about every 24 hours? Do you know what the
5 reason for that was?
6 A. To check their electrolytes.
7 THE CHAIRMAN: So if that's what was being done on Ward 6
8 for the medical patients you were looking after, do you
9 know why it wasn't done for surgical patients?
10 A. No, I don't know why it wasn't done. It was the
11 doctor's decision and their plan.
12 THE CHAIRMAN: You were working there, so you would have
13 seen these two groups of patients being treated rather
14 differently. The medical patients were a big majority,
15 weren't they?
16 A. Yes, they would have been.
17 THE CHAIRMAN: So there's a large majority of the children
18 getting their bloods tested every day to check their
19 electrolytes and the surgical patients, the children
20 who'd been through surgery, weren't having them checked.
21 Did you understand at that time what the rationale was
22 for the distinction between the two sets of patients?
23 A. The medical children were looked after by the medical
24 doctor and the surgical children would looked after by
25 the surgical doctors, and that was how they looked after

1 their children.
2 THE CHAIRMAN: But did it ever occur to you: this is a bit
3 curious, I wonder what the rationale is for that?
4 A. For doing a blood test, they were to check their
5 electrolytes --
6 THE CHAIRMAN: Yes, that's the rationale for doing it for
7 the medical patient children. So do you know what the
8 rationale is for not doing it for the surgical patient
9 children?
10 A. I don't know what the surgical stance was on that, no,
11 why they --
12 THE CHAIRMAN: The surgical stance was that you didn't do
13 it --
14 A. Yes.
15 THE CHAIRMAN: -- in broad terms, right?
16 A. Mm-hm.
17 THE CHAIRMAN: Or you certainly didn't do it automatically
18 in the way it was done for the paediatric patients. But
19 do you know why?
20 A. I don't know why the surgical people didn't, no.
21 I can't answer for the surgical people, no.
22 THE CHAIRMAN: Thank you.
23 MR WOLFE: In 2001, again, Mrs Bryce, were you aware of the
24 concept of maintenance fluid, a child being given
25 a maintenance dose or a maintenance prescription of

1 fluid?
2 A. It wasn't really the -- the maintenance wasn't
3 really ... The terminology just wasn't... No, I
4 wouldn't ... It was IV fluids that they were put on,
5 but whether you called it maintenance ... The
6 terminology wasn't ... No.
7 Q. Were you aware of the phrase or the term "replacement
8 fluids"?
9 A. No.
10 Q. Well, let me approach the problem in this way. You were
11 present when Raychel's preoperative fluids were
12 commenced.
13 A. That's right.
14 Q. And they were commenced pursuant to a prescription
15 issued by a Dr Makar.
16 A. Yes.
17 Q. You checked them off with your nurse colleague --
18 A. Yes.
19 Q. -- Nurse Patterson.
20 A. Yes.
21 Q. And a particular rate of intravenous fluid was
22 prescribed, 80 ml an hour of Solution No. 18.
23 A. Yes.
24 Q. That was designed to maintain Raychel's normal fluid
25 levels before she went to surgery.

1 A. Yes.
2 Q. At that time, Raychel wasn't vomiting; isn't that right?
3 A. That's correct.
4 Q. Raychel had no diarrhoea.
5 A. That's correct.
6 Q. In other words, she had no abnormal gastric losses;
7 isn't that right?
8 A. That's right.
9 Q. So in the language of the time and the current language,
10 she was being given a maintenance regime; isn't that
11 right?
12 A. Yes.
13 Q. The aim of the fluids that she was getting was
14 maintenance.
15 A. Well, she was fasting.
16 Q. She was fasting, yes, so she needed to be maintained at
17 her normal level; isn't that right?
18 A. Yes.
19 Q. Did you understand that that was the aim of the fluid
20 regime that she was on?
21 A. That she was fasting? Raychel was fasting?
22 Q. Yes.
23 A. And would be fasting and would continue to not to have
24 anything oral until she recovered from her surgery.
25 Q. That's right.

1 A. Yes.
2 Q. That is by contrast with a replacement regime. So you
3 might then have a child after surgery such as Raychel,
4 who became quite unwell and vomited several times during
5 the day.
6 A. Mm-hm.
7 Q. In Raychel's case if you'd thought about it at that
8 time, what was replacing those gastric losses?
9 A. Well, in my experience, Solution No. 18 was an adequate
10 fluid used within paediatrics to do that.
11 THE CHAIRMAN: I think you can move on, Mr Wolfe.
12 MR WOLFE: When you think back on that now, Mrs Bryce,
13 do you consider that you were terribly misinformed of
14 these key principles of fluid management?
15 A. Again, in my experience, Solution No. 18 had been always
16 a suitable fluid to replace children's losses, and that
17 was my experience.
18 Q. Yes. This is starting to become a little like a mantra,
19 Mrs Bryce. Do you understand what I'm saying?
20 A. No.
21 Q. I'm asking you a specific question. When you look back,
22 do you consider yourself to have been misinformed or to
23 have misunderstood these important fluid management
24 issues, given the knowledge that you might have now?
25 A. What I have now, yes. The knowledge that I have now,

1 yes, I can understand what you're saying.
2 Q. And have you received information and instruction since
3 Raychel's death that has improved your knowledge of
4 fluid management?
5 A. Yes.
6 Q. And could you outline what you now know that you didn't
7 know at the time?
8 A. Well, if somebody is vomiting, yes, there would be blood
9 tests taken more frequently to keep -- and that would be
10 the main way of keeping a very close eye on the
11 electrolyte balance.
12 Q. Yes.
13 A. And the fluids have been changed in Altnagelvin.
14 Q. Yes. Let me bring you to 7 June 2001. You came on duty
15 at approximately 7.45 in the evening; is that correct?
16 A. That's correct.
17 Q. And you were part of a nursing team comprising
18 Patterson, Noble and Hewitt --
19 A. Yes.
20 Q. -- albeit, as the inquiry understands it, Nurse Hewitt
21 was working mainly in the infant unit; is that your
22 recollection?
23 A. I can't remember. I really can't recollect that.
24 I don't know.
25 Q. And you worked throughout that night and came off duty

1 at about 8 o'clock in the morning; is that correct?
2 A. That's correct.
3 Q. When Raychel was admitted on to Ward 6, were you advised
4 of the reason for her admission?
5 A. We probably -- yes, we probably were. We knew she was
6 a child who was coming in with abdominal pain.
7 Q. You carried out some initial observations with regards
8 to Raychel; is that right?
9 A. I did.
10 Q. And you checked the preoperative fluids with Staff
11 Nurse Patterson, as we've already outlined.
12 A. I did.
13 Q. Did you have any dealings with Raychel's mother or
14 father during the evening?
15 A. Not that I can recall -- apart from I did take her down
16 to theatre. I was with her mummy when I took her down
17 to theatre.
18 Q. Yes, of course. You weighed Raychel.
19 A. I did.
20 Q. As we understand it, Nurse Patterson was the named nurse
21 and she composed the episodic care plan. I don't intend
22 taking you over that in any great detail, but can I ask
23 you this: did you contribute at all to the composition
24 of the episodic care plan?
25 A. No.

