

Friday, 1 March 2013

1
2 (10.00 am)
3 (Delay in proceedings)
4 (10.10 am)
5 Discussion
6 MR STITT: Mr Chairman, if I may mention a matter arising
7 out of the questioning of Nurse Noble.
8 THE CHAIRMAN: Yes.
9 MR STITT: The witness has been provided with a transcript
10 of the relevant portion, which of course no doubt will
11 be helpful to her, and I anticipate the line of
12 questioning will be mirroring that of Nurse Noble. In
13 anticipation of that, I'm assuming from Mr Wolfe not
14 contradicting what I'm supposing, that that's
15 a reasonable supposition. There is a point which is
16 concerning me and perhaps I can articulate it this way.
17 It's to do with what I'll call the cover-up theory,
18 namely that it was clear to those in June that there
19 were two main problems and that these went on to the
20 attention of the family in September.
21 THE CHAIRMAN: Yes.
22 MR STITT: If I may, in order to make a balanced point, if
23 I could ask that the transcript of Wednesday the 27th,
24 page 178 could be put onto the screen.
25 If you'll bear with me, Mr Chairman, I have to go

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1 indicated earlier, before the extracts which have been
2 provided to the witness, she did say, yes, too much
3 fluid was another problem that was discussed in June.
4 So you quite correctly, sir, asked her to confirm that
5 and she does.
6 THE CHAIRMAN: Right.
7 MR STITT: So we have established therefore that there were
8 two problems discussed at the meeting between the
9 doctors and the nurses on 12 June. If we can go forward
10 to page 187. Your observation at line 11:
11 "So to the extent that Mrs Noble remembers
12 a discussion led by somebody from the anaesthetic side
13 about excessive fluids ..."
14 We're dealing with the excessive fluids, not the
15 electrolytes:
16 "... then it is most likely to have come from
17 Dr Nesbitt because he was the only anaesthetist that was
18 there."
19 We've ruled out Gund and Jamison and, if I may say,
20 that is correct, and your observation is correct, and in
21 time, Dr Nesbitt will confirm that he was the
22 anaesthetist who was discussing these problems.
23 We then go to page 191. At line 14 you recap quite
24 accurately:
25 "Sorry, just to make this point. You said to me

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1 through to make my point -- I have to go through
2 a number of entries. I'll do so succinctly, and I've
3 taken the trouble to minimise the references, but it's
4 still necessary to refer to half a dozen or so to get my
5 point.
6 THE CHAIRMAN: Okay.
7 MR STITT: If we look at line 21 on page 178, the question
8 from Mr Wolfe to Nurse Noble is:
9 "The primary failure which you articulate was
10 a failure to ensure that Raychel's electrolyte
11 assessment was carried out in or about the evening of
12 8 June."
13 So that's established as the primary failure
14 discussed at the meeting on 12 June. And it's accepted
15 by Nurse Noble that that's the case.
16 If you go to page 179, if I may ask, can the page
17 just be left unless for some reason anyone has
18 difficulty reading it, rather than highlighting
19 a section. So we've established that in June, the
20 primary problem was electrolytes.
21 Then at 19, you observe:
22 "Was it part of that discussion that, apart from
23 Solution No. 18, there was actually too much fluid given
24 to Raychel?"
25 And that's a questioning of Nurse Noble that she had

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1 a few minutes ago that it was recognised on 12 June that
2 the main mistake which had been made was a failure to
3 monitor the electrolytes."
4 We've still got the too much fluid as well, but this
5 is a point you're making. She says yes.
6 "Were Mrs Ferguson and her sister told that
7 in September?"
8 This is the first reference to September, a meeting
9 Nurse Noble was at.
10 She says:
11 "I can't recall. I can't recall."
12 So this is Nurse Noble dealing with September, able
13 to recall June, but can't recall what was said to the
14 family. We know what the family say because we've read
15 their statements.
16 THE CHAIRMAN: But we also know what the Trust says because
17 we have the Trust minutes of that meeting.
18 MR STITT: No, they're not Trust minutes, they are patient
19 advocates, and they're not minutes, they are a note of
20 the meeting. I think they were made by Mrs Doherty.
21 That's not in itself a criticism.
22 THE CHAIRMAN: Right, sorry, it is the only record of the
23 meeting that we have.
24 MR STITT: That's correct.
25 THE CHAIRMAN: Because the Trust has not given us any

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1 alternative.
2 MR STITT: That is so. What I'm saying though, if
3 I respectfully say, is not to adopt them as a transcript
4 or as a formal minute.
5 THE CHAIRMAN: But a patient advocate's note.
6 MR STITT: Yes, a patient advocate's note. And then
7 if we look over the page to 192, at the top of the page
8 she says at line 2:
9 "Again, I can't recall the exact conversations or
10 I don't recall all the points of the meeting."
11 So, so far in terms of the examination of the
12 witness, Mr Wolfe has established quite clearly what
13 happened in June but not what happened in September.
14 THE CHAIRMAN: Yes.
15 MR STITT: Mr Wolfe then says at line 4:
16 "To the extent that the record tells us [that's the
17 patient advocate's record] what was said, we will not
18 find anything in that record admitting to the mistake of
19 failing to carry out electrolyte analysis. We won't
20 find anything in that record admitting that the wrong
21 amount, the wrong rate of fluid had been prescribed."
22 THE CHAIRMAN: Right.
23 MR STITT: So that is put clearly, the record doesn't show
24 either. What then happens on the next page at 193,
25 at the top, you say, chairman:

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1 something? And the answer is:
2 "I can't remember."
3 So you're not getting any help from the witness; she
4 just doesn't remember. But what you are saying, sir,
5 is that at the end of the meeting, line 11:
6 "At the end of the meeting ..."
7 If I may say so, you are rather adopting this as
8 a fact, that the Fergusons hadn't been told. Now, my
9 caution at this point is -- and I want to make it clear
10 that I'm not challenging the Fergusons' integrity
11 in relation to what they say in their statement. We may
12 have to challenge their recollection on a number of
13 issues.
14 THE CHAIRMAN: That's a fair distinction.
15 MR STITT: Totally different. I'm not challenging their
16 integrity. But what must happen in this case is, it's
17 hugely important that the evidence is heard before any
18 conclusions are reached or any preliminary conclusions,
19 judgments made. She has said to you a third time
20 "I don't remember"; she can't help you. So, so far, all
21 we have is the patient record and the parents'
22 statement.
23 Then at page 194 -- this is an important page -- you
24 say at line 6:
25 "But it's not really good enough, Mrs Noble, is it,

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1 "I accept that, from your perspective ..."
2 The circumstances in which this question arose was
3 it was questions as to whether Nurse Noble should have
4 spoken up, having been at the June meeting, and if
5 nobody else was going to admit to no electrolytes and
6 too much fluid, why didn't she.
7 THE CHAIRMAN: Yes.
8 MR STITT: And you say:
9 "I accept from your perspective, if it has been
10 decided or recognised at an internal meeting that the
11 electrolytes should have been checked and if it has been
12 recognised that she got too much fluid, the people who
13 should [and I emphasise this] face up to that [those are
14 your words] and who should tell the Fergusons are the
15 most senior people at the meeting."
16 Then you say on line 10:
17 "But let me put it to you this way. At the end of
18 that meeting when the Fergusons left and they hadn't
19 been told that there was a mistake about checking the
20 electrolytes and they hadn't been told that Raychel had
21 got too much fluid, did you feel uneasy or unhappy that
22 the Fergusons were not being told the full story or did
23 that occur to you or dawn on you at the end of that
24 meeting?"
25 In other words: why did you not speak up and say

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1 that when the Fergusons met with this big team from
2 Altnagelvin in September that they weren't told at least
3 [emphasis on 'at least'] two of the very basic mistakes
4 which had been recognised?"
5 And she says:
6 "Yes, I accept that."
7 THE CHAIRMAN: Do you accept that?"
8 "Answer: Yes."
9 Two points. With the greatest respect, and I'm not
10 challenging your independence and your fairness in the
11 running of this tribunal, in my respectful opinion your
12 handling of this tribunal, if I may say so, has been
13 entirely impartial. But I have to say that this
14 question does seem to be predicated on an assumption
15 that the Fergusons were not told of at least two basic
16 mistakes.
17 THE CHAIRMAN: Right.
18 MR STITT: The witness then says:
19 "Yes, I accept that."
20 She's already said three times that she doesn't
21 remember the conversation and she's answering your
22 question on the hypothesis that if this wasn't told --
23 THE CHAIRMAN: Yes.
24 MR STITT: But obviously, if I may point this out also,
25 she's not saying, "Yes, I remember that that wasn't

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1 said". This was at the end of the day, a lady who had
2 been in the witness box probably all day, I think.
3 THE CHAIRMAN: And the previous day.
4 MR STITT: And who had also had a difficult time at one
5 point and we rose to allow her to compose herself.
6 THE CHAIRMAN: Yes.
7 MR STITT: Then if I may ask you to look at the bottom of
8 the same page at 194.
9 THE CHAIRMAN: Just before you go to the bottom of the page,
10 you don't skip over the fact that at line 14 I'm
11 recorded as saying that this is subject to the evidence
12 that comes later.
13 MR STITT: Let me just read that:
14 "I have to say, subject to the evidence that comes
15 later [which underscores the point I made a moment ago
16 about your general handling of the inquiry, with
17 respect] I think the admissions and facing up to what
18 went wrong should come from the most senior people there
19 and it's difficult to put the responsibility on to
20 somebody like Mrs Noble."
21 So that's reasonable for the balance.
22 Then Mr Quinn comes in at line 19:
23 "I totally agree. I totally agree and the family
24 wouldn't expect this nurse to come out bluntly and say
25 there's mistakes made."

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1 preliminary view in relation to this matter. And
2 I think it's important that that is clarified because
3 there are two basic points summarising the pages which
4 I have opened. The first is that Nurse Noble does not
5 add to the sum of knowledge as to what was said at the
6 meeting in September. What has happened is she has been
7 used -- notwithstanding the fact she says, and she's not
8 challenged, "I don't recall what was said in September".
9 That is still used as a vehicle for putting to her
10 essentially the conspiracy theory and it's articulated
11 clearly on page 197. Mr Wolfe asks at line 6:
12 "And at this meeting in September 2001, the family
13 were not given the full story; isn't that right?"
14 This is a witness who has been in the witness box
15 all day and has said three times already that she can't
16 remember:
17 "Well, from what I can see, yes. I can't recall the
18 actual meeting itself. I can't recall the exact points
19 of it."
20 THE CHAIRMAN: But "from what I can see" is from the only
21 written record of the meeting.
22 MR STITT: We'll come to that, and from what has been put to
23 her as well. It has been put to her as a fait accompli
24 that nobody said anything about electrolytes should have
25 been checked or that there was too much fluid.

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1 She has already indicated that she doesn't remember.
2 She hasn't been challenged that that was untrue, she was
3 merely saying "I don't remember" because she didn't want
4 to let her colleagues down. That's not a case that's
5 ever been put to her.
6 Then you say, sir:
7 "When her more senior colleagues are sitting around
8 and not saying what mistakes are made."
9 Now, anybody reading that who mightn't know the
10 personae in this inquiry and, more particularly the
11 chairman, might think that senior colleagues sitting
12 around and not saying what mistakes were made was
13 indicative of a state of mind where you, sir, had come
14 to the conclusion that in the light of the Fergusons'
15 statement and the patient record and the light of the
16 first witness on this subject -- the other witnesses
17 haven't touch on the June or September meetings, which
18 is why I'm intervening before this witness gives her
19 evidence and she will be the second, and I anticipate
20 a similar line of questioning with a number of
21 individuals.
22 THE CHAIRMAN: Yes.
23 MR STITT: I would like you, sir, if I may -- my point, when
24 I finish it, is that I'm going to ask you to confirm
25 that in fact you haven't reached any concrete or

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1 Then the question:
2 "Question: If the record that appears before us is
3 accurate, they weren't told the very things that were
4 admitted among yourselves behind closed doors."
5 "Answer: Yes."
6 She's agreeing that if the record is accurate, then
7 that wasn't said, she's not saying that from her own
8 recollection.
9 THE CHAIRMAN: Yes.
10 MR STITT: Finally, if I may refer to the next page, 198, at
11 line 5. I have to read into it. This is a question
12 from yourself, sir:
13 "Can you understand how Mrs Ferguson got the
14 impression that there was a cover-up? Because to put it
15 very, very succinctly, the mistakes which were admitted
16 to internally at the meeting on 12 June were not
17 admitted to externally with the Fergusons on
18 3 September."
19 "Answer: Yes."
20 "THE CHAIRMAN: So if you were sitting there like
21 Mrs Ferguson, you'd think, 'That's a cover-up'.
22 I go back to line 9, the mistakes which were
23 admitted to internally at the meeting on 12 June were
24 not admitted to externally with the Fergusons on
25 3 September.

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1 THE CHAIRMAN: Right.
2 MR STITT: I have to say, sir, that you've gone a long way
3 down the line in that paragraph to accepting the
4 Fergusons' version of events and the record.
5 THE CHAIRMAN: Yes, it's a combination of the Fergusons'
6 recollection and the record. But it's primarily the
7 record, Mr Stitt, and it is the record. If there's more
8 evidence coming that the patient advocate's record is
9 incomplete or inaccurate, obviously that evidence will
10 be put into the balance about the extent to which one
11 relies on the record as against -- I'm not relying
12 on ... Mrs Noble doesn't have a recollection which
13 really takes her anywhere, so the evidence that she was
14 being questioned about is her own recollection, which
15 doesn't take us anywhere, and the written record of the
16 patient advocate's meeting.
17 MR STITT: And it has been specifically put to her by
18 Mr Wolfe that the record doesn't refer to any failure to
19 measure electrolytes on the 8th and failure to mention
20 to the family the excess fluid.
21 THE CHAIRMAN: Right.
22 MR STITT: The conclusion and the words which are used and
23 are adopted by the inquiry are "cover-up". In other
24 words, by not mentioning these electrolytes and
25 excessive fluid, then the Fergusons could be seen to be

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1 reasons which I cannot comment on, it was September
2 before the meeting took place.
3 THE CHAIRMAN: Okay.
4 MR STITT: That is not germane to this point and it is not
5 a criticism in any way of the Fergusons.
6 THE CHAIRMAN: Yes.
7 MR STITT: If I may take you halfway down the page to
8 Mrs Doherty. Mrs Doherty, as I understand it, is acting
9 as the sort of advocate because Mrs Ferguson was present
10 but quite understandably was leaving it to Mrs Doherty.
11 Mrs Doherty asked:
12 "What were Raychel's sodium levels the first time
13 they were done? What is routine?"
14 Sodium levels are electrolytes essentially:
15 "What checks do you do? Dr McCord said bloods are
16 checked routinely on admission, 36 hours prior to this
17 Raychel's bloods were normal."
18 Mrs Doherty asked if they should not have been
19 checked after the operation. I'll stop there for one
20 moment. If this is a cover-up, the answer is going to
21 be: no, that's not the sort of thing we do, no need to
22 do that, it's got nothing to do with this case.
23 The answer is:
24 "Dr Nesbitt said they may have to review procedures.
25 It may be necessary to check routine admissions pre-op

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1 justified in believing that there was a cover-up.
2 THE CHAIRMAN: Yes.
3 MR STITT: Against that background, if we look at the record
4 to see if in fact there is a cover-up, and if I may ask
5 to call up the document 022-084-220. This is page 6 of
6 the patient advocate's record. It's not a transcript,
7 Dr Nesbitt will make observations as to its
8 completeness, but it's not being alleged that there is
9 any deliberate attempt to misportray what was said
10 at the meeting.
11 THE CHAIRMAN: Could I make the point as you start this that
12 the meeting on page 1 -- the meeting starts at
13 6 o'clock, and on the last page the meeting concluded at
14 7.15. So the last page that I have is numbered 10.
15 You're taking me to page 6. Without going to the
16 starting and finishing pages, what I have is a 10-page
17 typed record of a meeting which is one and a quarter
18 hours. So these aren't just a couple of notes randomly
19 written down, there's a very considerable amount of
20 detail in this record.
21 MR STITT: There is, and that's appropriate, if I may
22 respectfully say so, to put on the record at this point.
23 I would also put on the record that the evidence will be
24 from Dr Nesbitt that an earlier meeting was offered to
25 the Fergusons, earlier than September, but that for

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1 and post-op. The reason why they are not done routinely
2 is that it requires a needle into the vein to take the
3 blood. At 3.30 am Raychel's sodium was down."
4 That's the first point. There's an acceptance by
5 Dr Nesbitt that the system may have to change.
6 THE CHAIRMAN: Sorry, Mr Stitt, that may be the very point,
7 because if I understand the account given by Dr Nesbitt
8 of the meeting on 12 June, it was decided at that
9 meeting that procedures would change.
10 MR STITT: Yes.
11 THE CHAIRMAN: Right. So there had been an internal meeting
12 in Altnagelvin on 12 June, at which they said, "We will
13 change procedures". When the specific issue is raised
14 by Mrs Doherty as a patient advocate, Dr Nesbitt's
15 recorded answer is that Altnagelvin may have to review
16 procedures.
17 MR STITT: Yes. This has to be put -- yes, there was an
18 initial decision and a six-point plan was reached.
19 THE CHAIRMAN: Part of the six-point plan is: we will change
20 our procedures so that electrolytes are checked
21 post-operatively.
22 MR STITT: Perhaps we could check the wording of that.
23 THE CHAIRMAN: Yes.
24 MR QUINN: Dr Nesbitt's statement is at WS035/1. That's his
25 statement to the inquiry. In the body of that statement

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1 he discusses the critical incident meeting on 12 June on
2 page 10.
3 THE CHAIRMAN: Let me just check if I can find it because
4 the record I'm looking for is the one where he set out
5 who was present. We've discussed just before --
6 MR QUINN: That's his PSNI statement.
7 MR STITT: Sir, if you want the actual six-point plan, I can
8 give a reference in the inquiry documents if that would
9 be helpful.
10 THE CHAIRMAN: Give me one second.
11 MR WOLFE: Sir, what you're looking for is Dr Fulton's
12 statement, which sets out those who attended the
13 meeting.
14 THE CHAIRMAN: Yes, and then continues with the six-point
15 plan.
16 MR WOLFE: Yes. If you go to 095-011-049. If we could have
17 that on screen. The original handwritten action sheet,
18 presumably composed at that meeting, is 095-010-046w, if
19 that could be set up alongside that, please. The plan
20 is then refined and put into a typed form, but it might
21 assist you to see the original version, sir.
22 THE CHAIRMAN: It's a handwritten document headed "Action
23 sheet 12 June".
24 MR WOLFE: It's the second entry.
25 THE CHAIRMAN: The first one is "evidence change to

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1 the point that it may be necessary to check routine
2 admissions pre-op and post-op. There's no indication
3 there whether that's 24 hours or whether even a more
4 stringent checking of electrolytes might be necessary.
5 THE CHAIRMAN: If that record is accurate, what Dr Nesbitt
6 doesn't say is, "Well, we have changed the procedures,
7 we changed the procedures within a few days of Raychel's
8 death", and then refer to the second point of the
9 six-point plan. You take me on to the next page.
10 MR STITT: The top of page 7, the second paragraph.
11 THE CHAIRMAN: If you bring this up, please. 022-084-221.
12 MR STITT: The second paragraph:
13 "Mrs Doherty said Raychel then had her blood checked
14 regularly. Dr McCord said that was when she was in ICU.
15 People are there for more intense monitoring.
16 Dr Nesbitt [Dr Nesbitt being the senior anaesthetist who
17 was sitting around doing nothing and saying nothing at
18 this meeting, according to the earlier reference] said
19 that is something that we might have to do, check blood
20 six hourly. I have never seen this before."
21 So what Dr Nesbitt is saying is, "I accept entirely
22 that the record does not show they said, "Right, we have
23 actually arranged for 24-hour electrolytes on paediatric
24 patients". But what Dr Nesbitt is saying is, "Yes, we
25 need to look at this and we might have to go to six hour

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1 Hartmann's". And the second is "daily U&E, all
2 post-op". So that's the action plan. And this is
3 a point I'm making, Mr Stitt. This was the action plan
4 agreed on 12 June. Mrs Doherty asked this question on
5 3 September about checking bloods after the operation.
6 Dr Nesbitt, on this record, is stated as responding by
7 saying that Altnagelvin may have to review procedures.
8 MR QUINN: If you look at page 52 of the document on the
9 left, 095-011-052, you'll see the start of the six-point
10 plan. It's page 52 of the police statement.
11 THE CHAIRMAN: It's point 2:
12 "To detect early hyponatraemia, all post-operative
13 children on IV infusion should have routine electrolyte
14 bloods every 24 hours. Sister Millar would ensure this
15 was done and make the results known to the surgical
16 staff."
17 So this was to be done with effect from 12 or
18 13 June.
19 MR STITT: Yes. It reflects what the six-point plan typed
20 says. This reflects a discussion which took place
21 yesterday with the current witness that it could well
22 have been the following day before the actual tests were
23 done, but that's by the way.
24 THE CHAIRMAN: Okay.
25 MR STITT: So here we have, first of all, saying -- I take

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1 checks of electrolytes".
2 That's not somebody -- I'm trying to put this in the
3 balance because this has not been articulated so far --
4 somebody who is sitting back and trying to cover up
5 a failure to take electrolyte readings on the 8th.
6 That is someone saying, "Yes, our systems need looked
7 at". I appreciate your first point, Mr Chairman, but
8 it's going further than saying, "We may need to review
9 our procedures. We may actually need to do six hourly
10 procedures".
11 In other words, there was a decision to go for
12 24 hours and he's going further than that in September
13 and saying, "Look, we might have to go so far as to do
14 these electrolytes every six hours", in answer to
15 a question as to why they were not checked more
16 regularly. Not checked at all, as a matter of fact, in
17 this particular case. The point I'm making in relation
18 to the electrolytes is that this is a conversation which
19 is flowing between Dr McCord, Dr Nesbitt and the family,
20 and they are not saying there's no electrolyte issue,
21 they're saying, "Yes, we're going to have to do
22 something about this". I accept entirely the point,
23 point 2 of the two-point plan was in operation, but --
24 THE CHAIRMAN: Why not say so?
25 MR STITT: I can't answer that. But it is still a work in

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1 progress. This is September, this is a particularly
2 complex problem, hyponatraemia. You, sir, probably know
3 better than most people how complex it is. We know from
4 experience in other aspects of this inquiry that there's
5 even a debate amongst experts as to whether or not in
6 any given case hyponatraemia is the actual cause of
7 death. We also know that unfortunately the state of
8 knowledge -- and I won't specify a particular year, but
9 let's just say in or around 12 years ago -- was poor
10 in relation to this whole problem.