1 Q. In terms of that plan, as the inquiry has now learnt,
2 it's generally written up in arrears, if you like:
3 information is compiled on it at the end of a shift, so
4 it's looking back in time over the period of the
5 previous 8 or 10 hours and recording relevant
6 information with regard to a patient's health during
7 that period.
8 A. Yes.
9 Q. The particular care plan that was developed for Raychel
10 didn't mention post-operative nausea or vomiting.
11 Is that something you would have known at the time?
12 Would you have appreciated that that was not included
13 in the plan?
14 A. Probably not. Probably not, no.
15 Q. Should it have been included in the plan? Or to put it
16 another way: would it have been common to include it
17 in the plan before surgery?
18 A. It wasn't a problem before surgery.
19 Q. That's right.
20 A. Some children may not vomit.
21 Q. Can I take from your answer then that, unless it's
22 a problem at the time, unless vomiting is a problem
23 at the time, you're saying you wouldn't include it in
24 the care plan as a potential problem?
25 A. Probably not, and again, the care plans were a -- they

1 were in the computer and preset to a certain extent.
2 Q. Would you expect then that the plan would be evaluated
3 or revised as different problems arose?
4 A. As the problems ...
5 THE CHAIRMAN: If a problem developed, which wasn't covered
6 in the care plan, would you expect that the care plan
7 would be adapted to include that problem?
8 A. It could be, yes.
9 THE CHAIRMAN: Would that not be the point of a care plan,
10 that the care plan should be adapted?
11 A. Yes.
12 MR WOLFE: And if an issue such as persistent vomiting arose
13 in the post-operative period, would you expect that the
14 nurses caring for the child at that point would be
15 looking at the plan to see if it's adequate for the
16 purposes of addressing the vomiting and inputting into
17 the plan ways of dealing with the vomit, ways of trying
18 to bring the vomit under control? In other words, set
19 out a nursing plan.
20 A. Yes, it could be adapted as time goes on, yes.
21 Q. Is that what you would have expected to have been done
22 at that time in 2001?
23 A. Yes. It also could be recorded on her intake and output
24 because it was output as well.
25 Q. Sorry, are you talking about the fluid balance chart?

1 A. Sorry, I wear hearing aids and the loop system is not
2 kicking in there.
3 THE CHAIRMAN: Let's take a break and we'll try to get that
4 problem sorted out and we'll resume and go on until
5 4.45.
6 A. Thank you.
7 (3.25 pm)
8 (A short break)
9 (3.40 pm)
10 THE CHAIRMAN: I hope everything's back to normal.
11 A. I hear you again.
12 THE CHAIRMAN: Good. Thank you.
13 MR WOLFE: Mrs Bryce, we were looking at some aspects of the
14 care plan. If we could maybe descend a little more
15 detail on that. One of the aspects of the care plan
16 that is of particular interest to the inquiry are those
17 parts which require nurses to observe and record urine
18 output and to monitor and record oral input.
19 A. Mm-hm.
20 Q. Would it have been your expectation that both urine
21 output and oral input would have been recorded on the
22 fluid balance chart in a case such as Raychel's?
23 A. Yes.
24 Q. And taking urine output to start with, is it your
25 expectation that this should have been recorded

1 throughout Raychel's stay as a patient?
2 A. Yes.
3 Q. So every time Raychel went to the toilet, that fact or
4 that episode should have been noted?
5 A. Yes, but mainly we would be looking that she had
6 passed -- the first one would be very important for us.
7 Q. Yes, of course.
8 THE CHAIRMAN: After the first one, would it have mattered
9 to you in June 2001 if there was a subsequent passing of
10 urine or if it was small or large or how many there
11 were?
12 A. We would have recorded, if we were aware, just if she
13 passed -- we didn't actually measure urine, it just --
14 went to the toilet.
15 THE CHAIRMAN: And that would just lead to "PU" being put
16 into the notes?
17 A. Yes.
18 THE CHAIRMAN: But there's a shortage of PU in the notes,
19 which seems to indicate that it wasn't actually being
20 recorded. It wasn't just that the volume wasn't being
21 recorded, the fact that she was passing urine wasn't
22 recorded. Is that what you would have expected
23 in June 2001?
24 A. Ideally, it should have been recorded, yes.
25 THE CHAIRMAN: Right.

1 MR WOLFE: And in terms of oral input, in other words drinks
2 received by the child, should that have been recorded
3 throughout Raychel's stay in hospital?
4 A. Yes. Ideally.
5 Q. When asked about this whole area in your witness
6 statement, you said -- and the reference is 054/2,
7 page 9, we don't need it up on the screen -- that:
8 "As Ward 6 was a very busy ward, nurses relied on
9 parents communicating to them any episodes of urine or
10 episodes of intake of oral fluids."
11 How did that arrangement become established? Were
12 parents told of the need to make reports to nurses or
13 was it the other way around, did nurses approach parents
14 periodically and ask had their child gone to the toilet
15 or had their child had a drink?
16 A. It worked both ways. If we were with the child we could
17 have asked the parents, have they been to the toilet or
18 have they vomited or if the parent was able to come to
19 us as well. Because we did depend on parents a lot
20 because we were - we believed that parents were the
21 right people to provide the care for their child,
22 especially when they were sick. That's when they needed
23 their mummy and daddy.
24 Q. Some evidence that we have heard reflects the view that
25 there was a convenient time each hour, when the

1 intravenous fluids were being checked, when nurses would
2 speak to the parents if they were there and ask them
3 a question about urine or about oral input and would
4 then be in a position to record that data on the fluid
5 balance chart, which of course they would be using and
6 probably have in their hands at the point in time when
7 they were checking the intravenous fluids. Would you
8 comment on that for us?
9 A. It could have been that time, but there was no
10 particular -- there was no rule or you know, total rule
11 about that.
12 Q. It was clearly an important matter, was it not, to
13 record this data?
14 A. Yes, it was.
15 Q. How were Raychel's parents given to understand that they
16 should be giving this information to the nurses?
17 A. Well, Raychel was seen every hour and somebody would
18 have been with her every hour and I would imagine
19 we would have been speaking to the parents if they were
20 there to ask them at that time or the parents to also
21 tell us as well. Because usually when we came to
22 a child, we communicated with the child or parents.
23 THE CHAIRMAN: The parents would only tell you if Raychel
24 had passed urine if they were asked. Unless somebody
25 had said to them, "Look, if she does pass urine would

1 you make a point of telling us?"; okay?
2 A. Yes.
3 THE CHAIRMAN: Was it standard procedure to say to parents,
4 "Look, we need to keep a record of your child's fluid
5 balance, so if she does pass urine, would you please
6 make a point of telling us about it"?
7 A. I don't know, I don't think -- I don't know if we did
8 tell Raychel's parents to do that or not. But because
9 we were seeing her every hour, somebody would have been
10 speaking to them.
11 THE CHAIRMAN: Because you saw her every hour, then it was
12 easy for somebody to ask?
13 A. It was, yes.
14 THE CHAIRMAN: Right.
15 MR WOLFE: When Raychel arrived on the ward, and we've
16 discussed the observations that you made of her, you
17 recorded her respirations, blood pressure and pulse.
18 Everything was normal.
19 A. Yes.
20 Q. And the records show that her pain at that time was at
21 quite a low level, it was rated as "0 to 1". Would you
22 agree that that was a low level?
23 A. Yes, definitely, yes.
24 Q. And of course, she had received Cyclimorph at or just
25 before the time she came up to the ward. In terms of

1 the surgery that she was ultimately to undergo at 11.30,
2 can you remember and help us in terms of whether there
3 was a definite plan to undertake surgery for Raychel
4 when she arrived at the ward? In other words, had the
5 plan been set in stone at that point?
6 A. No, I can't recall any plan, no.
7 Q. At the time when you were examining her for these
8 observations, what was the road ahead? As far as you
9 saw it, what did you understand was the plan for
10 Raychel?
11 A. I can't recall exactly. I just know we were admitting
12 her, but I can't recall the plan exactly for Raychel.
13 Q. Did you have any contact with the surgeon, Dr Makar?
14 A. No.
15 Q. Just to be clear, you didn't see him to discuss
16 Raychel's case with him?
17 A. No, not that I can recall.
18 Q. And the surgeon [sic], Dr Gund, did you speak to him?
19 A. No.
20 Q. The inquiry has learnt that --
21 THE CHAIRMAN: Sorry, that's the anaesthetist.
22 MR WOLFE: Did I say the surgeon?
23 THE CHAIRMAN: Yes.
24 MR WOLFE: I beg your pardon.
25 Dr Gund was the anaesthetist who we understand came

1 to the ward to see Raychel somewhere between 10.30 and
2 11 o'clock.
3 A. Mm-hm.
4 Q. You didn't see him?
5 A. No, I don't recall seeing him, no.
6 Q. In terms of the procedure that a surgeon might have to
7 go through before commencing surgery, did you understand
8 at that time that a surgeon of the SHO cadre or rank
9 should be contacting his or her registrar prior to
10 surgery to discuss the plan for a child?
11 A. No, I had -- I wasn't aware who -- or anything about
12 what their plan would have been.
13 Q. Yes, but I'm just talking about, not necessarily about
14 this case, but in general terms. If a junior surgeon
15 such as an SHO was planning surgery on a child, would
16 there be an expectation that he should contact somebody
17 more senior prior to getting on with the surgery itself?
18 A. I can't answer that question because I ...
19 Q. That's outside your knowledge?
20 A. It's outside my remit, yes.
21 THE CHAIRMAN: Can I ask you another one that ties in with
22 it: did you know that there was a caution or
23 a reservation about operating on children after
24 midnight?
25 A. No.

1 MR WOLFE: In terms of the fluids that Raychel obtained
2 before her operation, that's something that you had some
3 direct involvement with.
4 A. Yes.
5 Q. If I could put up on the screen, please: 020-021-040.
6 This is the prescription in respect of Raychel's fluids
7 that was signed by the prescriber, Dr Makar. Do you see
8 that in the third last column?
9 A. Sorry, that's?
10 Q. In the third last column as you go from left to right,
11 Dr Makar has signed it.
12 A. Yes.
13 Q. And then your signature appears as the last entry on the
14 far right-hand side of that page.
15 A. That's correct.
16 Q. Prior to getting to the stage whereby you were checking
17 off these fluids at the time they were erected for
18 Raychel, there appears to have been something of an
19 interaction between the nurses and the surgeon who had
20 originally prescribed Hartmann's for Raychel. Were you
21 aware of that on the evening of 7 June 2001?
22 A. I can't recall anything about that prescription.
23 Q. The thing that appears to have happened is that the
24 doctor wrote a prescription for Hartmann's and Staff
25 Nurse Noble went to speak to the doctor and, arising out

1 of that conversation, the fluids were changed to
2 Solution No. 18. It has been explained to the inquiry
3 that Staff Nurse Noble made that approach because
4 a prescription for Hartmann's was not in keeping with
5 standard or normal ward practice at that time. Does
6 that assist you in any way? Were you aware of that as
7 a standard ward practice?
8 A. Yes, I was aware that Solution No. 18, yes, was standard
9 ward practice, yes.
10 Q. And if a doctor wrote a prescription for something other
11 than the standard ward fluid, a nurse would see it as
12 her responsibility to challenge the doctor in respect of
13 that?
14 A. You would probably have questioned it, yes.
15 Q. "Challenge" is probably the wrong word, but questioned
16 the doctor.
17 A. Yes.
18 Q. Is that something you've had to do in the past?
19 A. I don't recall having to question a doctor on
20 prescriptions. I don't recall any time when I had to.
21 Q. In terms of this ward practice that Solution No. 18
22 would be used so far as possible, do you know where that
23 practice emerged from or came from?
24 A. No, I can't answer that question.
25 Q. How did you become aware of it?