11 What I am saying is this: we haven't at this stage
12 got the inquest. The inquest was not to take place for
13 another 15 months -- sorry, I think it was postponed and
14 it wasn't until 2003. The statements are November 2002,
15 so it's into 2003 before this matter is examined in
16 detail and given the forensic attention which it so
17 richly deserves. Here was a meeting with the family to
18 bring the family up-to-date as to what had happened
19 leading to Raychel's death and what had happened since.
20 And I accept entirely your point that it's not
21 specifically said, "We have changed our procedures".
22 But dealing with that point, if it's suggested that
23 that is some sort of cover-up, changing a procedure to
24 daily U&Es, it's open, it's overt. This isn't some sort
25 of secret plan, this was what the rules were. And

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1 The more important point is this. It is, with
2 respect, wrong for counsel to the inquiry, and I say
3 this in a friendly manner, if I may, it's wrong for him
4 to predicate a question to a witness who has no
5 recollection of the September meeting, that the record
6 shows that there was no mention of electrolyte problem.
7 And in my respectful submission, clearly the
8 electrolytes were discussed, subject to your caveat, and
9 so much so that Dr Nesbitt himself even said, "We might
10 have to go to six hourly checks here".

11 THE CHAIRMAN: Well, first of all, let me say about Mr Wolfe
12 and about counsel to the inquiry generally. They have
13 bent over backwards to be fair in their questioning to
14 all parties and to all witnesses from the start of the
15 witnesses giving evidence last spring. I see that
16 you have a particular concern about that question. In
17 the course of questioning of witnesses, inquiry counsel
18 put forward from time to time issues that have been
19 raised or the views held by different interested
20 parties, the families being important interested parties
21 but not the only interested parties. I don't think it's
22 inappropriate for Mr Wolfe to have suggested to
23 Mrs Noble that the Fergusons -- effectively raising with
24 Mrs Noble the Fergusons' view, which was that this was
25 the start of a cover-up because of a failure to face up

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1 that is what Altnagelvin decided to do: we will alter
2 our previous regime and we will make electrolyte testing
3 in all children mandatory on a 24-hour post-operative
4 basis as long as they remain on fluids.

5 THE CHAIRMAN: Okay. Let me make a couple of points. First
6 of all, I don't have a closed mind on this. The
7 exchanges I had with Mrs Noble were based on her
8 recollection of the evidence and the patient advocate's
9 note, which I regard as a very substantial note. I'm
10 not taking it as absolute gospel. If someone says she
11 didn't quite get this point or that point right, I will
12 consider that in due course. But it looks to me, on the
13 face of it, to be a fairly reliable and substantial
14 note. I don't understand from what you're saying today
15 that you have any fundamental challenge to the accuracy
16 of that note, you're simply making the point that it is
17 not a typed-up shorthand minute.

18 MR STITT: You summed it up correctly. What I'm saying on
19 top of that is, one never knows what will come up in an
20 inquiry. There may be some point relating to this note
21 of which I'm not currently aware that may be required to
22 be challenged on some point. I don't know what that
23 point might be, but I'm just setting down the marker
24 that it's to be given that degree of officialdom, as it
25 were, and I accept it is a full note.

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1 at a meeting with them to what had been recognised
2 internally beforehand. However gently you put it,
3 Mr Stitt, I think it's rather unfair to Mr Wolfe to
4 suggest that his questioning was inappropriate.

5 For the record, I confirm that that is the position
6 which has been taken by inquiry counsel consistently,
7 Mr Wolfe, Mr Reid, Mr Stewart and Ms Anyadike-Danes, on
8 the various occasions on which they've questioned
9 witnesses since last year.

10 MR STITT: May I on behalf of both trusts make it absolutely
11 clear that the manner in which Mr Wolfe has questioned
12 has been entirely fair and appropriate, as has his
13 co-counsel. I nonetheless make the point in relation to
14 the proposition to the witness that the record was
15 silent in relation to any problems with electrolytes.

16 THE CHAIRMAN: You see, that's not quite the point. I don't
17 think that is quite the point that Mr Wolfe was putting.
18 Mr Wolfe was saying to Mrs Noble -- Mrs Noble had said
19 in her evidence there were two basic mistakes made, the
20 fundamental mistake was a failure to do electrolyte
21 testing on the Friday. And the second mistake was
22 excess fluid. Now, that note does not show Dr Nesbitt
23 accepting that there had been a failure in Raychel's
24 case to do electrolyte testing and that electrolyte
25 testing should have been done. That's one point.

24

1 The second point is that that note does not show any
2 acceptance that Raychel received too much fluid.
3 MR STITT: Finishing with the first point, and it's this --
4 the record does not show Dr Nesbitt saying, "We made
5 a terrible mistake here, we were negligent, we should
6 have done bloods at 3 pm". What it does show is
7 a constructive discussion between the doctors and the
8 family at an early stage, and in my respectful
9 submission to conclude that that could justifiably have
10 led to the family believing it was a cover-up is
11 unreasonable.

12 THE CHAIRMAN: Okay.

13 MR STITT: I accept entirely that the record does not refer
14 to excess fluid. My caveat and my caution is
15 this: whilst it is undoubtedly tempting to push
16 Nurse Noble and maybe Sister Millar on this point as to
17 why this was not brought up, the important person to ask
18 is Dr Nesbitt, and I'm confident -- I'm not going to say
19 anything about his evidence, he can give his own
20 evidence, but you may take it that as counsel for the
21 Trust I have discussed it with him and listened to what
22 he has to say. I know I'm pushing at an open door on
23 this one: please keep an open mind on the second limb of
24 this point until you have heard Dr Nesbitt and until he
25 has been tested by both yourself, counsel to the inquiry

25

1 lessons from Raychel's demise and is doing its best to
2 continue on a day-to-day basis.

3 THE CHAIRMAN: What I'm taking out of this submission,
4 Mr Stitt, is two points. The first is that there is
5 an issue about the way in which this note should be
6 interpreted or seen in the context of the events after
7 Raychel died. That's the first point, and I accept
8 that.

9 The second point is the concern which you have about
10 how the issues are reported. There is -- I think you
11 and I know this from doing discrimination cases with and
12 against each other over the years. You can sometimes
13 have a report where the report is factually accurate,
14 and I don't think you're suggesting that the Telegraph
15 report is not factually inaccurate, your concern is the
16 headline.

17 MR STITT: Yes.

18 THE CHAIRMAN: That's an old issue about whether the
19 sub-editor's headline in a newspaper article may or may
20 not sometimes go too far and not be matched by the
21 content of the article.

22 MR STITT: Exactly. What I'm hoping for, what I'm asking
23 for, is that you might make it clear that without
24 prejudice to whatever conclusion you reach in this
25 inquiry that you have not reached any conclusion

27

1 and other interested parties, particularly the family.

2 What has brought all this about was the
3 Belfast Telegraph, Thursday 28 February. This is my
4 concern on behalf of both trusts. Here we have -- I'm
5 holding up a picture, for the record.

6 THE CHAIRMAN: I have seen it.

7 MR STITT: There's Nurse Noble, who has had a long day
8 in the witness box, and she is still practising and
9 she's going back. This newspaper is in circulation in
10 the Derry area as well as all over the Province. More
11 importantly, the headline reads -- points I have made so
12 far, this headline comes out of it, and I'm saying this
13 is unfair, and this is what can happen. "Hospital staff
14 tried to cover up errors". It's not even suggested that
15 there might have been a cover-up:

16 "Hospital staff tried to cover up errors after girl
17 (9) died following a routine operation, inquiry told."

18 My concern is that an inquiry should be just that,
19 it should be a fair and balanced inquiry, and I know,
20 sir, you will come to a fair and balanced conclusion.
21 But the dangers of reaching any conclusion or appearing
22 to those who are not legally trained to have reached
23 a conclusion can only lead to headlines like that, which
24 is, in my respectful submission, damaging to a hospital,
25 which is doing its best, has done its best to learn

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1 in relation to any alleged cover-up.

2 THE CHAIRMAN: Well, I have no difficulty at all in doing
3 that. I have heard some evidence, I have not heard all
4 of the evidence, and I think it's also fair to say that
5 what features in Thursday's evidence -- and I made this
6 point at the stage when Mrs Noble became upset.
7 I specifically acknowledged the concern which I know is
8 held in Altnagelvin that the mistakes which were made in
9 Raychel's case might well not have been made had other
10 hospitals shared lessons which might have been learned
11 from the deaths of the other children. I'm not just
12 talking about the Royal because although we've focused
13 on the Royal in Adam and Claire's cases, there were
14 lessons to be learned when Lucy Crawford died in 2000,
15 which might have been more immediately or at least as
16 immediately directly relevant. So I've acknowledged
17 Altnagelvin's concerns about that explicitly.

18 I've also explicitly acknowledged that the critical
19 incident review was itself -- it stands out like
20 a beacon in this inquiry because of the contrast between
21 what Altnagelvin did in 2001 after Raychel died compared
22 to what the Royal did after Adam and Claire died. For
23 a start, this was the first hospital to bother talking
24 to the nurses. The nurses in Adam and Claire's cases
25 were somehow treated as being irrelevant to any review

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1 or inquiry afterwards. I also note that the reason why,
2 part of the reason why this critical incident review
3 came about was because a textbook on governance had been
4 published two years before. Altnagelvin had taken the
5 trouble to bring over the authors of the textbook, give
6 an internal lecture in Altnagelvin, which then led in
7 turn to the critical incident review procedure being
8 introduced.

9 On the face of it, this critical incident review
10 meeting was significant. I haven't heard any suggestion
11 from the family that there aren't a lot of positives to
12 be taken from the critical incident review. I think
13 that is recognised as comparing very favourably with the
14 deaths of the earlier children. But the issue is
15 whether what was learned internally was communicated or
16 how it was communicated to the family on 3 September.
17 I have concerns about that as a result of the contents,
18 the rather detailed and precise contents of this minute.
19 If there's more evidence to be given about the accuracy
20 and completeness of that minute, I will of course hear
21 it.

22 MR STITT: A final word, if I may, and thank you for saying
23 what you have done, sir, it confirms our belief of your
24 total impartiality. The Trust were concerned that
25 notwithstanding all they had tried to do in this case

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1 That's point 1.

2 MR STITT: Could I ask who gave this information?

3 THE CHAIRMAN: Mrs Burnside.

4 MR QUINN: She said she was taking a note.

5 THE CHAIRMAN: Mrs Doherty, the patient's advocate, is the
6 patient's advocate -- excuse my ignorance, is that
7 somebody who is brought in by the Trust to be a patient
8 advocate or brought in by the family?

9 MR QUINN: The Trust, as I understand it.

10 THE CHAIRMAN: Mrs Millar is saying it's the Trust, but if
11 there's more information I'm happy to take it.

12 MR WOLFE: While that is being confirmed, in ease of
13 Mr Stitt, and no doubt he will make further enquiries,
14 but Dr Nesbitt has told the inquiry in his witness
15 statement and no official notes were kept of this
16 meeting, but the patient's advocate representing the
17 Ferguson family did keep a record. That's what he says
18 in his statement.

19 MR STITT: I think it's important for me to say that
20 a patient advocate is actually employed by the Trust.

21 THE CHAIRMAN: Right. Just to get clarity on that then,
22 this isn't somebody who the family brings along, it's
23 a person who -- again, of course, that's a positive
24 thing, that there is somebody at the meeting employed by
25 the Trust, whose role it is to probe and ask questions

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1 after Raychel's death, that as a result of questioning
2 of a witness who had no direct recollection of the
3 meeting in September, a headline to which I've referred
4 has occurred.

5 THE CHAIRMAN: Okay, thank you.

6 MR QUINN: Mr Chairman, I would like to say very briefly --
7 I'm mindful of the time. I make the following points
8 arising out of this discussion. Number 1, the family
9 who attended the meeting, that is the meeting
10 in September, were told -- and they have a clear
11 recollection -- that a minute would be taken of this
12 meeting by Mrs Burnside. That is point 1. So the
13 family who were there, particularly Mrs Doherty, have
14 a clear recollection.

15 THE CHAIRMAN: Let me just ask that. Could it be confirmed,
16 Mr Stitt, whether Altnagelvin has a separate minute or
17 record of that meeting? I don't need an immediate
18 answer now, but the sooner I get it the better. Because
19 if there is an alternative record of that meeting,
20 I would like to see it.

21 MR STITT: Yes, absolutely.

22 MR QUINN: Why there was such a clear recollection of this
23 is that they were going to note the meeting. They went
24 with a view to noting the meeting, but were told clearly
25 that a detailed minute would be taken of the meeting.

30

1 on behalf of the family.

2 MR STITT: Rather than leaving it to the family, yes.

3 THE CHAIRMAN: Exactly.

4 MR QUINN: That's why they didn't take a minute because they
5 came equipped to minute this meeting and didn't do so.

6 THE CHAIRMAN: The record which we have of this meeting is
7 a record which was made by a Trust employee.

8 MR QUINN: That's correct. I want to make a brief point
9 about page 7 that still appears on the screen.

10 Mrs Doherty did ask a number of questions, and I should
11 say that my information at the moment is that -- my
12 instinct was initially that on the second paragraph
13 where it says Mrs Doherty said Raychel then had her
14 blood checked regularly, was more in the form of
15 a question. So that was a sort of open question,
16 discussion type issue. That's why we then see that the
17 ICU is discussed because we know that in ICU the bloods
18 are done on a much more regular basis. So that's how
19 that came about, because there was no suggestion, as we
20 understand it, that the Trust may take bloods every six
21 hours. It was by way of an explanation and the sort of
22 hanging question that the Trust may look at this again.
23 So that's how the family see that issue.

24 But the main issue, as we see it, Nurse Noble's
25 evidence, is that her evidence is quite clear, and it

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1 was stunning for the family because she told this
2 inquiry that in the meeting of June, shortly after
3 Raychel's death, there were anaesthetists at the meeting
4 who worked out a calculation that the child had got too
5 much fluid. That's quite clear. That's on the
6 transcript. If Mr Stitt needs to check it, so be it,
7 we can wait for that. That's clear.

8 That's where the revelation came from because it
9 doesn't actually say on point 2 of Dr Raymond Fulton's
10 statement that this child had too much fluid.

11 THE CHAIRMAN: No, but Dr Fulton's statement does talk
12 about -- he does say -- this is in relation to the June
13 meeting.

14 MR QUINN: Yes.

15 THE CHAIRMAN: He says in his statement:

16 "Dr Nesbitt reviewed the infusion rate of
17 Solution No. 18 and felt it was too high for Raychel's
18 weight."

19 MR QUINN: That's correct.

20 THE CHAIRMAN: So according to Dr Fulton's statement, this
21 was an issue which was issued at the -- and this is
22 really what supports Mrs Noble's evidence, that there
23 was a discussion about the amount of fluid which had
24 been received. Mrs Noble recalled it being agreed that
25 she received too much fluid. And the concern was that

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1 will give evidence about that.

2 MR QUINN: Yes. When he's giving --

3 MR STITT: That's precisely the point. I accept entirely
4 that it was discussed in June, I accept entirely that it
5 was not discussed in September, and the record is
6 accurate in that regard. But I'm asking the tribunal to
7 wait until all the evidence has been heard, particularly
8 Dr Nesbitt, who will be here and no doubt will be
9 questioned rigorously by all parties. Then we can reach
10 a conclusion.

11 THE CHAIRMAN: If it is going to be contended by any witness
12 that this record that we're looking at of the September
13 meeting is not accurate, I would like to know that as
14 soon as possible and I would like to know that before
15 any of these witnesses come to give evidence.

16 MR STITT: Yes.

17 THE CHAIRMAN: I'll tell you now, we are going at the moment
18 on the basis that this is an accurate record.

19 MR STITT: When I put in my caveat earlier it was that if
20 it's a document which -- it's not typed at the time,
21 it's not a transcript like we have at the moment.
22 There's always a possibility that there might be
23 a challenge. I have no instructions at the current time
24 in relation to such a challenge.

25 THE CHAIRMAN: And there's nothing in any witness statement

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1 that had not fed into the discussion with the family
2 in September.

3 MR QUINN: Yes.

4 THE CHAIRMAN: Dr Fulton's statement about what Dr Nesbitt
5 said at the meeting does talk about Dr Nesbitt reviewing
6 the infusion rate, felt it was too high for Raychel's
7 weight, and then it continues with another sentence:

8 "However, the recommended rate was for maintenance
9 and therefore a slightly higher rate would have been
10 appropriate in the early stages of Raychel's illness."

11 So that seems to be a slightly conditional
12 acceptance of excess fluid, but we'll hear more about
13 that presumably in due course.

14 MR QUINN: But, sir, the point is from the family's point of
15 view that no one said to them in terms that they could
16 understand -- and in fact, on my reading of this
17 document, on any terms whatsoever. I'll stand
18 corrected. If someone can look at this and say there's
19 a suggestion here that someone said that Raychel had an
20 overdose of fluids, then I stand corrected. But on my
21 reading of this note, no one in that meeting says, "By
22 the way, Raychel also had too much fluid".

23 THE CHAIRMAN: No, and I think Mr Stitt has said a few
24 minutes ago he accepts that there is no reference in
25 the September meeting to excess fluid and Dr Nesbitt

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1 from anyone in Altnagelvin that it is inaccurate.

2 MR WOLFE: Sir, [inaudible] my questions to Mrs Noble were
3 informed with an understanding of what Dr Nesbitt was
4 saying about the accuracy of the note. If I could just
5 clarify it now. At WS035/1 at page 5, Dr Geoff Nesbitt
6 in his inquiry statement in the paragraph commencing
7 with the word "following", said about halfway down that
8 paragraph:

9 "I was present at this meeting and spoke frankly,
10 openly and honestly to those present. No official notes
11 were kept of this meeting, but the patient's advocate
12 representing the family did keep a record. This however
13 is not a full note of the meeting in that it does not
14 include the opening remarks of both Mrs Burnside and
15 myself where we clearly expressed our deep sense of
16 sorrow and sympathy for the family following Raychel's
17 loss. We stated that we were sorry that Raychel had
18 died whilst in our care and stressed that the treatment
19 she had received, which was the same as in other
20 hospitals, would be reviewed and whatever changes
21 necessary be made as quickly as possible."

22 The point that I would make -- and I emphasise that
23 in my role as counsel to the inquiry it is my duty to
24 robustly put points to witnesses, which appear evident
25 from all of the documentation. In that respect, and

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1 taking into account Dr Nesbitt's caveat in relation to
2 the accuracy of the record, it is quite plain that he's
3 not saying there, Mr Chairman, that we openly accounted
4 for our mistakes, and it was in that spirit that
5 I raised the particular questions with Mrs Noble.

6 THE CHAIRMAN: But your point then is to the extent that
7 Dr Nesbitt challenges or queries the record, it is
8 because it has not included opening remarks expressing
9 sorrow and sympathy, rather than it has misunderstood or
10 misinterpreted any later discussions about other issues.

11 MR WOLFE: That's right, and indeed Mrs Burnside, just for
12 completeness, in her witness statement to the inquiry at
13 WS046/1 at page 6, the penultimate paragraph:

14 "The patient advocate made her note of the meeting.
15 It is my judgment that this note is not a full account
16 of the content or an adequate reflection of the
17 atmosphere of the meeting."

18 So nobody has yet spelt out to the inquiry any
19 concern about the record beyond an assertion that it
20 didn't quite capture the atmosphere of apology or
21 concern.

22 THE CHAIRMAN: Yes, okay. Thank you.

23 MR WOLFE: It would certainly help the inquiry's progress,
24 sir, if Dr Nesbitt is to say other things about the
25 accuracy of the record or if any other witness intends

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1 Just a point of clarification on something that
2 arose yesterday. If I could have up on the screen
3 WS056/2, page 20, please.

4 THE CHAIRMAN: This is Mrs Millar's own statement.

5 MR WOLFE: If we could go back a page. At the top of the
6 page, sir, through you, you'll recall yesterday when
7 I was questioning Mrs Millar in relation to the accuracy
8 of the coroner's note with regard to this issue of
9 listlessness, Mr Campbell intervened to point out the
10 difference between counsel's note, which I had initially
11 put to the witness, and the coroner's note.

12 THE CHAIRMAN: Yes.

13 MR WOLFE: It appears to be the case, as you can see at
14 question (a) there, that neither note, neither counsel's
15 note nor the coroner's note, adequately reflects what
16 the witness is saying to this inquiry about her view of
17 the listlessness or otherwise of the child. In other
18 words, just to be clear, the coroner's note said that
19 Mrs Millar did not believe the child to be listless,
20 whereas counsel's note appeared to indicate that
21 Mrs Millar accepted that the child could be described as
22 listless. And what you have in front of you at (a) is
23 Mrs Millar's full articulation of her position.

24 THE CHAIRMAN: Which is consistent with the signed version
25 she gave to the coroner?

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1 saying other things about the accuracy of the record,
2 that that is done as soon as possible.

3 MR STITT: I have not challenged the record. I'm aware of
4 a non-material comment by -- I'm quite aware of that.
5 With respect, that doesn't take us anywhere. That is
6 Dr Nesbitt's view that there were sentiments expressed
7 at the beginning of the meeting, but that is not germane
8 to the issues.