1 A. It was just from working on the ward and being made
2 aware of it, just working, although it was a solution
3 we would have used also when I was working in Belfast
4 when I was training, we'd have used a lot --
5 Solution No. 18 was used a lot.
6 Q. Was Hartmann's available on the ward?
7 A. I'm not sure. I can't comment on that.
8 Q. Is that because you don't know?
9 A. No, I don't know.
10 Q. When you were erecting the fluids with Staff
11 Nurse Patterson, is it fair to say that you were simply
12 checking for, if you like, administrative accuracy, that
13 the fluids that you were putting up were matching
14 what was written on paper?
15 A. Yes.
16 Q. That was the nursing responsibility?
17 A. Yes.
18 Q. And the nursing task that you were performing?
19 A. Correct.
20 Q. In terms of the rate of fluid that was prescribed,
21 is that something that you gave any consideration to?
22 A. No, that was not a nurse's responsibility.
23 Q. We'll come back to that in a moment in the context of
24 the post-operative fluids, but you didn't see it as
25 a nursing responsibility?

1 A. We put up what was prescribed.
2 Q. Yes. This prescription, which was written in the
3 preoperative period, was, it appears, taken down off the
4 shelf again and used to effect Raychel's post-operative
5 fluids. That was what was followed post-operatively.
6 A. Yes.
7 Q. Did you understand that this was a prescription that was
8 to have effect post-operatively at the time you were
9 erecting the fluids preoperatively?
10 A. Well, that was the practice at the time, that the
11 post-operative fluids, unless requested to be different
12 by the doctor ... But the preoperative fluids were
13 continued post-operatively.
14 Q. You brought Raychel to theatre; is that correct?
15 A. I did.
16 Q. Can you remember her condition and demeanour as she was
17 brought to theatre? What form was she in?
18 A. I can't recall exactly how she was, but I just know that
19 she was a bit nervous, as anybody would be going into
20 theatre. She was accompanied by her mummy with her and
21 stayed with her while she was -- as long as she was
22 able.
23 THE CHAIRMAN: Was she in pain?
24 A. Was she in pain? Not -- well, not that I can ... She
25 wasn't crying in pain as far as I recall.

1 MR WOLFE: When you brought Raychel down to theatre, would
2 you have conversed with the theatre nurse? I understand
3 that Staff Nurse McGrath was on duty. There was also
4 a Staff Nurse Ayton.
5 A. I can't recall who was in theatre or in the anaesthetic
6 room, the theatre room. There was a nurse -- I was
7 handing over to a nurse, but I don't recall who it was.
8 Q. At that time, would it have been your habit to seek out
9 information from those who were going to be attending at
10 the operation just how long the child was going to be
11 in the theatre before she would get back to the ward?
12 A. I don't recall any conversation, I don't know. I can't
13 recall whether I asked --
14 Q. No, no, my question was a different one. Would it have
15 been your habit to raise that kind of query?
16 A. I don't think so.
17 Q. The parents of Raychel believe that you were the nurse
18 who advised Mrs Ferguson that Raychel would be back
19 in the ward in an hour or so.
20 MR QUINN: Just to clarify that, Mr Chairman: I took
21 instructions at lunchtime on this issue. The parents
22 will say that it is this witness who advised them.
23 They're clear about that. They've now been able to see
24 her in the witness box and they also say that it was
25 actually said to both because Mr Ferguson was in the

1 corridor when it was asked: as her mother was going down
2 to theatre, he was in the corridor and, as they passed,
3 he asked.
4 THE CHAIRMAN: It was as Raychel was being taken to theatre?
5 MR QUINN: Yes, in the corridor and Mr Ferguson also heard
6 the enquiry.
7 THE CHAIRMAN: Thank you.
8 MR WOLFE: If I could just ask, through you, sir, Mr Quinn:
9 is the point that the conversation was between this
10 witness and the mother, but the father overheard?
11 MR QUINN: Yes, the father overheard.
12 MR WOLFE: You've heard that exchange, Mrs Bryce.
13 A. Mm-hm.
14 Q. Let me crystallise it for you. You gave information to
15 the mother with the father being present or not far
16 away, which indicated that Raychel would be back on the
17 ward in an hour. On one level that would be quite
18 a natural exchange to take place at that point.
19 Obviously, you have an anxious set of parents who are
20 bringing their daughter into theatre for the first time
21 in her life and they'll want to know, as I say not
22 unnaturally, when she would be back into their care.
23 And it would be a natural question to ask of the nurse
24 delivering the child to the theatre. Is that something
25 you could have said to them?

1 A. An hour? Very unlikely that I would have told them that
2 the child would be back in an hour. Most surgeries
3 would never had lasted just an hour; it would be at
4 least an hour and a half, two hours. Sometimes what
5 I would have advised a parent is to go and have a cup of
6 tea and maybe come back to the ward in an hour or
7 whenever and wait on the ward then for their child to
8 return because we would have brought them back to the
9 ward, the parents didn't go to the recovery room.
10 Q. Yes. It's probably a conversation that is imbued with
11 a lot more meaning now than perhaps was intended at the
12 time. Just to get to this again: you might have
13 mentioned an hour in the context of going for a break
14 and coming back to the ward and keeping an ear out for
15 the child coming back?
16 A. I know I would have told some parents to do that, to go
17 and have a cup of tea while they were waiting.
18 THE CHAIRMAN: I can see how this ends up becoming
19 a misunderstanding because you might say to them, "Go
20 off and get a cup of tea and you don't need to come back
21 for at least an hour because Raychel won't be back
22 before then"; is that the sort of thing?
23 A. Yes, just wait on the ward.
24 THE CHAIRMAN: Raychel's parents -- or any other parents --
25 might understand that to mean she might be back within

1 an hour.
2 A. Maybe they did think that. My interpretation is just to
3 go and have a cup of tea, come back, and wait at her
4 bedside until she came back again.
5 MR WOLFE: Could you assist the inquiry with this? When
6 a child is in theatre, the operation then finishes and
7 the child goes into the recovery area, at that time --
8 or indeed now -- is there any process for keeping
9 parents informed of what is going on, what stage the
10 child is at in terms of the process?
11 A. I'm not aware, but I know at the time, if they had
12 voiced a concern, we would have just made a telephone
13 call to check what stage she was at. But I was unaware
14 of any parental anxiety regarding Raychel coming back.
15 THE CHAIRMAN: I can see how that could happen, I can see
16 why you say that. It also depends on where you are
17 because I get the picture that you and your colleagues
18 are moving around regularly on the night shift, looking
19 after children. It's a very big L-shaped ward, isn't
20 it?
21 A. Fairly big, yes.
22 THE CHAIRMAN: So it wouldn't necessarily be all that easy
23 for the parents to get your attention and ask you to
24 make that call, would it?
25 A. Well, we're always on the floor, you know, and the ward

1 is -- there's a corridor down the middle of it and the
2 rooms are off the corridor, so there'd be somebody about
3 at some stage.
4 THE CHAIRMAN: Okay, thank you.
5 MR WOLFE: You obviously remained on duty for the rest of
6 the night, but the observation sheets and what have you
7 show that you didn't have any further involvement with
8 her care.
9 A. No, that's correct.
10 Q. Nevertheless, as the nurse who brought her to theatre,
11 did you then keep an ear out or an ear open for her
12 coming back and learning what had happened at theatre?
13 A. Well, because on night duty there's only maybe three of
14 us on, so we would have all been aware of what was going
15 on, yes.
16 Q. Were you made aware of how well the operation went?
17 A. Made aware as in?
18 Q. Well, was it a straightforward operation, what state was
19 her appendix in.
20 A. I can't recall exactly, but I probably was.
21 Q. Clearly, the inquiry knows that it was Staff
22 Nurse Patterson who recommenced the fluids after
23 theatre. Earlier when I asked you about this, you said
24 that the practice was that you'd recommence fluids of
25 the same type and the same rate unless the doctor issued

1 a further prescription. The doctor you refer to is who,
2 is it the doctor in theatre?
3 A. Yes, the surgical team, because they were looking after
4 her.
5 Q. In your experience at that time, had you come across the
6 surgical team -- presumably the anaesthetist or the
7 surgeon; is that what you mean by surgical team?
8 A. Yes, whoever was -- did I meet them that ...
9 Q. Had you any experience of the surgical team writing
10 a prescription for the post-operative period?
11 A. Not -- it wasn't common practice, I don't think, with
12 them, in my experience.
13 Q. So the more regular practice was that fluids would be
14 recommenced, as you've described, as per the
15 preoperative period?
16 A. Yes.
17 Q. And are you saying wholly exceptional or exceptional
18 that a new prescription would be written?
19 A. I can't recall a new prescription being written.
20 Q. But you were aware of a rule or a rule of practice that,
21 if a new prescription was written, that that was
22 a situation in which nurses would consider not using
23 Solution No. 18?
24 A. If she came back with a --
25 Q. Yes. As I understand your evidence -- and clarify for

1 me if I get it wrong -- the standard practice was that
2 the preoperative prescription was applied
3 post-operatively --
4 A. Yes.
5 Q. -- but there would be situations where you wouldn't do
6 that if the surgical team wrote a prescription for the
7 post-operative period?
8 A. If they did.
9 Q. Yes. And are you saying that you had some experience of
10 that being done?
11 A. No, I didn't have any experience of that being done.
12 Q. Right. The inquiry has heard that if that was done and
13 if the anaesthetist, for example, had written up
14 Hartmann's for the post-operative period, nurses were
15 expected to question the anaesthetist about that
16 because, if you like, the standard approach was to use
17 Solution No. 18. Can you assist us with that? Is that
18 what you were expected to do in the exceptional
19 situation where a different prescription was written?
20 A. We probably would have just questioned the reason for
21 it.
22 Q. The anaesthetists who cared for Raychel during her
23 surgery had wanted to write a prescription for
24 Hartmann's, but he was, without going into the minutiae
25 of it, discouraged from doing so and put a line through

1 the prescription. But he advised the inquiry that
2 he had anticipated that in doing that, Raychel's fluids
3 would be examined on the ward in that nurses would bring
4 a doctor to Raychel to assess her post-operative fluid
5 needs. Was that a practice that you were familiar with?
6 A. No.
7 Q. So the situation was that this prescription which had
8 been written for a preoperative situation was taken down
9 off the shelf and used again and Raychel's fluid needs
10 were not freshly assessed; is that the way it worked?
11 A. Yes, it appeared to be, yes.
12 Q. That's not the current situation and hasn't been the
13 situation since that time; is that right?
14 A. No, it's changed.
15 Q. Was it recognised that there were problems with that
16 situation or that practice?
17 A. After 2001?
18 Q. Yes.
19 A. Yes.
20 THE CHAIRMAN: Sorry, what did you understand the problem to
21 be?
22 A. Regarding the fluids?
23 THE CHAIRMAN: Well, did you understand the problem to be
24 about resuming post-operative fluids on the basis of the
25 same prescription as the preoperative fluids?

1 A. After 2001, it was recognised that Solution No. 18
2 wasn't suitable --
3 THE CHAIRMAN: Right.
4 A. -- for post-operative or preoperative. So ...
5 THE CHAIRMAN: But is there not more to it than whether it's
6 Solution No. 18? Is there not more to it than that,
7 that you don't use a preoperative prescription, whatever
8 it is, to automatically become the post-operative
9 prescription?
10 A. Is it that her fluid needs -- they should be looked at
11 again?
12 THE CHAIRMAN: Yes.
13 A. I think that was after that as well -- yes, after 2001.
14 Yes, it wasn't right to use the same thing.
15 MR WOLFE: Dr Makar, who gave evidence about the
16 prescription he wrote, expressed the view that really
17 how could he be writing a prescription to cover the
18 post-operative period without knowing what the issues
19 were in terms of Raychel's condition after her
20 operation? You'd have to wait until the operation
21 happened before he could write a proper prescription.
22 Looking at that issue, one of the inquiry's experts,
23 Simon Haynes, has said that fluids for the
24 post-operative period were applied on the basis of
25 a custom and practice rather than with regard to an