9 THE CHAIRMAN: It's relevant in a general sense but not to
10 these specific narrow points.

11 MR STITT: Exactly, and I haven't made the case that the
12 record is inaccurate for the purposes of my submissions
13 this morning. I have merely kept, as counsel in my
14 respectful submission prudently should do just in case
15 something comes up in the case of the inquiry. And
16 I repeat, I don't know what that is. My instructions
17 don't tell me any challenge to this record. That's how
18 I stand.

19 THE CHAIRMAN: Thank you. Do you have anything left,
20 Mr Quinn? Okay.

21 Mrs Millar, we'll start your questioning now if
22 you're ready.

23 MRS ELIZABETH MILLAR (continued)

24 Questions from MR WOLFE (continued)

25 MR WOLFE: Mrs Millar, a belated good morning to you.

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1 MR WOLFE: It's the opposite.

2 THE CHAIRMAN: Okay.

3 MR WOLFE: Very briefly, Mrs Millar, we talked yesterday in
4 terms of the post-operative fluid regime, and you said
5 that it was common practice in Altnagelvin at that time
6 for the same fluid and the same rate to be applied
7 post-operatively as it was preoperatively.

8 A. Yes, until the child had started oral fluids, which --
9 the fluid would then be gradually reduced.

10 Q. That regime that you describe, would that have been
11 known to the surgeons in Altnagelvin at that time?

12 A. I would have thought so.

13 Q. Because surgeons come at the ward round, for example,
14 and review the fluids of the children.

15 A. Mm-hm. Well, normally, as I said yesterday, when they
16 come, the fluid that has been prescribed preoperatively
17 has been continued when the child comes back from
18 theatre, and then they will review the child in the
19 morning or -- yes, usually in the morning, before
20 10/11 o'clock. I have never seen the surgeons reduce
21 fluid or change fluid until the child is drinking
22 appropriately, and then we would reduce the -- the
23 nurses would reduce the fluid to half and then by
24 teatime you would hope the fluid would be discontinued.

25 THE CHAIRMAN: So effectively it's gradually reduced as the

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1 day goes on?
2 A. Usually. The patient will start taking fluid in the
3 morning, you would hope by lunchtime you can halve it,
4 in Raychel's case it would have gone down to 40, and as
5 the afternoon goes on, maybe with something like
6 ice cream or whatever, the fluid would be discontinued
7 and you would hope that by 5 or 6 o'clock the fluid
8 would be discontinued. But I've never seen fluid to be
9 discontinued or to be reduced at the surgeon's ward
10 round.
11 MR WOLFE: Could I have up on the screen --
12 THE CHAIRMAN: Sorry, let me feed into that. So it wouldn't
13 be unusual then for a surgeon on the ward round to say,
14 "Look, I want you to reduce and then discontinue the
15 fluids as the day goes on"; that would be standard?
16 A. Yes, that would be standard.
17 THE CHAIRMAN: In that scenario, would you expect the
18 surgeon to effectively dictate when and at what rate?
19 Would you expect a surgeon to say, "At 11 o'clock reduce
20 it by half, or at noon reduce it by half", or would he
21 leave that to your discretion on the ward?
22 A. It was left to our discretion.
23 THE CHAIRMAN: Right. So if Mr Zafar said, or any other
24 surgeon, "I want you to reduce the fluids", first of all
25 you'd be surprised if he didn't say that, about reducing

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1 slightly delay the running down of fluids but if that
2 was the only vomit, then the fluids would still be run
3 down maybe at a slightly later --
4 A. Yes, because Raychel was introduced to fluids
5 mid-morning, I understand. I'm not sure exactly the
6 time. But she had vomited again at 10 or 10.30, and
7 therefore we never got her established on oral fluids.
8 THE CHAIRMAN: Yes.
9 A. And I think in the late afternoon she may have had some
10 as well, but, as you know, they weren't documented.
11 THE CHAIRMAN: Okay.
12 MR WOLFE: Could I have up on screen, please, 098-018-042,
13 please. Again, this is the record made by counsel or
14 solicitor of your evidence to the inquest. At the top
15 of the page, the first few lines, it says:
16 "After Dr Makar's examination in the morning, she
17 was on normal fluids, reduced in the afternoon to half
18 fluids, this not being unusual in cases of minor
19 surgery."
20 Does that record make sense?
21 A. No, it doesn't. Dr Makar, he didn't examine -- I didn't
22 see him in the morning. He just came in to speak to
23 Mr Ferguson.
24 Q. Yes.
25 A. The fluids were not reduced.

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1 the fluids as the day goes on?
2 A. Yes, I would, because it wouldn't be a usual
3 conversation I would have with the surgeon.
4 THE CHAIRMAN: It's an absolutely standard thing to be done
5 that the surgeon would say, "Well, as usual" or
6 something along these lines, "Reduce the fluids as the
7 day goes on"?
8 A. Yes.
9 THE CHAIRMAN: That would be a standard direction. In that
10 event, the prescription for fluids, as I understand it,
11 in the formal sense is the preoperative prescription of
12 fluids?
13 A. Yes.
14 THE CHAIRMAN: And rather than have a formal new
15 prescription of reduced fluids, the surgeon leaves it
16 in the hands of the nursing staff to reduce the fluids
17 as appropriate as the day goes on, and if there's any
18 difficulty contact the surgeon?
19 A. Yes, that was the way it was. If the patient vomited,
20 like Raychel did, we would delay the introduction of
21 oral fluids. If the bag of fluid had run in and was
22 completed, we would then ring the surgeon to write up
23 a new bag of fluids.
24 THE CHAIRMAN: Okay. Let's suppose you have a child like
25 Raychel who has one vomit at 8 o'clock. That might

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1 Q. Yes, I was more focusing on that point than Dr Makar,
2 but you've clarified that for me. In terms of the
3 fluids being reduced in the afternoon, that didn't
4 happen?
5 A. No, because Raychel hadn't got established on her oral
6 fluids.
7 Q. It's quite clear that the official transcript, if you
8 like, the deposition, doesn't contain any suggestion
9 from you that the fluids were reduced to half in the
10 afternoon.
11 A. No.
12 THE CHAIRMAN: If that note is right, it's entirely out of
13 keeping with all the other evidence, isn't it?
14 MR WOLFE: That's right. I'm raising it to give the
15 opportunity for the witness to comment on it, but it
16 certainly is rogue in the sense that it doesn't reflect
17 the records or the evidence from elsewhere.
18 MR CAMPBELL: Mr Chairman, we have to take this document
19 with some caution because we don't know the author of
20 it. However, if we were to --
21 THE CHAIRMAN: I presume it's some solicitor in DLS.
22 MR CAMPBELL: Solicitor or counsel, we're not aware of who.
23 Could it be that the document would make sense if in
24 fact it would read as follows? I think the doctor
25 should be Dr Zafar.

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1 A. Yes.
2 MR CAMPBELL: After Dr Zafar's examination in the morning,
3 she was to be on normal fluids, to be reduced in the
4 afternoon to half fluids, this not being unusual in
5 cases of minor surgery.
6 THE CHAIRMAN: That would make much more sense and would fit
7 in with the rest of the evidence which, on this issue,
8 is not controversial. My inclination, Mr Campbell,
9 is that -- first of all, I have to go primarily on
10 Sister Millar's signed evidence to the coroner and to
11 the extent that other -- there are other additional
12 issues arise, I will be a bit cautious about them
13 because this note doesn't look to be entirely reliable.
14 A. May I say something? I don't recognise this.
15 Am I supposed to have written this?
16 THE CHAIRMAN: This is an example of it. As you're giving
17 your evidence, the coroner makes handwritten additions
18 at the end of your typed statement, which you then sign.
19 I think you've seen that document which has your
20 signature at the end. As you're doing that, there are
21 too many lawyers sitting around writing notes and most
22 of the time they get it right, every now and again they
23 get it wrong.
24 A. It should be Dr Zafar. I know Dr Makar came afterwards,
25 but my main dealings with a surgeon in the morning was

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1 A. Yes. I asked Nurse McAuley to ask Dr Devlin to give an
2 anti-emetic and that was because Raychel had continued
3 to vomit and this would hopefully make her more
4 comfortable and hopefully stop her vomiting.
5 Q. Again, as you told us yesterday, had you been on duty at
6 or about 9 o'clock with the vomiting continuing --
7 MR STITT: Sorry to interject, but can I seek some
8 clarification? I thought that we had come to the end of
9 this section of the questioning and it had been fully
10 dealt with and that we were moving on to the meetings,
11 hence I made my points earlier. It was my clear
12 understanding that, subject to any important
13 clarification point, we were moving on to the meetings,
14 and then Mr Zafar, who's in the back of the room at the
15 moment, would have been heard at 11. Partly I am the
16 one who is responsible for taking up our time, but could
17 I respectfully suggest --
18 THE CHAIRMAN: We'll move on as quickly as we can.
19 MR WOLFE: There are a number of brief points before we get
20 to the meetings.
21 THE CHAIRMAN: If we keep them tight.
22 MR WOLFE: Of course.
23 You told us yesterday that had you been on duty,
24 Mrs Millar, at 9 o'clock with the vomiting continuing,
25 you would have prompted a doctor to arrange for an

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1 Dr Zafar.
2 THE CHAIRMAN: That also suggests --
3 A. I didn't recognise that.
4 THE CHAIRMAN: That also suggests that the note might be
5 a little confused because Dr Makar was there but not for
6 the purposes of the ward round.
7 A. He didn't examine Raychel in the morning.
8 THE CHAIRMAN: Thank you.
9 MR WOLFE: Moving on, Mrs Millar. As we heard yesterday,
10 you went off duty somewhere in that corridor between
11 5.30 and 6 o'clock.
12 A. Yes.
13 Q. And you tell us in your witness statement that at that
14 time you had no particular concerns for Raychel, you
15 expected her vomit to settle and the IV to be
16 discontinued eventually and for her to be discharged on
17 Sunday, more likely than not.
18 A. Yes.
19 Q. As you were leaving or at or about the time you were
20 leaving, Raychel was about to receive an anti-emetic;
21 isn't that right?
22 A. She hadn't received it before I left, but she was to
23 have one.
24 Q. Yes. Just to be clear, that is what you asked
25 Nurse McAuley to ask the doctor to prescribe?

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1 electrolyte test; isn't that correct?
2 A. I did.
3 Q. We heard from Mrs Noble in terms of the episodic care
4 plan that this was supposed to be a living document that
5 would be evaluated and reviewed from time to time. Now,
6 at that time, the time of your departure for the day,
7 was any consideration given to amending the plan or
8 evaluating the plan to put in place a plan to review
9 Raychel if her vomiting didn't settle?
10 A. No, I don't think there was. Nurse McAuley would have
11 been responsible for evaluating or updating the plan.
12 But no, there wasn't.
13 Q. Could I just briefly look at her last entries on to the
14 plan and ask for your comments. Could I have up
15 063-032-076. This is the annotated episodic care plan
16 that made its way to the nursing handover. If I could
17 highlight the entries on the bottom right-hand corner,
18 please.
19 Making an entry at 1700 hours, Nurse McAuley has
20 said:
21 "Observations appear satisfactory."
22 That's temperature, pulse, respirations, et cetera;
23 isn't that right, isn't that what we mean by
24 "observations"?
25 A. Yes.

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1 Q. Then "continues on PR Flagyl", which is the antibiotic,
2 and that's factually accurate; isn't that right?
3 A. Yes.
4 Q. Then it says:
5 "Vomit X 3 this am but tolerating small amounts of
6 water this evening."
7 Now, in terms of what you know of Raychel's
8 condition in the afternoon, that's wholly inaccurate,
9 isn't it? First of all, there were vomits in the
10 afternoon that are not mentioned there.
11 A. Yes. Well, "vomited X 3 this am", that would have been
12 8, 10 and 1.
13 Q. Yes.
14 A. But there was a vomit at 3 o'clock. Now, those are the
15 vomits that I'm aware of, I'm not aware of any other
16 vomits, but there was a vomit at 3 o'clock.
17 Q. And in terms of her tolerating fluids?
18 A. I understand that she got some fluids mid/late afternoon
19 and then she -- well, I'm not sure. Dr Devlin said that
20 Raychel vomited.
21 Q. If she was tolerating fluids, there wouldn't have been
22 need for an anti-emetic, would there?
23 A. Well, we'd asked for the anti-emetic earlier on and
24 there was a delay in the doctor coming to give it.
25 Q. If she was tolerating fluids moreover you could have

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1 MR WOLFE: The entry at 5 o'clock is inaccurate.
2 THE CHAIRMAN: Because it says there was vomiting this
3 morning, but the typed note does not refer to vomiting
4 during the afternoon, and it was the vomiting during the
5 afternoon which, on your evidence, swayed you to
6 agreeing with Staff Nurse McAuley that it was time to
7 call a doctor, with the probable next step being the
8 prescription of an anti-emetic.
9 A. Yes.
10 THE CHAIRMAN: But that note, the typed note, appears to be
11 different because it's suggesting that there has been
12 vomiting in the morning but the picture in the evening
13 has changed, and it omits any reference to the afternoon
14 vomiting. The typed part is typed at 5 o'clock, isn't
15 it?
16 A. There's some delay sometimes when these ... The
17 computerised system very frequently ... Sometimes when
18 the actually evaluation was done, it was some time later
19 before the printout came through.
20 THE CHAIRMAN: Okay.
21 A. Now, there's some problem -- I can't explain that
22 properly, but Nurse McAuley would.
23 THE CHAIRMAN: Shall we leave this for Nurse McAuley?
24 MR WOLFE: Yes. Just one final point in this sequence. It
25 didn't come out fully yesterday when I dealt with it,

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1 been thinking about reducing the need for IV fluids?
2 A. Well, it would depend on the amount of fluid she was
3 actually tolerating at that point. If it was just small
4 sips, mouthfuls, we wouldn't be reducing the fluids
5 until she was actually taking maybe 100, 150 ml.
6 Q. If you take that sentence as an attempt to portray the
7 picture of Raychel's state of health at 5 o'clock, it is
8 seeming to suggest, correct me if I'm wrong, that she
9 had vomited in the morning, but there were no vomits
10 in the afternoon, and things had settled down because
11 she was tolerating fluids.
12 A. Well, I think Nurse McAuley has written there "vomited
13 this pm", plus "IV Zofran given", so there was a vomit
14 there.
15 THE CHAIRMAN: So the handwritten note at the end is
16 Mrs Noble's; is that right?
17 A. It's Mrs McAuley.
18 MR WOLFE: We understand it being Mrs McAuley, but we'll
19 hear from her on that. What I'm suggesting is when she
20 wrote that note at 5 o'clock, the typed entry, it was
21 inaccurate.
22 THE CHAIRMAN: Mr Campbell?
23 MR CAMPBELL: I understand from previous evidence that was
24 Nurse McAuley's note.
25 THE CHAIRMAN: Right.

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1 but just for completeness. I asked you yesterday about
2 whether there was a need to prompt doctors to carry out
3 electrolytes at or about 6 o'clock. I've got your
4 evidence in relation to later in the evening when the
5 vomiting continued, but the inquiry has received reports
6 from Dr Simon Haynes and from the Trust, through
7 a Mr Orr, and they make it clear in their reports that
8 at any point during the late afternoon the correct plan
9 of action was to take blood sample for electrolytes,
10 given the continued vomiting. Now, do you accept that
11 by that time you ought to have been prompting the doctor
12 to carry out electrolyte analysis?
13 A. Well, as I say, when I went off duty, with hindsight now
14 obviously we would do that. But from my observation of
15 Raychel in the morning, I didn't see her early
16 afternoon, I wasn't given any concerns about her by
17 Nurse McAuley when I returned over to the ward. It may
18 have been prudent for me to ask or for Nurse McAuley to
19 ask Dr Devlin, but when Dr Devlin saw Raychel, I would
20 have expected him to talk to the parents and maybe for
21 him to do an assessment. Yes, obviously if electrolytes
22 had been done at that stage it may have shown that there
23 was a change in the electrolytes.
24 Q. Yes, but the assessment made by Mr Orr and by Dr Simon
25 Haynes that electrolytes were indicated at that point in

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1 time is based on their assessment of the amount of
2 vomiting at that point in time. So it is not with the
3 benefit of hindsight that I'm asking you the question.
4 When you think about it now, if these matters had been
5 carefully considered by nursing staff, should you have
6 been prompting the doctor, when he came, to carry out
7 a full review, which would have included raising with
8 him a prompt to consider electrolyte analysis?
9 A. Yes. Well, probably we should be asking him to assess
10 Raychel for that.
11 Q. Could I move then to the events of 12 June. You would
12 obviously have heard of the sad loss of Raychel when you
13 returned to work in the following week; is that correct?
14 A. Yes. I returned -- I went off on Friday evening and
15 I returned on Tuesday morning and I was told about
16 Raychel, which was absolutely devastating for me, for
17 all the staff. I actually couldn't believe it, I didn't
18 actually think we were talking about the right child
19 because I had asked, "Are you sure?", but it was
20 unfortunately what had happened.
21 Q. Now, you were asked to attend a meeting on 12 June,
22 which we understand was termed a critical incident
23 meeting.
24 A. Yes, that's right.
25 Q. And if I could turn up your witness statement at WS056/1

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1 happens to be the version she refers to.
2 That action plan was agreed at this meeting,
3 Mrs Millar; is that right?
4 A. Yes. Yes, there were two points for me to implement.
5 Q. We can see them there. At number 2 you were going to be
6 asked to arrange daily U&E on all post-operative
7 children receiving IV infusion. And at number 4,
8 emphasis was now being given to measuring and recording
9 all urinary output while IV infusion progress was in
10 place?
11 A. Yes.
12 Q. At the meeting, plainly the events leading to Raychel's
13 collapse and ultimate death were discussed; isn't that
14 right?
15 A. Yes. I do not have a clear recollection of the meeting,
16 but yes, I was given a transcript of Nurse Noble's
17 witness statement -- at least her ...
18 THE CHAIRMAN: Her evidence.
19 A. Her evidence during the week. There are parts of it
20 that, yes, I do remember, but there is a large part of
21 it that I just don't remember. I want to emphasise
22 that, that I came into the meeting that day, I had just
23 been told that morning that Raychel had died, and my
24 mind was on what had happened. As nurses -- I was very
25 much looking at, "Had we fallen down?" We know now yes.

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1 at page 6. You set out a narrative on this page,
2 recollecting the events of that meeting. In this
3 context as well, Mrs Millar, you've had an opportunity
4 to review the evidence given by Mrs Noble.
5 A. Mm-hm, yes.
6 Q. On Wednesday of this week.
7 A. Yes.
8 Q. Picking up your witness statement at page 6 in front of
9 us, the meeting was attended by staff who cared for
10 Raychel, both medical and nursing. You also attended in
11 your role as the senior nurse. So as well as wearing
12 your hat of having cared for Raychel, you were there, if
13 you like, reflecting your seniority in the nursing
14 discipline?
15 A. Yes, my clinical services manager was there, as far as
16 I remember, Mrs Doherty, Margaret Doherty, as well.
17 Q. And you say that following the meeting, an action plan
18 was agreed. Would it be possible to have that up on the
19 screen side by side? It's 022-108-334.
20 You might know from your reading of the papers that
21 this action plan appears in various forms. There's
22 a handwritten version, there's various clean versions.
23 This is the one referred to by the witness in her
24 witness statement. There is no particular point of
25 accuracy or difference that I'm going to probe, it just

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1 But that was my main thought going into the meeting.
2 Plus I was very upset, and also I had very strong views
3 on certain things that had upset me as well.
4 MR WOLFE: We'll take all of that as the baseline. Can
5 I ask you this, had you ever had to attend such
6 a meeting before?
7 A. I cannot remember, but at that stage when Raychel died
8 we had set up risk management meetings in the hospital
9 within paediatrics. As far as I'm right, it was around
10 that time or shortly before it. So if there was an
11 uneventful [sic] event that happened, we would have got
12 together to discuss the events leading up to whatever
13 the event was and to see whether there was something we
14 could learn from it to prevent it happening again.
15 Q. Can I suggest to you that meetings like this are,
16 happily, comparatively rare in your working experience?
17 A. Yes.
18 Q. And therefore, while you may not remember every fine
19 detail of this meeting, you must remember broad things
20 that emerged.
21 A. Yes, I do remember some main points.
22 THE CHAIRMAN: Can I ask you, Mrs Millar, what were the
23 things that had upset you, which you had strong views
24 on?
25 A. Well, when I returned to hear that Raychel had died,

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1 I was upset, and when I went over to attend the meeting
2 in the afternoon there was quite a large number of
3 people there. Surgeons were there. I let it be known
4 very frankly that I felt very let down and disappointed
5 in -- obviously what had happened to Raychel was
6 devastating and, to be quite frank, I had for some time
7 been unhappy with the, not the care but the system
8 within the hospital for caring for surgical children.

9 THE CHAIRMAN: In what way?

10 A. Well, in the way that ... It's not that there was
11 anybody giving me any problem, but there was always
12 a difficulty in getting doctors. And if I had two or
13 three surgical children, I could spend more time with
14 them than I would with maybe 15 or 20 medical children.
15 So the amount of time wasted on trying to get doctors --
16 and it wasn't that they weren't answering their bleeps,
17 it was they were in theatre, they were in clinics, they
18 were in A&E, they were in outlying wards, there was
19 emergency going on in A&E. You know, it was very
20 difficult to get them.

21 THE CHAIRMAN: So they seemed to be everywhere else other
22 than where you needed them?

23 A. Yes, I'm saying this, I said it at this meeting as far
24 as I remember. I cannot remember exactly what I said.

25 THE CHAIRMAN: Don't worry about the exact words, it's the

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1 us. And whilst I was able to vocalise to them and get
2 them -- junior staff, when I was off or weekends or
3 whatever, I felt it was unfair that they were
4 experiencing these problems.