1 assessment of the patient's actual needs. Would you
2 agree with Dr Haynes that that is what had happened in
3 those days, that this was a custom and practice rather
4 than an actual examination of Raychel's post-operative
5 needs?
6 A. Yes, but as nurses, we don't have any decision on what
7 fluids go up, either preoperatively or post-operatively.
8 It's not within our remit to be doing that.
9 Q. In terms of this practice that you say was widespread
10 and how it would only be in exceptional situations where
11 an anaesthetist would write a new prescription, was this
12 practice well-known in your estimation? Would the
13 surgeons have been aware of it?
14 A. Aware that the preoperative fluids were used
15 post-operatively?
16 Q. Yes.
17 A. I would have thought so, but I don't -- it was the
18 surgical team who would have written up the fluids for
19 children --
20 Q. Yes.
21 A. -- the surgical children.
22 Q. Yes. In terms of the rate of fluid, the inquiry has
23 expert evidence from Mr Orr, Mr Foster, and indeed
24 there's a report from Susan Chapman, which the Police
25 Service for Northern Ireland obtained back in 2005. All

1 of those people seem to be of the view that
2 post-operatively the rate of administration of fluids
3 should be reduced to perhaps 20 per cent below the
4 normal maintenance rate. And indeed, Ms Chapman has
5 suggested that nurses should be aware of how to
6 calculate the rate of fluid being administered to
7 a patient.
8 Can I ask you about that? It seems to have been
9 your experience that the rate was never reduced
10 post-operatively; is that right?
11 A. That seems to be the case, yes.
12 Q. Would you as a nurse have been able to calculate the
13 rate of fluid applicable to a child if you knew her
14 weight, for example?
15 A. In 2001, no.
16 Q. There are various formulas for calculating a rate. One
17 is called the Holliday-Segar formula. Is that something
18 you ever --
19 A. I wasn't aware of that, no.
20 Q. The fluids having been commenced again post-operatively,
21 what was your understanding of the arrangement for
22 reviewing those fluids? When was a review of the
23 post-operative fluids bound to take place?
24 A. I would have believed when there was a doctor's round
25 done in the morning.

1 Q. So you'd have the surgical ward round?
2 A. Mm-hm.
3 Q. And, as part of that, in your experience, are you saying
4 that the doctor should be evaluating the fluids in place
5 at that time and making any changes that were necessary?
6 A. Well, I would have believed that, although my work
7 at the time was all night duty and therefore I wasn't --
8 I didn't have any input into ward rounds because they
9 didn't take place during the night.
10 Q. Is your understanding then that, nevertheless, it was
11 a matter for the surgical team --
12 A. Yes.
13 Q. -- the doctors --
14 A. Yes.
15 Q. -- to make the change if necessary?
16 A. Yes.
17 THE CHAIRMAN: Can I ask you, this expectation, when you had
18 worked previously as a bank nurse for some years on and
19 off, had you worked some days?
20 A. No.
21 THE CHAIRMAN: So when was the last time that you had worked
22 days? Is that back in the late 1980s?
23 A. Yes. Whenever I ... Yes, in 80/81.
24 THE CHAIRMAN: Correct me if this is wrong, but was it your
25 experience that the ward round, the morning ward round,

1 involves a review of everything, particularly if it
2 comes after surgery, and "everything" would include
3 a review of the fluids?
4 A. Yes, I'd have believed that.
5 MR WOLFE: In terms of the conduct of the ward round, you
6 obviously didn't have direct exposure to it because you
7 typically worked nights.
8 A. That's right.
9 Q. Had you any understanding in terms of personnel of who
10 should be attending the ward round for a post-surgical
11 patient?
12 A. I can't comment. I don't know. I can't make a comment
13 on that.
14 Q. You went off duty at about 8 o'clock in the morning.
15 A. I did, yes.
16 Q. Did you attend the ward round [sic] for the nurses
17 coming on duty?
18 THE CHAIRMAN: The handover?
19 MR WOLFE: The nursing handover.
20 A. Did I attend it? No, not in the morning, no.
21 Q. Our understanding is that it was given by Nurse Noble --
22 A. That's right.
23 Q. -- and that she would be communicating to the new
24 nurses, in relation to each child on the ward, their
25 condition and any particular issues relating to them.

1 We know from the fluid balance chart -- if we could have
2 it up on screen, please, 020-018-037 -- that in that
3 time zone between 8 o'clock and 9 o'clock in the
4 morning, a vomit is identified as having occurred.
5 A. Yes.
6 Q. Do you know who recorded that?
7 A. I don't. I don't recognise the writing, no.
8 THE CHAIRMAN: You're confirming that it's not your writing,
9 are you?
10 A. No, it's not my writing.
11 MR WOLFE: As you went off duty that morning to return that
12 night, Raychel had had a good overnight recovery;
13 is that right?
14 A. Yes, from what I'm aware. I didn't see Raychel much
15 over the night; I was attending to other ward duties.
16 Q. Yes.
17 A. But yes, I believed that she did have.
18 Q. If Raychel had continued on that course, in other words
19 if there hadn't been any of the vomiting that we see
20 illustrated on the document in front of us, is it fair
21 to say that you'd have been expecting her to have been
22 increasingly mobile during the day?
23 A. Yes.
24 Q. To have taken on more oral fluids?
25 A. Yes.

1 Q. For her intravenous fluids to have been run down and
2 eventually stopped during that day?
3 A. Yes.
4 Q. And for her perhaps to be eating later in the day?
5 A. Something light, yes.
6 Q. Yes. Do you mean a snack, in other words, as opposed to
7 a full dinner?
8 A. Oh yes. Toast or something light.
9 Q. Right. So all things being equal, you'd have expected
10 to come back to work that night to find Raychel in that
11 condition?
12 A. Well, every child's different.
13 Q. Of course.
14 THE CHAIRMAN: But this operation turned out to be for
15 a mildly congested or mildly inflamed appendix. So it
16 hadn't turned out to be a particularly nasty appendix
17 operation, which I'm sure some can be.
18 A. Mm-hm.
19 THE CHAIRMAN: So even though other things can happen, if
20 a 9-year-old girl has her mildly inflamed appendix
21 removed, that should boost her recovery, shouldn't it?
22 It should make her recover easier because the
23 operation's less severe.
24 A. Yes.
25 THE CHAIRMAN: Right.