5 THE CHAIRMAN: So in terms, does that mean that because you
6 were the most senior sister in paediatrics, you had
7 a bit of extra weight that a doctor might respond to
8 you, but you couldn't --

9 A. Yes.

10 THE CHAIRMAN: Your junior nurses didn't necessarily get the
11 same response?

12 A. There were two junior sisters and they were able to act
13 like me, and I had a lot of very experienced senior
14 nurses. But whether they would have phoned a doctor at
15 home, I'm not sure. They may have, I don't know.

16 THE CHAIRMAN: Was this difficulty that you had in getting
17 surgeons over to the children's ward, was that
18 a question of numbers, that there weren't enough
19 surgeons around, or did you have a feeling that they
20 weren't really giving the paediatric unit the priority
21 or the importance which it merited?

22 A. No, I felt there weren't enough of them, and I felt they
23 were doing their best, they just didn't have the time.
24 That was my impression that there just weren't enough of
25 them.

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1 gist of what you said that I'm interested in.

2 A. And actually, until I read Nurse Noble's transcript last
3 night, I had actually forgotten what I had said. What
4 I'm telling you now maybe is not exactly what I said,
5 but I did give a very -- I just felt ... Yes, the main
6 thing I said was, I used the word "responsibility".

7 I remember that. I said that I thought it was totally
8 unfair that the nurses had such responsibility for the
9 surgical children. I felt it was unfair. I felt that
10 we had to be the lead all the time in looking after the
11 surgical children. We are nurses, we're not doctors,
12 and whilst we do our very best, I don't think we should
13 be prompting doctors. We would now maybe, but 12 years
14 ago ... Or I don't think we should be telling a doctor
15 to do electrolytes. It's different now, we're more
16 knowledgeable, we've had quite a bit of education. But
17 in those days, really we were leading the care, I feel,
18 in looking after children. And my nurses --

19 THE CHAIRMAN: Sorry, this is on the surgical side?

20 A. This is only the surgical side. It was just totally
21 different. And whilst I could get on the phone and
22 phone doctors and speak to them, ask them "please come
23 now", also I have actually telephoned surgeons at home,
24 not a lot, but I have on the odd time at a weekend.

25 I just felt that the main responsibility was falling on

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1 THE CHAIRMAN: Can I ask you, just feeding on from that,
2 there does seem to have been a significant turnover of
3 junior doctors, JHOs and SHOs. Have I got a false
4 impression of that or was that a concern?

5 A. No, I mean, the consultants were obviously there all the
6 time and the registrars. I think the registrars, their
7 placement was a year. But the SHOs, I'm not sure
8 whether it was six months. I mean, they did change
9 fairly regularly.

10 THE CHAIRMAN: Would that be the same anywhere else?

11 A. No, I think that's similar with ...

12 THE CHAIRMAN: Your concern that you felt that there just
13 weren't enough surgeons and that's what was leaving the
14 nurses to take the lead, is that something which you had
15 expressed before Raychel's death or is that something
16 which was -- was it Raychel's death which brought this
17 to a head and made you speak out in the way that did you
18 on 12 June?

19 A. No, I had spoken about this before. I know I'd spoken
20 about it at the meetings within our -- sisters' meetings
21 and we at that time had regular paediatric consultants'
22 meetings. I may well have spoken about it at that.
23 I mean, people knew I wasn't happy with the ...

24 THE CHAIRMAN: Just let me push you a little bit on that.
25 If you said to the other sisters, then the nurses who

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1 work under you know you're concerned, if you express
2 that view to the paediatric consultants then they know
3 you are concerned. Had you expressed that view to
4 anyone in the surgeons' hierarchy, any consultant
5 surgeons? Because they might -- it seems to me, maybe
6 this is wrong, but that might be the very person to
7 speak to about it.
8 A. Yes.
9 THE CHAIRMAN: Because ultimately, the consultant surgeon is
10 responsible for the registrar and on down.
11 A. I may have -- I wouldn't have found the surgeons ...
12 They're all very good people I'm sure, and very hard
13 working, but I wouldn't have had the relationship with
14 them that I would have had with the paediatric
15 consultants. Surgeons are different to physicians.
16 THE CHAIRMAN: Okay. To put it bluntly, did it take
17 Raychel's death to lead to some sort of sea change in
18 Ward 6?
19 A. Well, it did, obviously there were changes after Raychel
20 died. But I think prior to Raychel dying, I think --
21 one of my main problems was that ... And I think this
22 was before Raychel died, that you would have liked the
23 children to be reviewed early in the morning so that you
24 could plan your day. And also, if there were children
25 to be discharged, that we could get them discharged and

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1 A. You mean about the ...
2 THE CHAIRMAN: About the meeting on 12 June or what you said
3 at it. I think we've got a pretty good picture of the
4 meeting on 12 June, and as I said previously, it stands
5 in very favourable contrast to what had happened after
6 the deaths of the other children that we've looked at.
7 A. Well, there was very open discussion about what had
8 happened. As I say, I can't remember exactly, but the
9 main thing that I remember out of it was there was a big
10 discussion around the fluid, the Solution No. 18, what
11 were we to do. I think Dr Nesbitt may have got some
12 initial information on the Monday, I wasn't working on
13 the Monday. There was a lot of discussion around, do we
14 put the children on Hartmann's, the surgical children.
15 At the end of the meeting, it was decided, no, he would
16 enquire around other hospitals and see, but at the
17 moment, no, to leave Solution No. 18 for the surgical
18 children and as here, there were two points that I had
19 to implement. The daily electrolytes on all children
20 receiving intravenous fluids and how I would do that,
21 I had to inform staff, and I had to document in our
22 treatment communication book the electrolytes. And
23 also -- oh yes, it was recognised at the meeting that --
24 and that was my main concern at that meeting, was our
25 failure in the documentation. Because that, you know,

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1 that the parents weren't waiting all day. That was
2 a big problem. I'm not sure exactly when, but it was
3 before Raychel died. I think that I had --
4 THE CHAIRMAN: Sorry, that's the surgical ward round you're
5 talking about?
6 A. Yes.
7 THE CHAIRMAN: So although it happened to be reasonably
8 early with Raychel on the Friday, that wasn't typical?
9 The surgical ward --
10 A. I think I conveyed that to the surgeons and they had
11 decided that -- at least they then said that they would
12 try to do the children's ward first. Now, as far as
13 I remember, that was before Raychel died. So then the
14 plan was that they would come up every morning, they'd
15 see the children first before going to the adult wards.
16 So that was a concern I had. That helped, that did help
17 in the planning of care for the surgical children.
18 THE CHAIRMAN: Right. Okay, so that was something which
19 you -- we got on to that because you'd said you had
20 strong views on things which had upset you. This was
21 what you expressed at that meeting on 12 June?
22 A. I did.
23 THE CHAIRMAN: Is there anything else in particular that you
24 can recall, either from your own memory or from what
25 Mrs Noble remembers?

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1 was a nursing issue.
2 THE CHAIRMAN: You said it was your main concern, but the
3 lack of support from surgeons and the nurses having to
4 take a lead would surely be at least as big as that?
5 A. Oh it would, yes.
6 THE CHAIRMAN: Thank you.
7 MR WOLFE: You said, Mrs Millar, that one of your concerns
8 was really 12 or 13 years ago it shouldn't have been the
9 nurses prompting the surgeons to do electrolytes. Now,
10 plainly, at this meeting, the issue of the need to
11 arrange daily urea and electrolytes on all
12 post-operative children on IV fluids emerged as a major
13 theme. Can I ask you if you can assist us on this.
14 Presumably it emerged as a major theme because it was
15 recognised that one of the cardinal errors in the care
16 of Raychel was the failure to assess her electrolytes in
17 a timely fashion.
18 A. Yes. My recollection of the meeting was that the main
19 issue that was discussed that day was the fluid. That
20 was the main issue. There was a long, long discussion
21 about the appropriateness of the fluid, because I think
22 when Raychel was taken to the Royal, one of my nurses
23 accompanied Raychel. And a nurse in the intensive care
24 in the Children's in Belfast said when Raychel arrived
25 and there was handover, that she was on the wrong fluid.

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1 The nurse came back, obviously, and said this to me and
2 my colleagues. That was brought up at the meeting, as
3 far as I remember, because we thought, "How could she be
4 on the wrong fluid?". So I think that was brought up as
5 an issue and Dr Nesbitt was there, I don't remember any
6 other anaesthetists being there, but I remember
7 Dr Nesbitt was there. He had said he was looking into
8 the appropriate fluids or appropriateness of ... He
9 said he would be contacting other hospitals.

10 I think as well the Department of Health was
11 mentioned, you know, as to whether standards had been
12 forwarded to hospitals.

13 Q. Mrs Noble in her evidence recalled that notwithstanding
14 the expression of concern that Altnagelvin didn't know
15 that Solution No. 18 was no longer being used in the
16 Royal, notwithstanding that that was a problem
17 nevertheless it was recognised at this meeting on
18 12 June, particularly by you, that there was a need to
19 carry out electrolytes on Raychel that night, that you
20 were pushing the electrolyte point.

21 A. Yes. Well, the electrolytes were discussed as well.
22 Yes, it was agreed that electrolytes should have been
23 done.

24 Q. Was it recognised that it was a failure or an error for
25 them not to have been done?

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1 THE CHAIRMAN: If any of your clients could help us with who
2 that nurse was, Mr Campbell, I'd be grateful, or if
3 anyone else could.

4 MR WOLFE: Summarising the outcome of that meeting,
5 Mrs Millar, an action plan was to be drawn up and
6 various people had to take various steps pursuant to
7 that action plan, including yourself. This is based on
8 an acceptance that Solution No. 18, it was now emerging
9 as being a fluid that one would have to be careful with
10 in the post-surgical phase.

11 A. Yes.

12 Q. And in Raychel's case clearly electrolytes ought to have
13 been done because of the severity of her vomiting?

14 A. Yes.

15 Q. The failure to do electrolytes was an error?

16 A. Yes.

17 Q. In terms of the use of junior house officers to come to
18 surgical patients, Mrs Noble told us that that was
19 a concern that was raised by her, that she felt that
20 junior house officers such as Dr Curran didn't really
21 understand how severely ill Raychel was and that
22 thereafter a change was brought about in Altnagelvin, by
23 which senior house officers became, if you like, the
24 rank of doctor to attend surgical patients. Do you
25 remember that?

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1 A. I would say it was recognised as a failure.

2 Q. And the other issue that I think it appears clear
3 through Dr Nesbitt's statement to the PSNI -- the fact
4 that Raychel had been given too much fluid or too high
5 a rate of fluid was also recognised.

6 A. I don't recollect a discussion around that. As I say,
7 I see Nurse Noble's evidence, but I have no recollection
8 of the volume of fluid being given and, as has been
9 discussed, I cannot remember that it was.

10 Q. Do you know the name of the nurse who received the
11 message from the Royal that the wrong fluid had been
12 given?

13 A. No. No, it was -- I just can't remember. It was the
14 nurse who accompanied ...

15 THE CHAIRMAN: I think Dr Nesbitt went with Raychel as well,
16 did he?

17 A. He did, yes.

18 THE CHAIRMAN: And a nurse.

19 A. A nurse, and an anaesthetist probably.

20 MR WOLFE: So if we can --

21 THE CHAIRMAN: Sorry, maybe not Dr Nesbitt. Sorry, he did.

22 MR WOLFE: Dr Nesbitt tells the inquiry that he learns of
23 this information through Dr Chisakuta in the Royal.

24 MR CAMPBELL: It was Dr Nesbitt who drove in the ambulance
25 and a nurse.

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1 A. Yes, I do.

2 Q. Was there a fear factor or a reluctance in the period
3 before Raychel's death and including, I suppose, the day
4 of her death, to bring senior doctors to the bedside of
5 a child?

6 A. Yes, I know there was a change in the system of who
7 would review children and who would admit children
8 in the surgical side. It had always been a JHO or, if
9 he was busy, obviously the SHO. But there was -- and I
10 cannot remember whether it was prior to Raychel's death
11 that the SHO or registrar should be the person to admit
12 and make decisions about the care of the surgical child.

13 Q. Plainly, in Raychel's case, after her admission, which
14 was by an SHO, there was a ward round by an SHO, but
15 during the day when she was getting increasingly ill,
16 she was attended by a JHO. Now, is it a cultural thing,
17 is a fear thing that your nurses contacted JHOs to come
18 to see Raychel, or in turn was it an issue for the JHOs
19 to get the more senior doctor in to see Raychel?

20 A. Can you repeat that, please?

21 Q. Maybe more succinctly, I could ask you: why was a more
22 senior doctor not brought to see Raychel on any of those
23 two occasions during the day when she was granted the
24 anti-emetic?

25 A. If you remember, at 3 o'clock when Nurse McAuley rang me

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1 to say Raychel had vomited, I said could she get
2 a doctor. And I think I said yesterday in my evidence
3 that I understood that would be Dr Makar or Dr Zafar.
4 But I didn't know that she actually wasn't able to
5 contact them. So when I returned over to the ward,
6 after ringing her to say, "Have you got a doctor?", she
7 said no, and I thought, "Right, I'll go over and see if
8 I can get somebody", but then I saw Dr Devlin on the
9 ward and asked Nurse McAuley to ask him. But it would
10 have been preferable for a more senior doctor, yes, to
11 have seen Raychel.
12 Q. You attended the meeting on 3 September with the
13 Ferguson family. What was your understanding of the
14 purpose of that meeting?
15 A. I was asked to attend the meeting by Mrs Burnside, she
16 had sent out a message via, I'm not sure who, probably
17 my clinical services manager that the nurses involved
18 with Raychel should attend a meeting with Mr and
19 Mrs Ferguson. I didn't know -- I mean, I didn't know
20 what the meeting was for, but I presumed it was to meet
21 with the family and talk to them and answer any
22 questions they might have. That was my understanding.
23 Q. You would have appreciated at that time that the
24 Fergusons were going through the agony of the grief of
25 losing their daughter and that this meeting was designed

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1 recollection of the 12 June meeting.
2 A. I do remember parts of this meeting. I had a better
3 recollection of this meeting than I did of the critical
4 incident meeting.
5 THE CHAIRMAN: Thank you.
6 A. I haven't full -- I cannot remember the exact
7 conversations.
8 THE CHAIRMAN: Of course.
9 A. But I have some idea.
10 THE CHAIRMAN: And have you had a chance to look at the note
11 of the meeting? There's a 10-page record of this
12 meeting of 3 September.
13 A. Of Nurse Noble's ...
14 THE CHAIRMAN: No, the 3 September. We have a 10-page note
15 of it, which was taken by the patient's advocate,
16 Mrs Doherty.
17 A. No, I didn't get that, no.
18 MR WOLFE: Well, let me take you to the parts of that
19 meeting where you made some input. You can see on the
20 screen in front of you, two-thirds of the way down the
21 page:
22 "Sister Millar said she was on duty on Friday
23 evening. She went off at 6 o'clock. Raychel was
24 walking out to the toilet and did not appear to be in
25 pain. She was walking well."

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1 presumably to give them a full and accurate account of
2 the events leading to that death?
3 A. Yes.
4 Q. You would have known that to have been the purpose?
5 A. I would.
6 Q. Now --
7 A. Well, I understood the meeting was to explain what had
8 happened to Raychel. I didn't know -- I mean, I had no
9 idea, I'd never been to a meeting like this before in
10 all my, at this stage, 36 years of nursing, so I didn't
11 know. I went in and sat down. Nobody said to me,
12 "You're to take part, you're not to take part". I mean,
13 I ... I can't describe to you how I felt that day. I'd
14 only been told that morning that Raychel had died.
15 Sorry, it wasn't --
16 Q. This is the September meeting.
17 THE CHAIRMAN: We're talking about the end of the summer,
18 really, 3 September.
19 A. Yes, sorry about that. I'd only come back that morning,
20 as I say, and ... I was very upset.
21 MR WOLFE: Yes. Can I bring you to your input to the
22 meeting, 095-010-046k, please.
23 THE CHAIRMAN: Just as we start this, how much of this
24 meeting with the family on 3 September do you remember?
25 You've told me that you have very little detailed

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1 That relates to your observations that you've told
2 us about in the late morning/early afternoon.
3 A. Yes.
4 Q. "Sister Millar remarked to Raychel's dad how well
5 Raychel was doing. Sister Millar had been aware that
6 Raychel had vomited at around 9 am but she did not see
7 the vomit. Sister Millar did not consider this unusual
8 as lots of children vomit. She had no major worries
9 regarding Raychel but asked the doctor to give her
10 something for the vomiting. When Sister Millar went off
11 at 6 pm, the doctor was giving Raychel Zofran."
12 That is the first recorded input into the meeting
13 from you. I think there's a second one at page o,
14 please. "Sister Millar said she came back from days off
15 and was absolutely devastated when she heard. She said
16 she had been nursing for over 30 years and had never
17 seen anything like this happen. There would be some
18 children that you worried about but there was nothing
19 about Raychel that caused her concern."
20 Now, plainly, Mrs Millar, arising out of the events
21 of the critical incident meeting in June you and your
22 colleagues were coming to this meeting, having admitted
23 to yourselves behind closed doors that certain mistakes
24 had occurred. Is that a fair synopsis?
25 MR STITT: I'm sorry, Mr Chairman, I don't know where the

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1 expression "behind closed doors" comes from. It doesn't
2 add to the sum of knowledge in this case and it is
3 pejorative.
4 THE CHAIRMAN: An internal meeting within the Royal.
5 MR STITT: Yes. With respect, that would be a preferable
6 way to phrase it.
7 MR WOLFE: Very well. I don't believe it to be pejorative,
8 but I --
9 MR STITT: And it's something that was taken up two days
10 ago.
11 THE CHAIRMAN: Mr Wolfe was saying that there had been an
12 internal meeting on 12 June, at which people had faced
13 up to the fact that mistakes had been made in Raychel's
14 case and those mistakes -- mistakes had been made in
15 Raychel's case, you had also made, as I now understand,
16 some general points about the care of children on the
17 surgical side, and that led to change.
18 A. Yes.
19 THE CHAIRMAN: I think Mr Wolfe, you can pick it up there.
20 MR WOLFE: Yes. In terms of what you said at the meeting,
21 Mrs Millar, we have some of what you said in front of
22 us, where you expressed that there was no concern. Is
23 it fair to say that you didn't articulate to
24 Mrs Ferguson at this September meeting the fact that the
25 Trust recognised that the fluid rate was excessive in

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1 far as I remember, he did mention the electrolytes that
2 we had learnt lessons from Raychel's death and we would
3 now be -- we had changed our practice as far as
4 I remember.
5 Q. Was it said in plain terms to Mrs Ferguson that: we have
6 changed our practice because we recognise that we made
7 an error in Raychel's case?
8 A. Yes, I think that was said.
9 Q. And who said that?
10 A. Dr Nesbitt, as far as I remember. He explained, you
11 know, the problem with the fluid or the problem and the
12 different events leading up to Raychel's death. There
13 was explanation around the fluid and, as far as
14 I remember, there was mention of the electrolytes.
15 Q. There's no doubt there was mention of the electrolytes.
16 Let me bring you to that. If you would go back to page
17 n within this sequence of documents.
18 THE CHAIRMAN: I think you might want n and o together,
19 Mr Wolfe.
20 MR WOLFE: Yes.
21 Working off the left-hand page, first of all,
22 Mrs Doherty appears to introduce the issue of sodium
23 levels. Do you see that, halfway down the page? She
24 asks --
25 THE CHAIRMAN: Mrs Doherty asked what her Raychel's sodium

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1 Raychel's case?
2 A. As I've said to you, I cannot remember the volume of
3 fluid being discussed at the meeting on 12 June. I have
4 no clear recollection of that.
5 Q. Okay, so the answer to this question is, no, you didn't
6 articulate to Mrs Ferguson that there was an excess of
7 fluid.
8 A. No.
9 Q. The second point is this. There has been a recognition
10 at the June meeting that there was an error in failing
11 to carry out an electrolyte assay in Raychel's case.
12 And you've indicated this morning that one should have
13 been -- there was a recognition that one should have
14 been carried out because of the severe vomiting
15 experienced by Raychel.
16 Now, did you personally articulate that account to
17 Mrs Ferguson at the September meeting?
18 A. No, not that I can recall. I thought of my recollection
19 is that Dr Nesbitt did or he ... I cannot remember
20 exactly what he said, but I know that he did mention the
21 fluids and the appropriateness of the fluids and the
22 fact that we had learnt from the events around Raychel's
23 death. He tried to explain or he did explain to
24 Mrs Ferguson what the fluid would have done, you know,
25 the low sodium he thought was the main problem. But as

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1 levels.
2 A. Yes.
3 MR WOLFE: "What is routine? What checks do you do?"
4 Dr McCord said:
5 "Bloods are checked routinely on admission.
6 36 hours prior to this, Raychel's bloods were normal."
7 And we know that her serum sodium at admission was
8 137.
9 "Mrs Doherty asked if they should not have been
10 checked after the operation. Dr Nesbitt said they may
11 have to review procedures. It may be necessary to check
12 routine admissions pre-op and post-op. The reason why
13 they are not done routinely is that it requires a needle
14 into the vein to take the blood. At 3.30 am Raychel's
15 sodium was down."
16 Now, I can stand corrected, but that is the most
17 involved or detailed passage dealing with the issue of
18 blood tests.
19 THE CHAIRMAN: I think Mr Stitt might invite you to take the
20 witness to the top of page 7 where Mrs Doherty said,
21 four lines down:
22 "Raychel then had her blood checked regularly.
23 Dr McCord said that was when she was in ICU. Dr Nesbitt
24 said that is something that we might have to do, check
25 bloods six hourly, I have never seen this before."