1 MR WOLFE: But plainly, Raychel didn't continue on that
2 smooth recovery path, as this chart illustrates for us;
3 isn't that right?
4 A. Yes. According to that, yes.
5 Q. We can see that by lunchtime she had had three vomits.
6 Do you see that: one at 8; one recorded in the time slot
7 at 10, which we understand being at about 10.25,
8 recorded as a large vomit; and then another one at
9 1 o'clock. They're the recorded vomits and the inquiry
10 has heard evidence that there might have been other
11 vomits and nausea during that period of time.
12 First of all, can I ask you, the use of the symbol
13 plus, and then a double plus against the word "vomit"
14 or "vomited", how would you interpret that if you were
15 looking at that, not knowing, not having been present,
16 I suppose, when the child had vomited? How would you
17 interpret that?
18 A. I'd assume one plus to be a small, two pluses to be
19 medium and anything large would have been three pluses.
20 Q. It's like a traffic light system, three pluses is the
21 large?
22 A. Yes.
23 Q. And is that interpretation that you've given us taught
24 at Altnagelvin or is it part of a practice that is
25 disseminated to new nurses as they come onto the ward?

1 A. Well, it was quite common that you would have used that.
2 Some people did write "small", "medium" or "large", but
3 the pluses were also used.
4 Q. I know they were used, we can see that. But in terms of
5 defining what is meant by a plus so that there was
6 a common understanding, how was that achieved?
7 A. I don't know how it was achieved.
8 Q. It's just that we've heard various interpretations of
9 that.
10 THE CHAIRMAN: In fact it wasn't achieved because the last
11 witness told us that "vomit plus plus" in her eyes meant
12 large vomit.
13 A. Plus plus meant a large vomit?
14 THE CHAIRMAN: Yes, Ms Patterson.
15 A. I'd consider two pluses to be a medium vomit.
16 THE CHAIRMAN: And somebody else has said two pluses is
17 small to medium, so between three witnesses we have
18 "plus plus" meaning small to medium, medium, and large;
19 right? Thank you.
20 MR WOLFE: Of course, it's important not only to know the
21 number of vomits and how close they are between each
22 other, but it's also important to know volume of vomit,
23 isn't it?
24 A. It is, but it can be difficult. If a child vomited in
25 a bowl it's different, but if they vomit -- it can be

1 unexpected and, if you don't have bowl in front of them,
2 it difficult to judge.
3 Q. You can make the thing even more complex if you don't
4 achieve common and consistent definitions; isn't that
5 right? In any event, you attended a nursing handover
6 at the start of your shift on the evening of 8 June;
7 isn't that right?
8 A. Yes.
9 Q. Can you recall who delivered that handover?
10 A. No, I can't recall, no.
11 Q. Could I have up on the screen, please, 063-032-076?
12 Before we look at this document, the nurse who was
13 caring for Raychel primarily, it seems, during the
14 course of the day was Staff Nurse McAuley, who you might
15 also know as staff Nurse Rice.
16 A. Yes.
17 Q. Did she deliver the handover?
18 A. I can't recall who gave it.
19 Q. Very well. The inquiry again has heard evidence that
20 the person who delivers the handover to the nurses
21 coming on duty would be armed, if you like, with a set
22 of notes, as we can see here in front of us --
23 A. Yes.
24 Q. -- a print off from the episodic care plan.
25 A. Mm-hm.

1 Q. Is that an experience with which you're familiar?
2 A. Yes.
3 Q. Is that how it was done?
4 A. Yes.
5 Q. So self-evidently, the nurse delivering the handover
6 won't know all of the details about each individual
7 patient, but this document is designed to, if you like,
8 fill the information gap.
9 A. Yes.
10 Q. So it's a tool for communication.
11 A. That's correct.
12 Q. If we look at this document, if you could highlight the
13 bottom section from the last line down to the bottom,
14 including the annotation. Thank you. You can see there
15 an entry at 5 o'clock made by Staff Nurse Michaela
16 McAuley.
17 A. Yes.
18 Q. She has entered the following:
19 "Observations appear satisfactory."
20 When the term "observations" is used, Mrs Bryce,
21 is that a reference to pulse, temperature and
22 respirations?
23 A. Yes, I think so, yes.
24 Q. "Continues on PR Flagyl [the antibiotic]."
25 And then the reader would have been told that she:

1 "Vomit x3 that morning, but tolerating small amounts
2 of water this evening."
3 That was what was written at 5 o'clock, and you've
4 already had an opportunity to look at the fluid balance
5 chart there. We can put it back on the screen if you
6 wish. But plainly, there was vomiting at 3 o'clock.
7 And it would appear that that was the trigger for
8 bringing a surgeon, a junior surgeon, to look at Raychel
9 and to prescribe an anti-emetic.
10 A. Mm-hm.
11 Q. If there was vomiting in the afternoon, you would expect
12 to see that recorded in the episodic care plan, wouldn't
13 you, at the time of the 5 o'clock entry?
14 A. Okay, yes.
15 Q. And moreover, the fact that vomiting isn't mentioned at
16 5 o'clock, but it's recorded that she's tolerating small
17 amounts of water, does that give out the message that
18 the vomiting has settled?
19 A. At that stage?
20 Q. Yes, at 5 o'clock.
21 A. It could -- it could -- "tolerating small amounts of
22 water" could mean that the vomit is subsiding anyway.
23 Q. Is that they way you'd have read it if you'd read it
24 at the time?
25 A. When she was tolerating water?

1 Q. Yes.
2 A. But sometimes you can tolerate water and still vomit,
3 even having had a little bit of water. They could still
4 vomit again after that. It's possible.
5 Q. If a child is tolerating oral fluids, would that be
6 a trigger for considering whether you could reduce
7 intravenous fluids?
8 A. If it was sips, then you would be waiting until they
9 would be tolerating ...
10 Q. A greater ...
11 A. A bit, a bit more than a sip though.
12 Q. Then the note is annotated at some point later as you
13 can see at the bottom:
14 "Vomiting this PM and IV Zofran given with fair
15 effect."
16 Can you remember being told that at the handover?
17 A. I can't remember, I can't remember -- I can't recall
18 what we were actually told on that night.
19 THE CHAIRMAN: Does that note give you a clear picture of
20 what Raychel's condition has been throughout the
21 afternoon and early evening?
22 A. That is what we would be given as our handover, yes.
23 THE CHAIRMAN: What you would want is a clear picture of how
24 Raychel has been --
25 A. Yes.