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1 MR WOLFE: That's right. For completeness, that's right.
2 On the left-hand side, Mrs Doherty is asking specific
3 questions about Raychel's specific case. Leaving aside
4 the record, Mrs Millar, are you saying that Dr Nesbitt
5 said more at the meeting than what I have just read to
6 you, on the basis of your memory?
7 A. No, I can't remember anything ... I can't remember.
8 I mean, Dr Nesbitt said there they may have to review
9 procedures.
10 Q. Yes.
11 A. But there was already -- the procedures had been changed
12 at this stage.
13 Q. Of course.
14 A. The electrolytes were being done 12 hours, they were
15 being done preoperatively, intraoperatively and
16 12 hours.
17 Q. That's the point, isn't it, Mrs Millar? This record --
18 and no doubt everybody who was at that meeting will have
19 an opportunity to comment on aspects of it that they
20 remember and which might concern them. But that record
21 suggests that this issue about electrolyte analysis was
22 something that the hospital was considering reviewing as
23 opposed to something that they had reviewed and changed
24 based on a mistake in Raychel's case. Do you see the
25 distinction?

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1 parent at this meeting, do you have a recollection of
2 anything like that being said?
3 A. Well, I do remember that ... As far as I can remember,
4 Dr Nesbitt was very open in explaining that there was
5 a fault on the care of Raychel. As far as I remember,
6 that came across to ... He was very open and honest.
7 That was my impression of the meeting.
8 Q. In terms of the fault that he accepted or admitted to at
9 that meeting, what did he say, what was the fault?
10 A. I can't -- well, I cannot remember exactly, but it was
11 around the --
12 THE CHAIRMAN: I think Mrs Millar has already said, "I think
13 Dr Nesbitt said that Raychel should have had her
14 electrolytes done". Mrs Millar is remembering something
15 which is not perhaps spelt out in the same way or
16 detailed in the same way on the transcript, but her
17 recollection maybe goes beyond -- not the transcript,
18 the record. Mrs Millar's recollection goes somewhat
19 beyond that and her recollection is that Raychel,
20 according to Dr Nesbitt, should have had her
21 electrolytes done. You think he was very open and that
22 there was a fault in Raychel's care?
23 A. Yes. I thought he was very honest and open at that
24 meeting, and I was ... I didn't have great input into
25 the meeting, but he was very, very sympathetic and there

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1 A. Yes, I do. That was already in place.
2 Q. And you can't help us any more in terms of your memory
3 as opposed to this or as compared to this record?
4 A. You mean in what was said?
5 Q. Well, your memory, you tell us, broadly, is that the
6 issue of electrolytes was addressed at the meeting
7 through Dr Nesbitt. I'm bringing you to portions of the
8 record that have Dr Nesbitt dealing with this issue.
9 A. Well, I think in his explanation about the fluid --
10 I mean, I cannot remember fully, but I think in his
11 explanation about the fluid to Mrs Ferguson he did say,
12 as far as I can remember, that Raychel should have had
13 an electrolytes done. That's as far as I can remember.
14 Q. Because if that was said in that way, that would be
15 an important thing to say because, if I can explain it
16 in this way, Mrs Millar, notwithstanding that Raychel
17 was being given Solution No. 18, she had been vomiting
18 through large parts of the day. You have accepted that
19 the vomiting was severe and that electrolytes were
20 justified by at least 9 o'clock. Now, if electrolytes
21 had been done, the expert evidence appears to be that
22 that would have identified a biochemical imbalance that
23 could have been addressed and Raychel's life potentially
24 would have been saved.
25 In terms of the narrative that was revealed to the

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1 was an apology, he apologised to the family. I thought
2 his explanation of what had happened was very
3 sympathetic and I thought he did his best to explain it
4 in simple terms that the family would understand. But
5 I cannot remember exactly what he said. I felt he had
6 made a good effort to try to get through to the family.
7 MR WOLFE: Just to be clear, you said you don't have a clear
8 recollection of what he said.
9 A. Not of his exact words.
10 Q. But in terms of him saying to the family that there
11 ought to have been electrolyte testing, did he say that
12 on your best recollection?
13 A. He may have said that, you know, that monitoring of her
14 IV fluids -- it may have been in that context. But
15 I did ... At least I did think he did bring up the
16 issue of the electrolytes.
17 Q. He clearly did on this account. But what is apparently
18 missing from this account is relating the omission to
19 carry out electrolytes in Raychel's case to the decision
20 to consider reviewing electrolytes.
21 A. You're asking ...
22 THE CHAIRMAN: Sorry, let me try to put it more simply, just
23 to bring this to a head, because there's a limit to the
24 amount of times we'll go over this. If you look at the
25 left-hand side of the screen, page n -- could you take

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1 down page o, please, and just give us page n? Could you
2 highlight the bottom half of the page, please?

3 If you go to the fourth paragraph down, one line:

4 "Mrs Doherty asked if they should not have been
5 checked after the operation."

6 Right?

7 A. Yes.

8 THE CHAIRMAN: Dr Nesbitt's answer isn't yes, they should
9 have been checked after the operation. Dr Nesbitt's
10 answer, according to this note, is they may have to
11 review procedures, it may be necessary to check routine
12 admissions pre-op and post-op. If Dr Nesbitt was going
13 so far as to admit fault, as you recall in general terms
14 that he did, if he said, "I think she should have had
15 her electrolytes done", is that not most likely the
16 point at which he would have said it?

17 A. Sorry, I ...

18 THE CHAIRMAN: If he was asked -- he's asked specifically by
19 the patient advocate, "Should the bloods not have been
20 checked after the operation?". And he doesn't say yes
21 or he doesn't say, "Well, not immediately after the
22 operation, but later during Friday as she was repeatedly
23 vomiting". He doesn't say anything along those lines.
24 What he does say is that they may have to review
25 procedures. Now, if he was going to say, "Yes, we were

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1 I could say, if I may add, that it -- as I said, it was
2 a very difficult meeting and I have personally -- I just
3 felt there were too many people in the room. I ...

4 I said what I said, and I accept that, you know,
5 that ... that Raychel was, you know, deteriorating
6 earlier than we as nurses recognised. I accept that.

7 THE CHAIRMAN: It would be unfair to be critical about this,
8 but this is a point which was made by Professor Rooney
9 about a meeting in 2004/2005 after the UTV programme had
10 been broadcast. She was asked by the Royal to meet the
11 parents of Claire Roberts. She said at that time she
12 was anxious to keep down the number of people at the
13 meeting because she wanted -- she didn't want -- I'm
14 going from recollection, but I think it was to the
15 effect that she didn't want the family to be
16 overwhelmed, Mr Quinn, and she wanted a clear message to
17 be received.

18 I can see why in Altnagelvin Mrs Burnside would want
19 to be there, she's the leader in Altnagelvin as the
20 chief executive. I can see entirely why people like
21 Dr Nesbitt should be there, Dr McCord, you're there in
22 effect as a sister who was in charge and who was also
23 actively involved in treating Raychel. Mrs Noble is
24 there because she was there on two shifts. Maybe
25 there's a lesson or do you think there might be a lesson

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1 at fault" or "We should have done that better", or
2 however he phrased it, is that not the point at which
3 you would have expected him to say that, when he's asked
4 the direct question?

5 A. Yes.

6 THE CHAIRMAN: Thank you.

7 MR WOLFE: Mrs Ferguson has made a statement to the inquiry,
8 indicating that she left the meeting feeling confused
9 and believing that this was the start of an Altnagelvin
10 cover-up. Those are the words that she has used in
11 a statement. Did you leave the meeting thinking that
12 the family ought to have heard more from those present
13 in relation to how Raychel was treated?

14 A. No. I mean, I thought that Dr Nesbitt had done his very
15 best to give an explanation to the family. As I said,
16 I'd never been to a meeting like that before. I felt
17 he -- it was a long meeting, Mrs Burnside spoke, she
18 chaired the meeting, as far as I remember, and as
19 I said, Dr Nesbitt gave a very long account. I just
20 cannot remember, but I thought it was very fair,
21 I thought it was honest, and I thought he was open.
22 Dr McCord was asked by Mrs Burnside, I think at one
23 stage, I think it was about the fluids. I think he made
24 an explanation to Mrs Ferguson that this was the fluid
25 that was used widely at the time and that ... So

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1 to be learned there about how many people come in?

2 A. Well, I thought there was more than that, I thought most
3 of the nurses were there. Maybe I'm wrong. I know
4 Nurse McAuley wasn't there.

5 MR WOLFE: The full list, sir, is at page i.

6 THE CHAIRMAN: 095-010-046i. Of course the reason I'm not
7 being critical on this is because if part of the reason
8 is to answer questions from the family, then you might
9 want a range of people to be there who are involved in
10 different aspects.

11 That's the list of people, Mrs Millar.

12 MR WOLFE: There are 12 people there, sir.

13 A. Right. Well, all of those should have been there.

14 THE CHAIRMAN: The first four people are family. Then
15 you have the family GP, who will be of assistance, and
16 he or she was the person to whom the notes would be
17 sent. You have a representative of the Council, and
18 then you have five representatives of Altnagelvin, if
19 I can describe them in that way, and then you have
20 Mrs Doherty.

21 Is your concern there's a bit of a risk that with
22 that number of people there, it all becomes a bit
23 difficult for the family to absorb?

24 A. Yes. I thought there were more than that there.

25 MR STITT: May I intervene from a Trust perspective?

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1 I understand the thrust of the questions and I know it's
2 an entirely appropriate investigative line of
3 questioning. May I just remind the tribunal that this
4 in itself was a rare event, this type of meeting, and
5 the critical incident plan had only been effective for
6 effectively about 18 months. So this was a learning
7 curve and anything that comes out of this inquiry which
8 can improve will of course be valuable.

9 THE CHAIRMAN: But there's actually a problem here,
10 Mr Stitt, because if for instance -- if the family had
11 questions to ask about what happened during the day
12 shift, then Sister Millar would want to be there on the
13 nursing side. If they wanted to ask what happened on
14 the nursing side on either of the night shifts, you
15 might want Mrs Noble there. It's a bit hard -- I'm not
16 sure it's entirely obvious about who should be dropped
17 from that list. That's the problem.

18 MR STITT: I don't have instructions on this, but maybe the
19 answer is to, after being fully advised, a family might
20 request that certain persons be at a meeting to answer
21 certain issues.

22 THE CHAIRMAN: I'm just raising it because Professor Rooney
23 had raised this in Claire's case and she was wary about
24 having two meetings because she thought that can send
25 out mixed messages, but if you have one meeting with too

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1 THE CHAIRMAN: Okay. Mr Quinn, have you anything?
2 MR QUINN: Just on that point, I think it was Mrs Doherty,
3 the sister, who asked most of the questions.
4 THE CHAIRMAN: Is that K Doherty?
5 MR QUINN: Yes. If you look at the first line:
6 "Mrs K Doherty said she would ask the questions."
7 That's the recollection of the family.
8 THE CHAIRMAN: You're quite right, yes.
9 MR QUINN: I have no questions on this issue.
10 MR CAMPBELL: Mr Chairman, I have no questions, but the
11 point you asked about earlier, the identity of the nurse
12 who accompanied the transfer. The name that I have
13 gathered is Margaret Dooher. I'm unclear as to the
14 spelling of the surname, but apparently the name does
15 appear on a patient transfer sheet.
16 THE CHAIRMAN: We'll take it as the Tyrone Dooher, which is
17 double O.
18 A. She's the intensive care nurse.
19 THE CHAIRMAN: Thank you very much.
20 I think Mr Campbell gets the last shot if he has
21 anything. Mr Stitt, do you have anything for this
22 witness?
23 MR STITT: No, sir.
24 MR CAMPBELL: Nothing, sir.
25 THE CHAIRMAN: Mrs Millar, thank you very much for your

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1 many people at it, there's scope for confusion, too many
2 people talking or contributing and nobody ... In an
3 already difficult situation, a message which comes
4 across which isn't entirely clear. There it is. It may
5 just be one of those things for which there's no right
6 or wrong answer.

7 MR STITT: In fact, it seems to split down, six Trust and
8 six family, if you include the second Mrs Doherty as
9 family, being the patient's advocate. She's employed by
10 the Trust.

11 THE CHAIRMAN: That's also on the basis that you include the
12 GP as family.

13 MR STITT: Well, yes. I'm not suggesting two teams of
14 equal --

15 THE CHAIRMAN: There's a range of people there.

16 MR STITT: It's not as though it was Mr and Mrs Ferguson and
17 ten doctors. That's the point I'm making.

18 THE CHAIRMAN: Mr Quinn, had the Fergusons met Mrs Doherty,
19 the patient's advocate, before that meeting?

20 MR QUINN: My instructions are they hadn't, but I'll check
21 that at lunchtime.

22 THE CHAIRMAN: She does seem to have asked some pretty
23 relevant questions. Okay. There we are.

24 MR WOLFE: Sir, I have no further questions for this
25 witness.

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1 time. Unless there's anything else you want to say, you
2 are now free to leave.
3 A. Thank you. No, I've got nothing.
4 (The witness withdrew)
5 THE CHAIRMAN: Ladies and gentlemen, it's coming on 12.40.
6 We've got a doctor who's travelled from England to give
7 evidence today and his evidence will be finished today.
8 I'm in your hands about what you want to do. We started
9 just after 10. Do you want to stop for lunch now and
10 start at 1.30? We're going to have to break for ten
11 minutes for the stenographer. Maybe we'll run the two
12 into one, take an early lunch, start at 1.30 and we will
13 hear Mr Zafar's evidence from 1.30. Okay?
14 (12.40 pm)
15 (The Short Adjournment)
16 (1.30 pm)
17 THE CHAIRMAN: Mr Stitt, just before we start with the next
18 witness, can I flag up to you that I want to raise with
19 you now and the other parties a letter which we received
20 yesterday, signed by Ms Beggs, which I think has been
21 distributed. 316-048-001. I have a number of concerns
22 about this, but the main one is that in the second
23 paragraph the Trust -- I presume the "we claim" is
24 a reference to the Western Trust, is it?
25 MR STITT: Yes.

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1 THE CHAIRMAN: The Western Trust is claiming privilege
2 in relation to the contents of the DLS inquest file.
3 You may not know this because you weren't --
4 MR STITT: Sorry, I must correct an earlier answer. The
5 "we" is the DLS.
6 THE CHAIRMAN: The DLS is the solicitor to the trusts, so
7 any claim for privilege is made on behalf of the
8 Trust -- of the client.
9 MR STITT: Yes. It's been made by the DLS on behalf of the
10 Western Trust.
11 THE CHAIRMAN: Yes. So it's the Trust's claim for
12 privilege.
13 MR STITT: Yes.
14 THE CHAIRMAN: The reason I'm raising it is that we had
15 a very unhappy experience last June about a document
16 which was found in the Brangam Bagnall inquest file
17 in relation to Adam's inquest. That led to the inquiry
18 being adjourned late in June and it led to an exchange
19 of correspondence between myself and Mr Maginness.
20 Mr Maginness wrote to me in -- I'm raising this now and
21 we can give you the list of correspondence, but
22 Mr Maginness wrote to me in July last year to say that
23 the various trusts were taking instructions or were
24 requiring advices from senior counsel, particularly
25 in relation to legal professional privilege before they

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1 raising this now and I also presume that the
2 representatives of the Ferguson family might want to
3 consider this point about a claim for privilege, so
4 I don't want to pursue it now.
5 MR STITT: I'm not going to give a detailed submission
6 because clearly I haven't had chance to prepare it, but
7 might I just respond by saying at the outset any file
8 has got a range of documents in it.
9 THE CHAIRMAN: Yes.
10 MR STITT: Those which are more privileged than others, so
11 to speak, maybe they might be direct legal advice or
12 they might be peripheral documents. In this particular
13 case what has happened is that the solicitor to the
14 inquiry, Ms Dillon, has specifically asked for an
15 earlier document. A full search was made of the trust's
16 file, as in the file held by Ms Brown, and no document
17 was found there; the reason being the original statement
18 of Mr Zafar was a draft statement, which then became the
19 final statement, and my instructions are that at that
20 time Ms Brown's universal practice was to destroy any
21 draft document and keep a final document.
22 That meant that in an effort to try to respond to
23 the questions which were being raised, a further search
24 was made, and this time inside the DLS file, into the
25 inquiry, and the letter was there. I obviously will

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1 could confirm instructions.
2 I acknowledged that. So having been told last July
3 that the Western Trust and the other trusts were
4 considering a claim for privilege, I now find that
5 a claim for privilege is made on 20 February, more than
6 six months later, and during the hearing. That's one
7 point.
8 The second point is that there was an earlier issue
9 about privilege in Raychel's case, which straddled the
10 break between 2005 and 2009, and the Trust did not
11 pursue a claim for privilege or, alternatively, waive
12 privilege in relation to the reports of Dr Warde and
13 Dr Jenkins, which is how the inquiry comes to hold
14 Dr Warde's report. So it now seems to me that the Trust
15 is being selective or may be selective in the documents
16 for which it is claiming privilege.
17 That is an issue which I may require submissions on
18 next week, about whether you can partially waive
19 privilege and partially retain a claim for privilege.
20 It seems to me at first blush that it would clearly be
21 inappropriate for a party to say, "We'll give you some
22 documents for which we can claim privilege, but we're
23 not going to give you other documents", because on that
24 scenario that party has an opportunity to skew the
25 evidence by giving some and withholding others. I'm

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1 take time to prepare a full argument, if necessary. If
2 privilege is claimed, that privilege, in my respectful
3 submission, can be waived in terms of an individual
4 document. If it's specifically indicated that that
5 document -- I understand the public perception, perhaps,
6 but by the same token this has arisen because of
7 a specific reference to a specific document.
8 THE CHAIRMAN: Yes.
9 MR STITT: This isn't the Trust saying, "We're going to pull
10 out certain sweets in the bag, you can have those ones
11 and we're keeping the others". We have been asked for
12 a document and we're providing it.
13 THE CHAIRMAN: Apart from that, you are asserting a claim
14 for privilege over other contents of the file and I note
15 that that is not what the Belfast Trust did in relation
16 to the Adam inquest file. There is the appearance at
17 least of an unfortunate different approach being taken
18 by different trusts over equivalent documents, namely
19 inquest files. That's another matter.
20 I also am interested in your reference to Ms Brown's
21 practice of having documents and destroying them and
22 keeping file documents. I think as part of this, I will
23 be looking for a list of the contents of the inquest
24 file for which privilege is claimed. I would also like
25 a list of any documents contained in files which are in

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1 the possession of Ms Brown, which are effectively files
2 which are in the possession of the Trust, since she's
3 a Trust employee.
4 MR STITT: Yes.
5 THE CHAIRMAN: We'll revisit this next week. Is that okay,
6 Mr Coyle?
7 MR COYLE: Naturally, on behalf of the Ferguson family,
8 we're wary of the manner that this document has become
9 available, given the debacle over the Warde/Jenkins
10 reports to which you have alluded and the wariness of
11 the family pertaining to the information withheld. If
12 it is the case, listening to my learned friend, that
13 perhaps Ms Dillon, on your direction or on your
14 counsel's direction, asks for another document, is it
15 going to be dealt with on an incremental basis, or will
16 that problem have to be addressed on a continuing basis
17 as against the perspective and the healthier
18 perspective, in our view, of the Belfast Trust? So if
19 there is the assertion of privilege, sir, we would
20 invite you to set a timetable to have it properly argued
21 out with skeleton arguments to give you maximum
22 assistance, and your counsel.
23 THE CHAIRMAN: I'd like to see what the -- I mean, at the
24 moment we have a claim for privilege for a file.
25 MR COYLE: Yes.

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1 Mr Zafar, please.
2 MR MUHAMMAD ZAFAR (called)
3 Questions from MS ANYADIKE-DANES
4 MS ANYADIKE-DANES: Good afternoon, Mr Zafar.
5 A. Hello.
6 Q. Can I first confirm that you have a copy of your CV
7 there?
8 A. It is here.
9 Q. Thank you. You have made a number of statements, two of
10 which were for the inquiry. You made a statement for
11 the Trust, which I'm going to ask you something about,
12 on 3 April 2002. You had a deposition for the coroner,
13 which seems to be dated 5 February 2003, and I'm going
14 to ask you something about that as well. Then you had
15 two statements for the inquiry. The series reference
16 for them is 025. Your first is dated 13 January of last
17 year, the second is dated 15 November of last year.
18 Subject to anything that you say now in your oral
19 hearing, do you adopt as accurate those statements?
20 A. Well, I need to see the statements. Can we put them
21 forward, please?
22 Q. Let's start with the easiest one, which is your very
23 first one, 021-059-143.
24 A. I can't see on the computer.
25 Q. It should come up.

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1 THE CHAIRMAN: We don't know what's in the file. It's
2 probably more helpful to know what's in the file before
3 we start considering a claim for privilege.
4 MR COYLE: Yes. An itemised account might be of more
5 assistance. But these are all documents, rather like
6 the Warde/Jenkins reports, sir, all generated at public
7 expense, and one wonders what interest is being
8 protected.
9 THE CHAIRMAN: It's Friday afternoon now, Mr Stitt. Would
10 it be possible to have a list of documents for Tuesday
11 morning?
12 MR STITT: I think it would be, yes.
13 THE CHAIRMAN: Thank you.
14 MR STITT: I would respectfully suggest that that is an
15 appropriate way forward.
16 THE CHAIRMAN: The starting point is I have to recognise
17 that under the powers that we looked at a couple of
18 weeks ago on another issue, you have the same right,
19 your clients have the same right to claim privilege as
20 they do in the High Court. So that's the point, it then
21 becomes a matter of what they're claiming privilege for
22 and whether they decide to pursue their claim for
23 privilege or to maintain it.
24 Ms Anyadike-Danes?
25 MS ANYADIKE-DANES: Thank you very much, Mr Chairman.