1 THE CHAIRMAN: -- in the late afternoon and early evening in
2 the hours before you come on duty.
3 A. Yes.
4 THE CHAIRMAN: Does that note give you it? If you add to
5 the typed bit the handwritten bit, does that give you
6 a clear picture?
7 A. It probably does, yes.
8 THE CHAIRMAN: Do you see on the 5 o'clock bit that's typed,
9 when it says, "Tolerating small amounts of water this
10 evening", what do you regard as the evening?
11 A. Evening?
12 THE CHAIRMAN: Do you regard 3 o'clock 4, o'clock as the
13 evening, or do you regard that as the afternoon?
14 A. I would have said that was the afternoon.
15 THE CHAIRMAN: Yes.
16 A. But that's what I would have said.
17 THE CHAIRMAN: So the bit that's typed up at 5 o'clock
18 somehow says she's:
19 "Tolerating small amounts of water this evening."
20 A. Yes.
21 THE CHAIRMAN: And the next bit which is handwritten says,
22 "Vomiting this PM". So the PM could be anything from
23 the afternoon to the early evening, couldn't it? That
24 could be 2 pm or 7 pm.
25 A. With no time on it, yes, we wouldn't know.

1 THE CHAIRMAN: Exactly, yes. Okay.
2 MR WOLFE: In terms of the handover, would it typically be
3 by reference to a document like this? In other words,
4 as nurses sitting in the office, presumably, receiving
5 this handover, the fluid balance chart for example
6 wouldn't be pulled out and shown to you?
7 A. No, not while --
8 Q. So it is delivered in summary?
9 A. -- getting handover, no.
10 Q. Before we go on to look at how Raychel progressed and
11 your knowledge of how she progressed that evening, we
12 know that earlier in the day there had been three vomits
13 by lunchtime. If a child is vomiting like that --
14 8 o'clock, 10 o'clock, 1 o'clock -- and one of the
15 vomits is a medium, the other is a large, would you have
16 expected a doctor to have been informed?
17 A. I wasn't on day duty, so I didn't see Raychel during the
18 day, so I don't know how she was otherwise.
19 Q. Let's remove it from the Raychel specific, if we can,
20 and can you help us in this way: if a child's vomiting
21 heavily, one heavy or large vomit, another medium vomit,
22 and they're all within a period of four or five hours,
23 is that is a matter that a nurse should be bringing to
24 the attention of a doctor?
25 A. Yes, she probably would, yes.

1 Q. And you'd be bringing it to the attention of the doctor
2 because you'd want to be controlling the vomit?
3 A. Yes.
4 Q. Because vomiting, particularly for a young child, would
5 be distressing?
6 A. Yes.
7 Q. And uncomfortable?
8 A. Yes.
9 Q. Staff Nurse Gilchrist was on duty that night, along with
10 Staff Nurse Noble and yourself. Staff Nurse Patterson
11 had been directed to the infant unit that night.
12 A. Correct.
13 Q. The inquiry has heard from Staff Nurse Noble, who's told
14 us that she was not responsible for carrying out
15 observations that night, she was the nurse in charge.
16 She was responsible, for example, for delivering
17 medication and administering medication to children. So
18 it placed you and Staff Nurse Gilchrist in the role of
19 carrying out observations with children.
20 A. Yes.
21 Q. Does that accord with your memory?
22 A. Yes.
23 Q. In a statement made by Staff Nurse Gilchrist, she can
24 recall that shortly after the handover, Mr Ferguson,
25 that is Raychel's father, asked Staff Nurse Gilchrist to

1 change Raychel's bed because she had vomited on it. And
2 Gilchrist recalls in a statement that you assisted her
3 to change the bed. In fairness, she records in a second
4 statement that in fact it was the auxiliary nurse,
5 Lynch, who assisted her. Can you assist the inquiry in
6 terms of whether you were the nurse who helped Gilchrist
7 in this context or not?
8 A. No, I did not change the bed at that time of night.
9 Q. If we could perhaps have up on screen, WS054/1, page 3.
10 You say in the penultimate paragraph on that page that
11 you came on duty at 7.45, as we've heard. You were
12 dealing with other children on the ward until 12.30 on
13 9 June when you went into room I and noticed Raychel was
14 a little unsettled and you noticed a small amount of
15 vomit on her pyjama top and pillow case.
16 A. That's correct.
17 Q. We'll come to the vomiting perhaps early tomorrow
18 morning, but in terms of you dealing with other children
19 up until that point in time, it's my understanding from
20 what you have said elsewhere and from the statements of
21 other nursing colleagues from that night that you
22 worked as a team.
23 A. That's right.
24 Q. In other words, you didn't have specific responsibility
25 for individual patients --

1 A. That's right.
2 Q. -- that everybody mucked in, to use that expression.
3 A. Correct.
4 Q. So when you say that you were responsible for dealing
5 with other children on the ward, does that imply that
6 you had not been near Raychel to that point on that
7 night?
8 A. That's right, no. I didn't see Raychel until 12.30.
9 Q. Quite apart from not having seen her until 12.30 that
10 night, was there communication between you and the other
11 nurses in terms of Raychel's condition before 12.30 that
12 night?
13 A. Yes. Yes, if there was anything going on -- because
14 there was only three of us on the ward, we were all
15 aware of anything major that was going on and if
16 anything was going on. But I didn't have any reason to
17 mention -- or anything about Raychel in particular.
18 I did know a doctor had come to see her. I was aware of
19 that.
20 THE CHAIRMAN: Sorry, you did know?
21 A. Yes, I did know.
22 THE CHAIRMAN: You did know a doctor had come to see her?
23 A. Yes, I did know.
24 MR WOLFE: Let's start a little before the doctor coming.
25 THE CHAIRMAN: Shall we do this tomorrow morning?

1 MR WOLFE: Yes, we are probably getting a bit deep here.
2 THE CHAIRMAN: Rather than start this point now, I want to
3 stop at 4.45, which leads into the vomit you notice at
4 12.30. I'm going to stop now and we'll resume your
5 evidence tomorrow morning at 10 o'clock and we'll finish
6 your evidence tomorrow morning.
7 MR STITT: Mr Chairman, if I may come back to this question
8 of the patient advocate's note. You had asked me to
9 confirm the Trust position in relation to the accuracy
10 or otherwise of the note.
11 THE CHAIRMAN: Yes.
12 MR STITT: I would confirm that it's accepted as being
13 accurate, save for the fact that it doesn't deal with
14 the introductions and that soft element, as it were.
15 Otherwise, it's accepted.
16 THE CHAIRMAN: Thank you, that's very helpful. Thank you,
17 ladies and gentlemen, tomorrow morning at 10 o'clock.
18 (4.45 pm)
19 (The hearing adjourned until 10.00 am the following day)
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