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1 THE CHAIRMAN: It'll come up in one moment. The reason why
2 you're being asked these questions, Mr Zafar, is what
3 we are confirming is that -- and we do this with every
4 witness as he or she starts. You have made statements
5 to the inquiry and what we want to check is that we can
6 proceed on the basis that you are standing over that
7 statement. Sometimes a witness says that actually, in
8 looking through it, they want to change this or want to
9 correct that. But what we want to confirm is that
10 we can proceed on the basis that you stand over those
11 statements and the questioning which you will then
12 encounter this afternoon will be based on the contents
13 of those statements being accurate.
14 A. Fine.
15 THE CHAIRMAN: Do you understand?
16 A. That's fine.
17 THE CHAIRMAN: In that event, can I take it that you stand
18 over the various statements that you have made before?
19 A. Yes.
20 THE CHAIRMAN: Right. At this point, you have no changes or
21 additions that you want to make to them?
22 A. Only one statement, I think, the timing about this, I am
23 just worried about.
24 MS ANYADIKE-DANES: Perhaps we can enlarge that a little bit
25 in ease of you.

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1 A. The time, 3.15 am. I'm not sure that is the right time
2 or not. I don't remember that. It was early morning.
3 Early morning starts different times -- please consider
4 it.
5 Q. I'm going to take you to what I think is the genesis of
6 that statement and maybe that will assist you.
7 A. Yes.
8 Q. Can we please put up first 316-048-002. Can we enlarge
9 that also? Do you recognise that statement?
10 A. Yes.
11 Q. Is that the very first signed statement that you
12 provided to the Trust, to Altnagelvin?
13 A. Yes.
14 Q. And how did that come about?
15 A. Well, I have only first time here working, six months,
16 less than six months in Altnagelvin Hospital. This
17 incident happened, if we're considering the dates,
18 in March, and I -- no, sorry.
19 Q. In June.
20 A. Yes. "March" is written. Yes, June.
21 Q. Yes.
22 A. And I had moved from here, end of July, I think,
23 or August start, because I was not here in this Trust.
24 Q. I understand that and we'll see --
25 A. That's why -- this is all telephoning conversations and

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1 getting that fax and the statement?
2 A. I don't remember that.
3 Q. It seems to have been sent to you, but you don't
4 remember it?
5 A. I don't remember that.
6 Q. Do you remember being asked to amend that initial
7 statement that you signed at all?
8 A. Not amend. They asked, "Can you explain further?".
9 It's a small statement, I need to write more. That's
10 all.
11 Q. I only use the expression "amend" because that's what it
12 says on the fax cover sheet. When you were asked to do
13 that, were you provided with a draft statement? And can
14 I pull this up and see if you think this is what you may
15 have received? 012-024-134.
16 Is that what came to you as a suggestion for how you
17 might enlarge upon your statement?
18 A. No, really, that was written by me. I mean, that may be
19 after corrections because I was in England and the
20 incidence was in Northern Ireland, and I have no other
21 discussion or with whom I can discuss or do things, and
22 I have the correspondence here. That may be the case
23 that I have asked that the legal team -- please
24 could you see my wording if this is right or not.
25 Q. So what I'm trying to find out from you, Mr Zafar, is

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1 asked me -- I mean, by post as well, to send me
2 a letter, that she would send us a statement.
3 Q. And this was your response?
4 A. Yes. The response was to the truth that -- what I have
5 written in the notes, I have written in the statement.
6 Q. Yes. So when you were asked to provide a statement
7 dealing with your involvement, if I can put it that way,
8 into Raychel's care during her last admission, this is
9 what you produced in answer to that?
10 A. That was, yes.
11 Q. Thank you. Do you then remember -- and can we pull up
12 now 021-001a-002. This is a fax from Altnagelvin
13 Hospital. We don't know what its date is, but what it
14 says is:
15 "The inquest is now adjourned."
16 A. Yes.
17 Q. "I enclose a draft statement. Please amend. I enclose
18 a statement from Dr Johnson."
19 And if we pull up next, quickly so that we can see
20 what was involved, 021-058-139. That's the letter from
21 Dr Johnson, enclosing his statement, and his
22 statement -- and we can pull these two things together,
23 021-058-140 and the next page, 141. Can we have those
24 alongside each other?
25 That's Dr Johnson's statement. Do you recall

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1 whether, when you were being asked to enlarge on your
2 statement, you were provided with any document that
3 might help you do that.
4 A. They send me my notes where I have written before the
5 same two-line statement. The other thing is that what
6 I knew from there -- it depends on my involvement.
7 I think if you will take your case forward then you can
8 understand about that statement.
9 Q. What I'm trying to find out from you is, all the details
10 that we see in this draft here or this unsigned version,
11 if I can put it that way, did all those details come
12 from you or did anybody provide with you the
13 information --
14 A. I have written first, they have maybe checked my
15 spellings, et cetera, and that's it. It's mine.
16 Q. Then there is a signed version of that, which one sees
17 at 021-059-143. That's the signed version?
18 A. That's the signed version, yes.
19 Q. So as I understand you to say, you might have had some
20 help with your language, your English, but the details
21 of it --
22 A. Same.
23 Q. And where did you get the information since you were in
24 England and presumably didn't have any files with you?
25 A. No, this -- I remember that. What happened to those

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1 dates was a very fresh memory, it was not 12 years back,
2 it was within six months, I think, when I was moved from
3 here and I thought that that happened and I have
4 written. Then I have checked my notes, it was only one
5 line notes, which was also saying many things as
6 surgical notes. It is there, everything. And I have
7 taken from there what I have done. That's why I have
8 pointed out that the time is not correct.
9 Q. Yes. Just bear with me a moment. Are you saying that
10 you asked for a copy of the surgical notes to assist you
11 in providing --
12 A. I did.
13 Q. -- the statement.
14 A. Yes.
15 Q. You did?
16 A. They sent me, yes.
17 Q. And they sent you that?
18 A. They sent me, yes.
19 Q. Did they send you anything else?
20 A. Notes only.
21 Q. So the information that we see here, your only source
22 would be from those surgical notes --
23 A. Notes, yes.
24 Q. -- apart from what you independently remembered?
25 A. Yes.

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1 that timing because early morning time, we start from
2 different -- you can stay early morning from 12 o'clock
3 until morning, 9 o'clock. I don't remember that time.
4 It's exactly the facts because I don't remember. I just
5 approximately write that because there was nothing
6 in the notes documented, what time, what happened after
7 me.
8 Q. Okay. Then let's go to your curriculum vitae. It
9 starts at 317-010-001, but perhaps if we could put up
10 002, which is your academic record. You qualified in
11 1985. That's right, isn't it?
12 A. True.
13 Q. And you worked in Russia --
14 A. Not worked, studied.
15 Q. I beg your pardon. You studied in Russia?
16 A. Yes.
17 Q. Maybe if we can pull up the next page, 003, alongside
18 that. Right down at the bottom, can you see 1984/85,
19 "house surgeon, general surgery". That was not
20 a working position; is that right?
21 A. House surgeon at that time was considered as an FY1,
22 that's a training point.
23 Q. So that was a trainee?
24 A. Yes.
25 Q. And then we see, 1985 to 1987, you were a registrar?

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1 Q. Now, Raychel died on 10 June 2001.
2 A. Yes.
3 Q. You actually would have had an involvement with her on
4 8 June 2001?
5 A. Yes.
6 Q. And this is now an exchange coming, when it starts off,
7 some time in 2002. How clear a recollection did you
8 have of events?
9 A. Would you mind to repeat it again, please?
10 THE CHAIRMAN: Given that Raychel had been treated and had
11 died in June 2001, how clear was your recollection of
12 events in April 2002 when you were preparing this note?
13 A. Yes, I remembered that. That's why I'm saying that the
14 timing was -- I don't remember timings, chairman, and
15 I have already pointed out that the time is not correct.
16 The rest of things, it was right.
17 MS ANYADIKE-DANES: Does that mean that you're answering the
18 chairman that you had a very clear recollection of what
19 happened?
20 A. At that time.
21 Q. In April 2002?
22 A. In April 2002.
23 Q. If that's so, why did you put an incorrect time if you
24 had a very clear recollection of it?
25 A. I don't know. I'm telling you that I don't remember

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1 A. Yes.
2 Q. In general surgery?
3 A. General surgery.
4 Q. Yes. Then in fact, you carried on being a registrar in
5 cardio or cardiovascular, cardiothoracic discipline for
6 right up until 1998; is that right?
7 A. Yes.
8 Q. During that period of time, you had quite a significant
9 period of time in England working as a registrar in the
10 cardiothoracic discipline?
11 A. Yes.
12 Q. And you first came to England in 1993. You carried on
13 working there for a period of three years until 1996;
14 is that right?
15 A. That's right.
16 Q. And then you had a year in Pakistan when you were still
17 working at the level of registrar?
18 A. Yes.
19 Q. In cardiac surgery?
20 A. Yes.
21 Q. Then you came back to Wythenshawe, which is a hospital
22 where you'd worked as a registrar previously, as an SHO
23 in general surgery. What brought about that?
24 A. Right. I want to clarify first that my qualification
25 name is MD, which is a 6 to 7-year programme in Russia.

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1 Right? That's why you have started from there -- I
2 mean, a house surgeon. The final years they are
3 considered like a house surgeon job; okay? Before
4 qualifying someone, that he is qualified as a medical
5 doctor.

6 The second thing is, the latest of your questions,
7 why I have joined as the SHO, I was interested to do my
8 fellowship in general surgery. Considering that, in
9 this country, if you want to further go up, you have to
10 be awarded as a general surgeon first. No doubt I have
11 a general surgery qualification when I came over here as
12 well as a cardiovascular surgery specialist with my
13 qualifications. I came as a specialist from there,
14 qualified. But every country has its own local rules
15 and law. I have to follow that. That's why I have gone
16 to SHO job. Below SHO job I was not able to complete
17 and go through the college examinations and college
18 permissions.

19 Q. I want to make sure that I've correctly understood you.
20 If you wanted to rise further, are you saying
21 [OVERSPEAKING].

22 A. -- if I like carry on my cardiothoracic surgery further
23 training, then they were interested that I have gone
24 through general surgery fellowship exams.

25 Q. I see. So even you though you worked for a number --

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1 before you came to Altnagelvin, I think you have
2 referred to as having pre and post-operative care of
3 patients. We see that at 006 of this CV. Can you see
4 that, just in the middle section, the first bullet:

5 "Responsible for the preoperative and post-operative
6 care of patients."

7 A. Yes.

8 Q. Did that involve fluid management of patients in
9 Manchester?

10 A. It is involved.

11 Q. Yes, that was involved?

12 A. It is involved.

13 Q. But those were of adult patients; is that correct?

14 A. Adults.

15 Q. So you would have been familiar in, if it was necessary,
16 prescribing the preoperative fluids and, if it was
17 necessary, advising or prescribing the post-operative
18 fluids?

19 A. Yes.

20 Q. You also say that you participated in journal clubs.

21 That's the final bullet in that middle section. What is
22 a journal club for a surgeon?

23 A. Teaching.

24 Q. Who is teaching?

25 A. Consultant.

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1 A. [OVERSPEAKING]. I have to be qualified as the SHO here
2 in this country to complete my fellowship.

3 Q. So that's why you came back to do a number of positions
4 as an SHO in general surgery?

5 A. Yes.

6 Q. And just so that I see the understanding of that, you
7 did three of those positions, one in Wythenshawe, then
8 in Altnagelvin, and then in Derryford. And then you go
9 to Swansea at the level of a registrar in cardiothoracic
10 surgery?

11 A. Mm.

12 Q. Did that mean that you had completed sufficient in
13 general surgery to enable you to carry on up the --

14 A. I was able to sit in the exam.

15 Q. Sorry?

16 A. I have completed enough that I could sit in the exam.

17 Q. Yes. So you had achieved what you wanted to achieve?

18 A. Yes.

19 Q. Thank you. At each of those positions, I think you were
20 three years in Wythenshawe as a senior house officer.

21 Then you were just six months, I think, in Altnagelvin
22 and two years or thereabouts at Derryford. Why did you
23 come to Altnagelvin for the six-month period, can I ask?

24 A. It's -- I mean, wherever you can get a job, you can go.

25 Q. I understand. In Manchester, which is the post just

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1 Q. The consultant is teaching you?

2 A. Not only me, it's generally.

3 Q. I don't mean you individually, but it's a teaching
4 session?

5 A. Teaching session.

6 Q. Just for the sake of understanding, why is it called a
7 "journal club"?

8 A. Because you can present research papers as well. This
9 is research papers taken from the journals.

10 Q. So you're presenting papers and listening to other --

11 A. Yes. In different hospitals, different names.

12 Q. Thank you. Then can I ask you now, before Altnagelvin,
13 whether you had any paediatric experience at all.

14 A. No.

15 Q. So Altnagelvin was your first position where you'd had
16 to deal with paediatric patients?

17 A. Yes.

18 Q. Then you left Altnagelvin in July 2001, and that was to
19 move on to another position?

20 A. Yes.

21 Q. Was Altnagelvin always going to be a six-month position?

22 A. Six months, yes. Nearly, yes.

23 Q. Just while we're dealing with your level of
24 understanding of matters, if I can ask you this.

25 You were asked about NCEPOD and whether you were aware

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1 of the national confidential enquiry into perioperative
2 deaths, NCEPOD 1989. We can see where you refer to it
3 in your witness statement, your second witness
4 statement, 025/2, page 22. It's in answer to question
5 32:

6 "At the time [that's June 2001] were you aware of
7 the conclusions of NCEPOD, which finds that trainees
8 should not undertake any anaesthetic or surgical
9 operation on a child without consultation with
10 a consultant?"

11 And you say you were aware of that.

12 A. Well, I read about that, vaguely. I'm not saying I was
13 in detail, no, all that national guidelines, but I heard
14 about that. I mean, okay, these are the guidelines
15 nowadays, because I'm a general surgeon. My training
16 was finished a long time ago and I listened, but I don't
17 know too much at that time. That's why I said yes,
18 I know a little bit.

19 Q. But you were aware of the point?

20 A. The point, I was aware of that, yes.

21 Q. And is it something that you yourself, since at that
22 stage you'd have been an SHO in Manchester before you
23 came to Altnagelvin -- did you find yourself having to
24 notify a consultant if you were going to conduct
25 surgery?

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1 remember such situation with me or -- I understand your
2 point. I don't know. And in the past, I mean, in
3 medical -- my career, if junior is doing, most of the
4 time he's informed with the consultant or consultant and
5 the junior has so much close understanding that he could
6 do that procedure without telling to the consultant. I
7 mean that was the old time, but now time has changed,
8 now it's not that.

9 THE CHAIRMAN: What is it now?

10 A. Now consultant knows or consultant comes himself.

11 MS ANYADIKE-DANES: In 2001, so far as you can remember --

12 A. It's so far away, 12 years back.

13 Q. That means you can't remember?

14 A. It is, yes.

15 Q. Can we now go to induction and teaching and your
16 knowledge generally of hyponatraemia. You were asked
17 some of those questions in your inquiry witness
18 statement. You said in your second inquiry witness
19 statement that you don't recall any special training or
20 induction. I'm going to show you some documents and see
21 if you can assist us with them. Can we please pull up
22 316-004f-018. That's an induction programme for 2001.
23 As it happens, it starts on 1 August 2001, which would
24 have been too late for you and not appropriate, in any
25 event, for Raychel's case as she had died in June 2001.

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1 A. We haven't had chance that at night-time [inaudible].

2 Q. I beg your pardon?

3 A. I didn't get a chance such that I had notified at
4 night-time consultant and do the surgery, no.

5 THE CHAIRMAN: It didn't arise?

6 A. No, it didn't arise.

7 MS ANYADIKE-DANES: It didn't arise in Manchester?

8 A. No. In my on-calls, no.

9 Q. Did it arise for you in Altnagelvin?

10 A. Well, Altnagelvin, I don't remember that. I don't
11 remember how times at night-time, late -- I don't
12 remember at all.

13 THE CHAIRMAN: Did you understand that to mean that you
14 would not conduct any operation at all without speaking
15 to a consultant?

16 A. It's not -- we always communicate. And the consultant,
17 most of the time, knows what his junior is doing or the
18 consultant knows when he is on call.

19 THE CHAIRMAN: Sorry, the consultant on call will not know
20 if a surgeon intends to operate, for instance, by
21 removing a child's appendix unless somebody contacts him
22 to tell him that. Did you understand that this report
23 meant that you would not conduct any operation without
24 reference to a consultant?

25 A. Yes, Mr Chairman. I don't recall about that. I don't

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1 The reason for pulling it up for you is that we
2 understand from the Trust that every year they had an
3 induction programme. You arrived in February 2001.
4 What I want to ask you is whether, as you look at this,
5 you can recall having anything that resembled this. So
6 if we look at it, you see there's a departmental
7 welcome, that you meet the consultant and you discuss
8 the duties and the rota cover. Then there's a general
9 hospital induction course. Then there are specific
10 issues with their speakers, you see there's a welcome
11 from the chief executive, who was Stella Burnside at the
12 time. Then there are some general hospital issues and
13 you see what they are, notably note keeping. Then
14 there's educational issues and there are issues to do
15 with the educational programme and supervisors and so
16 on, and welfare and health issues, which aren't relevant
17 to us.

18 And down to post-mortems and training issues. Under
19 "training issues" there's a topic of audit. Then
20 there's a departmental induction. Running down the side
21 of that, you can see the written documents that are
22 being provided. So if one looks immediately under the
23 written notes, you see there's case note standards and
24 Junior Doctors' Handbook and a formulary and the
25 antibiotic policy and list of contact numbers and so on.

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1 Do you remember having anything like that at all?
2 A. I don't remember.
3 Q. Could it have happened and it's just that it's so long
4 ago that you can't remember it?
5 A. I don't remember that, anything such.
6 Q. Let me maybe help you with the Junior Doctors' Handbook.
7 If we go to 316-004g-001. There is the Junior Doctors'
8 Handbook. There are a series of these that have been
9 reissued over the years. Did you ever see anything like
10 this while you were at Altnagelvin?
11 A. I don't remember.
12 Q. Could it have been there and you simply cannot remember?
13 A. No, I haven't -- it was not with me.
14 Q. You didn't have that?
15 A. I don't remember that, yes.
16 Q. If we go to the final page of that, which is 024. You
17 can see not only does Altnagelvin apparently want its
18 trainees -- and for Altnagelvin's purpose as an SHO you
19 would have been a trainee. Not only did they want them
20 to have the handbook, but they made specific references
21 to some other documents. There's good medical practice
22 guidelines from the GMC; you'll be familiar with those?
23 A. Yes.
24 Q. You can see item 4 there "patient's case notes
25 standards."

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1 to have. You can see there under "study leave":
2 "Induction course. Attendance at the induction
3 course [you're not a preregistration house officer, but
4 you would be classed as junior medical staff] is
5 mandatory."
6 Did anyone tell you that?
7 A. I don't remember, no.
8 Q. Then if we go to the same document, 005, you can see
9 there in the second part under the nursing and
10 paramedical section they're talking about communications
11 with nursing staff, how important that is, and then it
12 goes down to:
13 "Documenting your communications with nurses in the
14 notes."
15 And also:
16 "Discussions with patients or relatives should also
17 be mentioned to nursing staff and recorded in the
18 notes."
19 Were you familiar with that sort of thing?
20 A. No, no. I haven't seen -- no. I don't recall such
21 documents I have seen there.
22 Q. No, I'm asking you a slightly different question because
23 you have said that you didn't see this document. So I'm
24 going through these issues, which clearly seem to be of
25 some importance to Altnagelvin, that's why they're

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1 That is also referred to on the induction programme.
2 Were you aware that there was a document called
3 "patient's case notes standards" at Altnagelvin?
4 A. I don't remember. I don't.
5 Q. Well, let's see if you can help us with what your
6 knowledge and understanding of practices and guidance
7 was at that time.
8 A. At that time or presently?
9 Q. No, at that time.
10 A. Okay.
11 Q. For example, were you aware that the department had
12 issued a charter for patients and clients?
13 THE CHAIRMAN: The department being the Northern Ireland
14 Department of Health?
15 MS ANYADIKE-DANES: Yes, it is. I can give you the
16 reference for that and we'll see if it is on the system.
17 062/1, page 328. I think it's a witness statement,
18 sorry. We'll pull that up during a break because I am
19 going to refer to that.
20 You have already said that you don't remember about
21 the Junior Doctors' Handbook and the case note
22 standards. If I go to the handbook and we can look at
23 some things which hopefully will not be unfamiliar to
24 you as issues. If we go to 316-004g-011. This is
25 Altnagelvin's own handbook it wanted its junior doctors

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1 releasing a booklet on it, and asking you whether you
2 were aware of those sorts of requirements.
3 A. No.
4 Q. No?
5 A. No.
6 THE CHAIRMAN: I'm sorry, doctor, I just want to make it
7 clear. Do I understand you to mean that if you had
8 a discussion with a patient or if you had a discussion
9 with the parents of a patient that if there was anything
10 of significance in that discussion that you didn't know,
11 it was to be recorded in the notes?
12 A. No, that is a separate issue. She is asking about the
13 documents they have provided to me or not.
14 THE CHAIRMAN: You have answered counsel and you have told
15 her you did not see this document. She is now asking
16 you about, effectively, the principles or the standards
17 which the document requires.
18 A. Yes.
19 THE CHAIRMAN: And the last question was specifically
20 whether you were aware of the need to communicate with
21 nursing staff because that is essential to the efficient
22 running of the ward.
23 If you could help me please by highlighting but not
24 enlarging on the right-hand side of the page the
25 paragraph starting with the word "communication".

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1 If you look at that, what you're being asked about
2 is whether you understood that to be important,
3 communicating with the staff, and if you make any
4 changes in management, not only are they verbally passed
5 on to the nurses but they're also documented in the
6 notes. Did you know that?
7 A. They are important. No one has told me that I have to
8 do notes that way.
9 THE CHAIRMAN: No one has told you that. For instance, in
10 your hospital experience, before you came to
11 Altnagelvin, if you directed changes in the management
12 of a patient did you record those or have them recorded
13 in the medical notes and records?
14 A. Mr Chairman, it needs to be recorded, but sometimes when
15 you are in an early ward round and you will see
16 something is not going on with the patient, the patient
17 is stable, then not necessarily that you have to write
18 immediately everything about that A to Z, but you have
19 to write particular things which are needed.
20 THE CHAIRMAN: If everything is stable and you're not
21 recommending any change, then it may not be very
22 important to record that in the notes?
23 A. Yes.
24 THE CHAIRMAN: But if you are recommending a change in the
25 treatment of a patient then that is to go in the notes?

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1 a discussion with a parent which revealed anything, any
2 worries or any significant concerns, that according to
3 these standards, two things were to happen. That was to
4 be recorded in the notes and it was also to be mentioned
5 by the doctor to the nurses. Was that the standard that
6 you aimed for if you could?
7 A. No, that could be -- I mean, I agree that standard
8 should be there.
9 THE CHAIRMAN: Thank you.
10 MS ANYADIKE-DANES: Thank you very much, Mr Chairman.
11 Can we stay in that same document and go to 017?
12 316-004g-017. Can you see the first bullet:
13 "All entries in case notes must be timed and dated."
14 A. Yes.
15 Q. As we have said, irrespective of whether you saw this
16 document, did you appreciate that you should time an
17 entry?
18 A. Yes, I agree that.
19 Q. If we follow the way down along the lines as the
20 chairman was taking you, you can see that there is
21 a bullet that starts "regular notes":
22 "Regular notes after admission should be made
23 including the progress of the patient and how the
24 results of investigations have confirmed or altered the
25 differential diagnosis."

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1 A. No, it is important that -- I mean, writing is
2 important, but at that time, what we are talking, if
3 we are talking at present --
4 THE CHAIRMAN: We're talking about 2001.
5 A. At that time I agreed that, this is written, notes
6 there, there are documents, but I didn't feel that
7 someone has followed that notes.
8 THE CHAIRMAN: Sorry, you didn't feel?
9 A. Someone has followed that direction.
10 THE CHAIRMAN: You didn't feel it was necessary?
11 A. No, it is necessary, it was necessary, I agree that.
12 THE CHAIRMAN: Okay. Was it also necessary that if you had
13 a discussion with the mother or father which informed
14 you of anything of significance, that that should go
15 into the notes and that should also be mentioned to the
16 nursing staff?
17 A. Again, I am just saying that when I have to go through
18 20, 30 patients and go through all that, and immediately
19 I have to reach in time the theatre when theatre is
20 starting already exact time, and the surgeon needs
21 a hand there, then it's very hard to complete
22 everything.
23 THE CHAIRMAN: I understand that, I know that it's not
24 always possible to do it. But as a standard to try to
25 achieve, do you agree that in 2001, if you had

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1 And then the next bullet along after the use of
2 ancillary services:
3 "A record should be made of the content of
4 discussions with the patient and relatives."
5 And so on.
6 So that is what Altnagelvin wanted at the time. If
7 I pause there and ask you, when you first arrived at
8 Altnagelvin as an SHO, was there a consultant who
9 essentially was accompanying you for a period of time to
10 show you how Altnagelvin did things and also to assess
11 your performance? Did you have anything like that?
12 A. No, how much I recall, no. I haven't seen that.
13 Q. Nobody assessed your performance?
14 A. No.
15 THE CHAIRMAN: For your first couple of weeks, let's say,
16 Mr Zafar, would you have been working side by side with
17 a consultant or a registrar?
18 A. Yes.
19 THE CHAIRMAN: Whereas, after that, did you work more on
20 your own?
21 A. I have taken rounds myself, initially -- I mean, rounds
22 also depends, sometimes only one person is going,
23 sometimes altogether a team is going. It depends again
24 on the situation and what you're doing in the morning
25 time. These are the notes which are from the induction

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1 and pointing out -- I haven't seen such notes.
2 THE CHAIRMAN: Yes. Don't worry so much about the notes.
3 What I'm interested in is, in your first week or two in
4 Altnagelvin, you were coming to Northern Ireland for the
5 first time?
6 A. Yes.
7 THE CHAIRMAN: It's a hospital which maybe has similarities
8 with other hospitals, but also may have differences
9 compared to other hospitals.
10 A. Yes.
11 THE CHAIRMAN: And during your first week or two weeks,
12 maybe, would you have spent a bit more time with
13 consultants or registrars than you would have been doing
14 a few months later?
15 A. Yes. That is the normal practice, it is happen, that.
16 We always did that. This is the way they are assessing
17 that a person can go independently or not.
18 THE CHAIRMAN: I think that's the point. Maybe you didn't
19 pick it up, but what counsel was asking you was whether
20 that was an informal way of assessing you, that you're
21 working with them and they are reassured, presumably by
22 what they see of you working with them, that you can now
23 increasingly work --
24 A. Work pressure(?), yes.
25 MS ANYADIKE-DANES: In the course of that, presumably they

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1 THE CHAIRMAN: Sorry, sometimes at that point if you were
2 working with a consultant or with a registrar, it would
3 have been you who was making the note, wouldn't it?
4 A. Yes. It is sometimes happens that I'm making the note.
5 THE CHAIRMAN: We've seen that in other cases in the inquiry
6 where a consultant or registrar takes, say, a ward round
7 and the note is written up by --
8 A. By the SHO. That's right.
9 THE CHAIRMAN: Is that what was happening with you?
10 A. It sometimes happened, definitely. I don't remember how
11 many times, but it's happened, yes.
12 MS ANYADIKE-DANES: But you would have appreciated quite
13 apart from your training elsewhere that you would be
14 required to time your entries, for example?
15 A. Mm-hm.
16 Q. You would know that?
17 A. Well, at that time, date was definitely. The time --
18 sometimes they did that. If you're in a quick rush and
19 they didn't write the time, okay. I mean ...
20 Q. Yes, but you knew that's what you should be aiming for,
21 to put a time for your entry?
22 A. Yes.
23 Q. To date it, sign it and give sufficient information in
24 it so that people could understand what was happening?
25 A. Yes.

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1 are showing you: this is how we do certain things in
2 Altnagelvin? Because, as the chairman will have pointed
3 out, you've never been there before. Is that part of
4 what was happening? As you went round with your more
5 senior colleagues, they were introducing you to the
6 systems and practices in Altnagelvin; would that be
7 fair?
8 A. Yes.
9 Q. While that was happening, you also have an opportunity
10 to watch how they do things?
11 A. That's true.
12 Q. It's not only that they positively tell you, you're
13 watching what they're doing and recognising that that
14 may be the custom or practice in Altnagelvin?
15 A. Yes.
16 Q. While that was happening, did you have an opportunity to
17 see or were they showing you how they wanted you to
18 record matters in a patient's notes?
19 A. That's generally -- I mean, I can't particularly bring
20 examples.
21 Q. I'm not asking you to think of any particular time when
22 that happened, but is that the sort of thing that was
23 happening?
24 A. Well, I mean, I have watched them, how they have written
25 that, and I have done the same way.

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1 THE CHAIRMAN: Isn't a timed entry potentially much more
2 valuable than an untimed entry?
3 A. A timed entry is more valuable, I understand that. Not
4 only that, the GMC registration [inaudible] who wrote
5 that notes. That could be as well possible. But
6 I don't remember that -- it was a normal routine
7 practice.
8 THE CHAIRMAN: I'm sorry, we didn't quite pick you up. What
9 did you say was --
10 A. The GMC registration.
11 THE CHAIRMAN: Right.
12 A. The GMC registration. In other practices, we are doing
13 that. When we are writing notes, write down your stamp
14 or GMC registration.
15 THE CHAIRMAN: You write down your -- sorry, you sign the
16 note?
17 A. Sign the note and GMC registration, yes. Registration
18 GMC, General Medical Council registration.
19 THE CHAIRMAN: Okay.
20 MS ANYADIKE-DANES: Your own registration number, you mean?
21 A. Yes.
22 Q. That you should put your registration?
23 A. Yes.
24 Q. Is that something that you think was --
25 A. This is a new thing coming up.

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1 Q. Ah, a new thing coming up, not something that you --
2 A. It is already in the practice.
3 THE CHAIRMAN: Okay. This can get very complicated
4 if we jump around in timescales. Unless you're asked
5 a question about a different time period, can we stick
6 to 2001?
7 A. Okay.
8 MS ANYADIKE-DANES: Thank you.
9 I've been taking you through the principles as were
10 shown in the Altnagelvin handbook, but, as you know,
11 because you've already mentioned them, there were other
12 practices than guidelines that you should be aware of.
13 You have mentioned one, the GMC, and if we look at
14 315-002-005. That's a GMC handbook. During the break
15 we'll try and get some of these documents up on the
16 system for you. I can tell you the bit I was going to
17 take you to and see whether that sounds familiar. It's
18 the GMC guidance for the relevant time and it's actually
19 referred to in the Altnagelvin handbook. It requires
20 you to keep clear, accurate and contemporaneous patient
21 records. You'd be familiar with that requirement.
22 Then also at the time there's the Royal College --
23 THE CHAIRMAN: Sorry. Is that --
24 MS ANYADIKE-DANES: I thought he nodded.
25 THE CHAIRMAN: Sorry, for the transcript, you agree with

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1 why you couldn't do it, presumably? You would be trying
2 to record any advice that you had given or significant
3 discussion, I think the chairman put it, that you had
4 had with Raychel's parents, you would be trying to
5 record that?
6 A. Yes, it should be, yes.
7 Q. Yes. You should have in any event.
8 A. Yes.
9 Q. Thank you. Then if we carry on with the principle to be
10 extracted from the Altnagelvin Junior Doctors' Handbook,
11 one sees at 316 --
12 MR STITT: Mr Chairman, sorry to interrupt my learned
13 colleague. Have we not established the point that it's
14 good practice to keep notes? Has that not been
15 accepted? We know that Mr Zafar's notes are what they
16 are.
17 MS ANYADIKE-DANES: Thank you very much. I'm just moving on
18 to a different element of what he might be expected to
19 have recorded, if my learned friend will bear with me.
20 316-004g-002, under "ethics". This is put in
21 a mandatory way, so as a doctor you must. You must:
22 "Give patients information in a way they can
23 understand."
24 And you see that there. Presumably if those
25 patients are paediatric patients, then you must explain

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1 that?
2 A. Yes.
3 MS ANYADIKE-DANES: I beg your pardon, Mr Chairman, I should
4 have clarified that. Thank you.
5 Then as a surgeon, the Royal College of Surgeons
6 also produced guidelines. You'd be aware of that?
7 A. Yes.
8 Q. They produced guidelines for clinicians on medical
9 records and notes, and in fact the relevant one at that
10 time was 1994. I'm going to -- I hope this comes up.
11 314-007-002. There we are. There you see the clinical
12 records. You see what you should include under B:
13 "These notes should be supplemented and updated
14 regularly to include details and reports of all
15 investigations, treatments and verbal advice given to
16 the patient and his or her relatives."
17 So if you give advice to a patient or if it's
18 a paediatric case, as was the position with Raychel,
19 then if you're giving advice to Raychel's parents then
20 that should be recorded. Now, were you aware that the
21 Royal College of Surgeons had produced that kind of
22 guideline?
23 A. Yes.
24 Q. You were aware of that. So that's what you would be
25 striving to do unless there was some very good reason

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1 to the child's parents the condition of the child, what
2 you're proposing for the child, in a way they can
3 understand; you would accept that?
4 A. Yes.
5 Q. In fact, one sees it also reflected in the GMC guidance,
6 but I'm not going to take you to that. Although what
7 the guidance goes on to say is that it's important that
8 you provide patients with information or those with
9 parental responsibility, and that you make sure that the
10 patients have understood your role in relation to them.
11 I'm not going to pull it up now, but let me give the
12 reference. The part about ensuring that you provide
13 information to patients or those with parental
14 responsibility can be found at 315-002-007. The part
15 about making sure that patients understand your role can
16 be found at 315-002-012.
17 Would you accept that, that it's important that the
18 patient or the patient's parents, if the patient is
19 a child, understand your role in the chain of
20 responsibility, if I can put it that way?
21 A. Yes.
22 Q. And how it is that you are having the care of their
23 child?
24 A. Yes.
25 Q. You would accept that?

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1 A. Yes.
2 Q. They should understand that?
3 A. Yes.
4 Q. Yes. Then there are some references to handovers. This
5 is also part of the general guidance and practice
6 produced by the colleges or, for that matter, produced
7 by Altnagelvin. If one goes to the BMA, which is the
8 safe handover, safer patients document. Although it's
9 dated 2004, it's derived from practice in 1996, and
10 we can pull that up, 317-017-007. Under "good quality
11 handover":
12 "Good quality handover is essential to protect the
13 safety of patients. Failure in this process or poor
14 quality handover is a significant risk to patients."
15 Would you accept that a handover is important for
16 continuity of care?
17 A. Yes.
18 Q. That's an important part of the changing of the guard,
19 if I can say, from one doctor to another?
20 A. Yes.
21 Q. We won't bring it up, but where it refers to the fact
22 that it derives from 1996 is 027 of that same document.
23 We don't need to pull that up.
24 So you would have accepted all these things are part
25 of how you -- the context of you providing medical care

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1 A. Well, I mean, I did that. Sometimes when I was busy
2 I couldn't go there. It depends on the work condition,
3 what I'm doing during that time.
4 Q. Of course. But you did attend some?
5 A. Yes.
6 Q. Then if we see the fifth Thursday, there's a case note
7 audit. Did you attend those?
8 A. Well, here, the thing is different. You have taken
9 Altnagelvin's programme.
10 Q. Yes.
11 A. Please can you take the Altnagelvin surgical programme
12 journal clubs?
13 Q. This is the programme that we've been provided with.
14 A. The surgical side, I was not a medical side -- to go and
15 sit in the medical meetings, no.
16 Q. Does that mean you didn't attend case note audits?
17 A. No. Well, I don't remember that, which time and when it
18 happened. I have gone to surgical sides, not to the
19 medical sides. Sorry.
20 THE CHAIRMAN: Was there ever a case note audit in
21 a surgical case?
22 A. If it is surgical case, I don't know if I have attended
23 or not. I don't remember that.
24 MS ANYADIKE-DANES: I think this is supposed to be an
25 all-embracing programme that -- as you can see if you

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1 and attention to your patients in 2001 in general and
2 Raychel in particular. Do you accept that?
3 A. Right.
4 Q. So you, I think, have referred to in your witness
5 statement at 025/2, page 4, that you attended regularly
6 weekly educational meetings.
7 A. Yes.
8 Q. This is what you said in relation to your time at
9 Altnagelvin. I'm going to pull up for you -- we have
10 a partial programme of those activities that were
11 available in 2001 to see if you can help us with which
12 ones you say you were attending.
13 The programme is at 316-004e-019. We've been
14 provided with a series of these, dating back as far as
15 1994. Unfortunately, the one for 2001 is not complete,
16 but there are, as you can see, some things that appear
17 to be being indicated as happening periodically, even
18 though we don't have the actual date.
19 A. Yes.
20 Q. So you can see that second line, the first and third
21 Thursday, there's a surgical journal club?
22 A. Yes.
23 Q. And you said you were familiar with these, you had
24 attended those in Manchester. Did you attend the
25 surgical journal club in Altnagelvin?

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1 look through, it includes those things that are
2 specifically targeted at surgeons and those at the
3 anaesthetists and those at the paediatricians, so it's
4 mixed in that way, so some will apply to you and some
5 won't. I'm simply trying to see what you can recall
6 attending because you have said that you attended
7 regularly.
8 A. No, regularly I understand that, I have a -- some time
9 when you're busy and you are doing some other
10 assignments, you can't go there, or either you're off
11 during that day and you can't go there.
12 Q. Yes, of course.
13 A. That's why I can't say that I have attended or not.
14 I don't remember any. General writing is there, that
15 I was -- "regular attendance" means not 100 per cent
16 I was attending that meetings. I was attending
17 meetings.
18 Q. I understand. This was your first appointment where
19 you'd have to deal with paediatric cases, you've said.
20 Did you ever go to any paediatric clinical meetings as
21 part of your education?
22 A. I don't remember that I have gone to any paediatric
23 meetings. I don't remember.
24 Q. Then if we see about halfway down there's daily, weekly
25 and weekly. We see there's a daily post-take SHO ward

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1 round. You engaged in those?
2 A. Yes.
3 Q. Then there's a weekly SHO teaching. Can you help us
4 with what that -- do you recognise that?
5 A. That is again surgical SHO meeting. Please don't
6 combine me with the medical SHOs.
7 Q. I haven't. I'm just asking you if you attended weekly
8 SHO meetings.
9 A. If I was there, I am present, I am free, I have attended
10 that. I don't remember, I can't recall that, or weekly
11 meetings on a date wise or daily basis. I don't
12 remember.
13 Q. Then if we go back to what you do remember, when you had
14 provided your witness statement saying that you attended
15 regular weekly educational meetings, what sort of things
16 were you attending?
17 A. I again have -- you are considering it's not
18 100 per cent, right? This way is coming like that,
19 right? If you will say to me did I attend the meeting,
20 I did attend the meeting, right? But I was not
21 regularly attending every day. I have attended
22 regularly. It doesn't mean that I have regularly
23 100 per cent attended the meetings.
24 THE CHAIRMAN: No, and you weren't being questioned on the
25 basis that you did attend on a 100 per cent basis. But

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1 was a mix. Who was on call or what assignments ...
2 I think that kind of work -- I don't remember.
3 Q. Did you have anybody that might be referred to as
4 a supervisor?
5 A. There was combined meetings. I don't remember who was
6 supervising SHOs at that time. There was one or two,
7 they were all together.
8 Q. Mr Bateson, would he be one?
9 A. Mr Bateson. I don't remember that.
10 Q. If we move now to your knowledge of hyponatraemia and
11 fluid management. In the same second statement, you
12 said that you received training regarding post-operative
13 fluid management during your medical school and your
14 postgraduate courses but you didn't receive any specific
15 training by the Altnagelvin Trust. Is that correct?
16 A. Yes.
17 Q. In fact, in this series of lectures, there are some
18 lectures dealing with the management of fluid balance,
19 but they happen periodically, and it may be that they
20 happened at a time when you weren't at the hospital. So
21 you don't remember any kind of lecture of that sort?
22 A. No, I don't remember.
23 Q. Then can you help us with this. What was your knowledge
24 in June 2001 about dilutional hyponatraemia?
25 A. Well, limited, I would say. I don't emphasise too much

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1 you gave the inquiry a statement in November 2012, about
2 three months ago, in which you said that you attended
3 regularly weekly educational meetings.
4 A. Yes.
5 THE CHAIRMAN: And what counsel is asking you is since
6 you have given that information, can you give us
7 examples of the types of meetings which you attended?
8 A. No, that is -- I remember how much. General surgical
9 meetings, I have attended, sometimes -- Mr Gilliland was
10 also organising. This is, surgical SHOs gather and they
11 have discussed some topics, surgical topics, we have
12 done that, which I remember.
13 THE CHAIRMAN: And those were under Mr Gilliland?
14 A. No, I only remember that Mr Gilliland was there.
15 I don't remember others, whether they came or not. But
16 mostly, most of the surgeons, they come and attend that
17 meeting.
18 THE CHAIRMAN: Thank you.
19 A. Surgical meeting.
20 MS ANYADIKE-DANES: Was there a particular surgeon with whom
21 you worked most closely and when the chairman was saying
22 in your initial period, maybe who you were following and
23 was assisting you? Were you assigned a particular
24 surgeon?
25 A. I don't remember that. I don't remember. I think it

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1 on that. I don't remember such, much. I know there's
2 hyponatraemia.
3 Q. You knew what it was?
4 A. It's hyponatraemia. Of course knows that, everybody,
5 I mean, who is at medical school and after that, during
6 postgraduate courses. I know hyponatraemia, what is.
7 Q. So you were aware of the condition of it?
8 A. Condition of hyponatraemia, yes.
9 Q. And were you aware of a form of it called dilutional
10 hyponatraemia?
11 A. I exactly don't remember at that time.
12 Q. Were you aware of ever having come into contact with
13 a patient who had hyponatraemia?
14 A. I haven't seen such kind of patients in my previous --
15 Q. Prior to 2001 you hadn't seen a case like that?
16 A. No, no.
17 Q. What sort of knowledge did you have about the
18 significance of electrolyte imbalance?
19 A. Again, it's related with my courses, postgraduate
20 courses and the medical school.
21 THE CHAIRMAN: I'm sorry, I don't quite understand. Could
22 you think again? The question you were asked was what
23 sort of knowledge did you have about the significance of
24 electrolyte imbalance. Sorry, let me start -- did you
25 know that it was significant if there was electrolyte

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1 imbalance?
2 A. It is significant, I understand that.
3 THE CHAIRMAN: In June 2001, you understood that it was
4 significant?
5 A. It is, I understand that.
6 MS ANYADIKE-DANES: And what is its significance?
7 A. When electrolytes -- I mean, sodium, potassium
8 [inaudible] at that time I know that. If sodium is low
9 or potassium is low or potassium is high, sodium is low
10 [inaudible].
11 Q. Yes. What is the significance of it?
12 A. Significance is it can affect on the body, if potassium
13 is high or low, and it can act on the heart, heart
14 problems start, and the brain problems start, and
15 anuria, dysuria can start that.
16 Q. Were you aware of how important it may or may not be to
17 the welfare of a patient?
18 A. No, this is important. I only know that, on the level
19 of SHO at that time I know about that.
20 Q. You did know it was important?
21 A. Yes, important. IV fluid, how much is important to give
22 or not to give.
23 Q. So what you're saying now, so we're absolutely clear
24 about that, you're talking about your knowledge in 2001
25 and not what you have learned since?

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1 I was going to build on and ask you something else
2 because I thought that you had appreciated that in your
3 witness statement. It's at 025/2, page 20.
4 THE CHAIRMAN: Sorry, just before you go there. Looking at
5 your answer a moment ago, Mr Zafar, you say:
6 "I wouldn't say -- I won't say I had a great
7 knowledge about this, but if this happened you have to
8 act appropriately".
9 When you said what acting appropriately would be,
10 you said you would do something or speak with the
11 seniors or your colleagues. I just want to make sure
12 that I understand what you meant when you said this. If
13 there was post-operative vomiting, did you know that
14 that could cause -- in a bad case, that that could cause
15 electrolyte imbalance?
16 A. Imbalance, yes.
17 THE CHAIRMAN: If that happened, then acting appropriately,
18 to use your term, that could involve speaking to senior
19 colleagues or, you said, do some investigations. Would
20 those investigations include taking a blood sample to
21 get an electrolyte reading?
22 A. Yes. No, no, check the -- send the blood samples for
23 electrolytes as well as I could do that, find out
24 a reason of vomiting first and then speak with my senior
25 colleague.

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1 A. Yes.
2 Q. In 2001, you were aware of the significance of
3 electrolyte imbalance?
4 A. Yes.
5 Q. It was important in the context of IV fluids and how
6 much to give, I think you said, and that sort of area?
7 A. Yes.
8 Q. Were you aware of the effect of, let us say,
9 post-operative vomiting on electrolyte imbalance?
10 A. Well, it is related with that. I will not say I have
11 a great knowledge about that. But I know this -- if
12 this happened, then you have to act appropriately. If
13 vomit is started and IV fluids are there, then you have
14 to do something or speak with the seniors or speak with
15 your colleagues or either do some investigations and
16 find out the cause of that vomiting.
17 Q. Just so that I'm clear, are you saying that you
18 appreciated that if you had post-operative vomiting,
19 that could lead to an electrolyte imbalance?
20 A. It depends how big and how much.
21 Q. That's why I say "could".
22 A. Could.
23 Q. Were you aware it could?
24 A. It could cause problems, yes.
25 Q. Yes. Well, the reason I'm asking you this is because

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1 THE CHAIRMAN: Thank you.
2 MS ANYADIKE-DANES: If you were concerned about
3 post-operative vomiting, that's the sort of thing that
4 would cause you to contact your senior colleague;
5 is that right?
6 A. It is, yes.
7 Q. You said that you would be trying to find out why, you'd
8 be instituting some tests, but the fact that it was
9 happening is the sort of thing you might want to consult
10 your senior colleague about?
11 A. I would let him know that. If something is happening,
12 I would let him know as a senior that this happened.
13 Q. Yes. And from your point of view, what would you be
14 wanting to do about the IV fluids? If I can help you
15 with this. Assuming a situation where you have
16 a paediatric patient, post-surgical, on IV fluids, who
17 is suffering from post-surgical vomiting, and you're
18 a bit concerned about that. So in addition to notifying
19 your senior that that is happening, taking some bloods
20 to get the electrolytes checked to see where the sodium
21 levels are or whatever else might be going on. Would
22 you be wanting to do anything about the IV fluids?
23 A. Again, you have to quick ask to the lab that they will
24 give express reserves, check sodium and potassium. From
25 there, you need to act; okay? As well as calculate the

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1 fluid, how much fluid is given to that child with the
2 help of -- I don't know how much fluid needed for that
3 child with the help of paediatricians. You can call
4 paediatricians, "Okay, I'm not sure how much fluid given
5 to this child", because it's always calculated by the
6 formulas for the kids. It's not adult.

7 And after that, act on that, you need to continue
8 that fluid or you need to stop that fluid according to
9 the blood results, according to the advice of the
10 paediatricians, as well as speak with my own senior,
11 "Look, this is happening, I'm doing this, this, this".

12 And then wait from him, what he wants me to do further.
13 Q. A little while ago I'd asked you whether -- at least to
14 have you confirm that you were familiar before you came
15 to Altnagelvin in prescribing fluids, both
16 preoperatively and post-operatively, and you said yes,
17 you were. Can I ask you what fluids you were familiar
18 with or used to prescribing?

19 A. It is a sodium chloride, normal saline called, as well
20 as dextrose saline, two fluids used mostly in the
21 practice they are giving. Plus bloods, plasma, that
22 kind of fluids, et cetera.

23 Q. Were you familiar with using what's called
24 Solution No. 18?

25 A. Honestly speaking, before coming here -- sorry, before

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1 A. Yes. In England they use that.

2 MS ANYADIKE-DANES: You had also fairly said that this was
3 your first paediatric posting and that might have
4 something to do with the fact that you had not come into
5 contact with that fluid before. Now if we go into your
6 role, I want to ask you in particular your
7 responsibility for the care and treatment of paediatric
8 surgical patients. Ward 6, which is where Raychel was,
9 was the paediatric ward in Altnagelvin; isn't that
10 correct?

11 A. I think, yes.

12 Q. And that was a mixed ward, mixed surgical and medical;
13 is that correct?

14 A. Yes.

15 Q. How familiar were you with Ward 6 before Raychel?

16 A. I think I have very limited chances that I have gone
17 there and admitted patients on Ward 6. During my
18 on-calls, I will say that, either when I was working
19 with -- a few days with one consultant, saying ...
20 I don't remember much about that. I do -- I'm not
21 saying I haven't gone there, I have, and I have admitted
22 paediatric patients, which is related with surgery,
23 surgical patients, but I don't remember much, I have
24 done too much there.

25 Q. Does that mean that not only was Altnagelvin your first

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1 Altnagelvin, I don't know.

2 Q. You mean --

3 A. About 18 Solution.

4 Q. You didn't know about that solution?

5 A. I didn't know about 18 Solution particularly. Sodium
6 chloride or dextrose saline was called.

7 Q. So you hadn't been involved in prescribing it or having
8 anything to do with that fluid?

9 A. No. You mean here in Altnagelvin?

10 Q. No, no, before you came to Altnagelvin.

11 A. Again, it's confusing here. You're asking me about
12 particularly Solution No. 18 or particularly all
13 solutions?

14 Q. No, Solution No. 18. I'm just confirming that you had
15 had nothing to do with Solution No. 18.

16 A. No, I have no chance in the past, before coming here, to
17 prescribe 18 Solution.

18 Q. Thank you. When you did come to Altnagelvin, did you
19 prescribe it in Altnagelvin?

20 A. 18 Solution?

21 Q. Yes.

22 A. I don't remember that. I don't think -- I don't
23 remember.

24 Q. Thank you.

25 THE CHAIRMAN: Were you familiar with Hartmann's?

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1 position where you had anything to do with paediatric
2 patients, but actually you may not have had very many
3 paediatric patients before Raychel; would that be fair?

4 A. Yes.

5 Q. For the patients on Ward 6, what is the specialty that
6 took care of them, if I can put it that way? Because
7 you've got medical patients and you've got surgical
8 patients. So of the doctors concerned, who is primarily
9 responsible for taking care of those patients?

10 A. All patients?

11 Q. Yes, in general.

12 A. In paediatric wards?

13 Q. In Ward 6.

14 A. Right. Well, it all depends on that, in that regard.
15 If ...

16 THE CHAIRMAN: Sorry, I thought it was clear that the
17 surgical patients were primarily the responsibility of
18 the surgical team and the medical patients were
19 primarily the responsibility of the paediatric team.

20 MS ANYADIKE-DANES: That's not necessarily how Mr Zafar has
21 put it later on in his witness statement. That's why
22 I'm asking him to explain now how he recalls it.

23 A. Well, I mean, in paediatric wards when paediatricians
24 are available there, they're writing drugs, prescribing
25 fluids, mostly they did that. How much I remember ...

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1 I can't recall all that, really. I understand -- the
2 surgical patients belong to surgeons and the medical
3 patients belong to medics. But at the same time,
4 I think the prescribing things belonged to them. The
5 reason was only that mostly the surgeons, most of the
6 surgeons, they are working on the surgical side, adult
7 surgery, and the paediatricians know how much -- there's
8 a difference between writing drug charts as well as
9 fluids, according to the body weight, according to the
10 formulas. That's why that was understanding that the
11 paediatrician will take over that and write that.
12 I don't remember exactly, but I understand that.
13 Q. Let me help you by pulling up your witness statement,
14 which is actually why I was asking you that question.
15 It's witness statement 025/2, page 18. In there you
16 say:
17 "Paediatrics take care of surgical patients on
18 paediatric ward."
19 It's right up at the top. If we pull page 17 up
20 alongside it, we can see what the question was, question
21 19:
22 "Clarify whether there were any arrangements in
23 place in 2001 to allow members of the surgical team in
24 Altnagelvin to obtain paediatric medical advice or
25 assistance for the care of a surgical patient."

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1 give a fluid or prescribing some drugs or ... They can
2 write that at that time.
3 Q. So that would mean that the fluid management --
4 A. Fluid management, yes.
5 Q. You would regard that as a medical problem?
6 A. A medical problem. It's not a problem --
7 Q. Yes, a medical issue.
8 A. Yes.
9 Q. So if I understand --
10 A. Sorry, it's also considering that they are paediatrics,
11 that's why I'm saying that. If they are in the adult
12 side, in the adult ward, of course surgeons they have
13 done that.
14 Q. So this is particular because these are general
15 surgeons, not specialist paediatric surgeons, with their
16 patients who are on the paediatric ward. So if there
17 were issues like fluid management, that is something
18 that you would be requiring the assistance of
19 a paediatrician --
20 A. Paediatricians.
21 Q. And you would expect them to be managing that aspect of
22 their care; is that correct?
23 A. Yes.
24 THE CHAIRMAN: Then let's go back to page 6 of the same
25 statement, WS025/2, page 6. You were asked, Mr Zafar,

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1 And the answer to that from you was:
2 "Paediatrics take care of surgical patients on
3 paediatric ward."
4 I wonder if you could help us by explaining what you
5 meant when you wrote that.
6 A. Its meaning is that if there is a medical problem with
7 the surgical patients, then at that time the
8 paediatricians will take over and look after them.
9 Q. And what would you mean by a medical problem?
10 A. Surgical problem means wounds, [inaudible], any pains
11 et cetera. Surgical problems is after surgery; right?
12 And after surgical, if some medical problems come, other
13 problems on the abdominal side or distension or et
14 cetera maybe, it's better to be consulted with the
15 paediatrics and the paediatrics can take over that.
16 Q. So if I may understand you, if for example the wound
17 wasn't healing very nicely, would you regard that as
18 being a surgical problem?
19 A. Very nicely? You mean ...
20 Q. It wasn't healing well.
21 A. It is a surgical problem. The surgeons have to look
22 after the wound.
23 Q. If that's the surgical end on the spectrum of problems,
24 what would you say is a medical problem?
25 A. Just writing, looking after dehydration or something,

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1 at question 4:
2 "On 8 June 2001 I conducted the morning ward round."
3 The question is:
4 "What were the arrangements for post-operative
5 management of children at that time?"
6 You said:
7 "The junior surgical team was responsible for doing
8 ward round for post-operative patients as well as
9 providing further care."
10 A. Yes.
11 THE CHAIRMAN: That's why you did the ward round on the
12 morning of 8 June, because Raychel was a post-operative
13 paediatric patient.
14 A. Yes.
15 THE CHAIRMAN: And when I read that on and it says:
16 "As well as providing further care ..."
17 The further care that you would provide does not
18 include fluid management; is that right?
19 A. Here is a surgical -- I mean, as she was first post-op
20 after appendicectomy, the surgeons are required to see
21 her and look after her surgical side, if there are any
22 other issues could be addressed and direct her
23 accordingly. That's what I'm saying here, the junior
24 surgical team, SHO, because the question was put in that
25 way, who is going to do rounds or look after that

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1 patient post-operatively.
2 THE CHAIRMAN: Sorry, the question was: who will provide the
3 post-operative management? And you have said:
4 "The surgeons do the ward round."
5 A. Yes.
6 THE CHAIRMAN: Which is what you did. Then you say:
7 "As well as providing further care."
8 Do I understand on the basis of the answers you gave
9 to Ms Anyadike-Danes over the last few minutes that
10 having done the ward round, if there was a problem with
11 a wound that wasn't healing, you would regard that as
12 a surgical issue, but if there was a problem for
13 instance about fluid management, you would regard that
14 as an issue for the paediatricians to deal with, not for
15 the surgical team to deal with?
16 A. If pointed out surgeons, of course surgeons can ask to
17 the paediatricians at the same time, "Look, this is the
18 issue. Please could you come and look at that child".
19 That's -- I'm considering that way.
20 THE CHAIRMAN: Okay. So for the paediatricians to become
21 involved, they do so because the surgeons ask them to
22 become involved?
23 A. No. This is nice of them because -- I mean, it's nice
24 to ask that, to request them. It's better, that.
25 THE CHAIRMAN: Let's suppose that I was working on Ward 6 as

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1 doing the fluid calculation?
2 A. I think it's better [inaudible] like intensive care. If
3 you're in intensive care, surgical patient is there.
4 The intensive careists, they look after their patients,
5 surgical patients, not surgeons. Surgeons go and do the
6 round and, "Okay, that's fine", and the fluid management
7 and et cetera, the intensive careists, they do that.
8 THE CHAIRMAN: Sorry, in intensive care it's the intensive
9 careists, like the anaesthetists?
10 A. Yes, the anaesthetists. That's why I'm saying that if
11 a patient is in a paediatrics ward and the
12 paediatricians are available, I think that will be
13 better addressed by the paediatricians, fluid
14 management, than to ask to the surgeon.
15 THE CHAIRMAN: I just need to get this absolutely clear from
16 you. The way that that happens is that the nurses
17 contact the surgeons because she's a surgical patient?
18 A. Yes.
19 THE CHAIRMAN: And if the surgeon wants the assistance of
20 a paediatrician, the surgeon will ask the paediatrician
21 for that assistance?
22 A. Yes.
23 THE CHAIRMAN: Thank you.
24 MS ANYADIKE-DANES: Mr Zafar, would it be fair to say
25 there's an element of shared care, really, for

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1 a paediatrician in 2001 and you were the surgeon who had
2 seen Raychel; okay? Would you say that as that Friday
3 went on and Raychel was vomiting and she had problems,
4 would you expect, or one of the surgical team expect, to
5 be called back to be asked to handle that problem, or
6 would you expect the nurses to ask me or another
7 paediatrician?
8 A. No, it is going back to address to the surgeons first.
9 The surgeons, okay, they will take over to the
10 paediatricians, that this is the issue.
11 THE CHAIRMAN: I see. So the nurses' point of contact is
12 with the surgeons because she is a surgical patient?
13 A. She is belonging to them, yes.
14 THE CHAIRMAN: If the surgeon wants paediatric assistance,
15 the surgeon will ask for it and one of the issues upon
16 which they might ask for paediatric assistance is fluid
17 management?
18 A. Yes. I prefer that, if patient is in a paediatric ward
19 and paediatricians are available 24 hours in that ward,
20 I think that could be better addressed to them, "Okay,
21 please could you come and write on the fluid?" The
22 reason is that, again, calculations, they are doing
23 daily basis. That calculation to a surgeon who is doing
24 after 4, 5, 10 days, come back and write on the fluid.
25 THE CHAIRMAN: So the paediatricians would be better at

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1 paediatric surgical patients on that ward? By that
2 I mean, between the surgeons and the paediatricians.
3 A. I don't remember that.
4 Q. But you have described effectively an element of shared
5 care?
6 A. Sorry, yes.
7 Q. With the paediatricians, albeit being invited by the
8 surgeons, but the paediatricians contributing in part in
9 certain circumstances to the child's care.
10 A. Yes.
11 Q. So there's an element of shared care is what I was
12 saying.
13 A. Yes.
14 Q. Which is something that wouldn't happen on an adult
15 surgical ward?
16 A. It's not happening there because -- I mean, they have
17 separate wards and they are separate specialists.
18 Medical ward is a medical ward and in a surgical ward
19 they are fully equipped and surgeons are available
20 there.
21 Q. Yes. The other reason why there might be an element of
22 shared care is because, as you've already said, the
23 surgeons are really busy and needing to get into the
24 theatre to perform surgery.
25 A. That's true, yes.

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1 Q. So they're not always perhaps as accessible as
2 a paediatrician might be. Would that be fair?
3 A. Yes.
4 Q. If I can pull up 025/2, page 11. It's question 6(f).
5 We're still in this sort of area. The question was:
6 "In what kinds of circumstances was the nursing team
7 expected to contact the surgical team in relation to the
8 condition of a post-surgical patient who was being kept
9 under observation?"
10 Which is the same sort of question as the chairman
11 was asking you. This is what you said:
12 "If there were any issues about Raychel's [so you
13 are now zooming in specifically on Raychel, not
14 generically] surgical condition and general medical
15 condition, she should have been seen by paediatricians.
16 The surgical team should be contacted if there were any
17 surgical issues such as wound problems or abdominal
18 pain/distension. For general medical issues, sometimes
19 the paediatric team would be contacted."
20 That seems to suggest not that the nurses would
21 contact the surgeons, who would then relay that to their
22 paediatric colleagues, but rather that the nurses seem
23 to be exercising a judgment, as I think you have
24 described it. "If it's a medical issue, we'll contact
25 the paediatricians. If it's a surgical issue, we'll

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1 then I could understand it. But you then add:
2 "For general medical issues, sometimes the
3 paediatric team would be contacted."
4 But you've already said just above that, "For
5 general medical condition, she should have been seen by
6 paediatrics". So are you repeating what you'd said
7 before or are you saying that for general medical issues
8 sometimes the paediatric team would be contacted but
9 it's primarily the job of the surgical team?
10 MR STITT: Might I intervene?
11 THE CHAIRMAN: I don't want to overanalyse this, Mr Stitt,
12 but it doesn't seem to me to be a clear answer.
13 MR STITT: It doesn't, and really I'm trying to be helpful
14 here. It is getting into semantics, and I think, given
15 that we are talking about that, it does seem to me as
16 though the first of the paragraphs is what should have
17 happened, which is "should have been seen by
18 paediatrics", whereas the last sentence of the second
19 paragraph is de facto.
20 THE CHAIRMAN: It doesn't quite add up and maybe that's
21 because the system itself didn't quite add up. Maybe
22 the confusion isn't from the witness, maybe the
23 confusion is in the system.
24 MR STITT: It may well be.
25 THE CHAIRMAN: Which you know is a theme we're looking at.

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1 contact the surgeons'. Is that correct, is that what
2 you meant to convey?
3 A. Yes. Here again, I have -- previously I've explained
4 that. If there's some medical problems going on -- just
5 in Raychel's condition, she was vomiting. It could be
6 seen at that time paediatricians. Paediatricians are
7 available all the time there in the ward.
8 Q. Sorry, Mr Zafar, let's just be clear about it. The
9 point that I'm getting at --
10 THE CHAIRMAN: Sorry, the answer is contradictory.
11 MS ANYADIKE-DANES: It seems to be.
12 THE CHAIRMAN: The answer is contradictory because in the
13 first two lines of your answer, you say:
14 "If there are issues about general medical
15 condition, she should have been seen by paediatrics."
16 And then two lines down:
17 "For general medical issues, sometimes the
18 paediatric team would be contacted."
19 Which suggests that sometimes -- well, really the
20 surgical team, but sometimes it would be the paediatric
21 team.
22 MS ANYADIKE-DANES: Do you see that, Mr Zafar? (Pause).
23 THE CHAIRMAN: Mr Zafar, I can understand your answer up to
24 the last sentence. If your answer had stopped on the
25 fourth line after the words "abdominal pain/distension",

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1 MR STITT: Of course it is. Central.
2 THE CHAIRMAN: What Mr Zafar has said is for the paediatric
3 team to be involved, it would usually be at the
4 instigation of the surgical team who had been contacted
5 by the nurses. I think Mr Zafar is really suggesting
6 that would be the appropriate way for them to become
7 involved because otherwise they're not the patients of
8 the paediatric team, they're the patients of the
9 surgical team. So maybe this is de facto how it worked.
10 MR STITT: Part of the problem, if I may speculate, is that
11 we are dealing with patients who are not in surgical
12 wards.
13 THE CHAIRMAN: Yes.
14 MR STITT: They're in a children's ward because of
15 a decision taken, for obvious reasons, that they'd be
16 better nursed in a children's environment.
17 THE CHAIRMAN: Yes.
18 MR STITT: It may well be a possible explanation as to the
19 lack of clarity for the demarcation lines.
20 MS ANYADIKE-DANES: Thank you very much. My learned friend
21 has it, and it is a matter that we will pursue in
22 governance, the implications of that, if I can put it
23 that way.
24 THE CHAIRMAN: Sorry, we need to pursue it in clinical.
25 MS ANYADIKE-DANES: Yes. But can I ask you this, Mr Zafar,

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1 and forgive me for getting into some detail on it, but
2 this involves other people if you're going to set out
3 what you think the system was. It may impact on the
4 questions we ask other witnesses. Are you indicating
5 that depending on the nature of the problem that the
6 child may have, and the first people usually to see that
7 will be the nurses because they're there looking after
8 the child most of the time, that the nurses form
9 a judgment as to whether they should be contacting the
10 surgeons if it's a surgical issue or the paediatricians
11 if it's a medical issue? Is that your understanding of
12 what the nurses did?
13 A. I think, yes. That is ... It is that because if some
14 problems -- I mean, how they are feeling at that time,
15 how they are thinking the patient -- which direction
16 it's going. It seems to be a medical problem or if
17 wrongly they think it seems to be a medical problem, if
18 they think that they can call a paediatrician as well.
19 It's not a harm to call a paediatrician.
20 Q. No, I'm not suggesting it is, I'm just trying to
21 understand the system at the moment. So far as you are
22 explaining it, in your view the nurse could exercise
23 a judgment. If she thought the matter of concern to her
24 with that patient was a medical question then she could
25 refer that to a paediatrician and get some medical input

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1 question, you were recognising that the paediatricians
2 were perhaps more readily available or accessible than
3 the surgeons were, who had theatre commitments, if I can
4 put it that way.
5 A. Sorry?
6 Q. You had recognised that the paediatricians may be more
7 readily available because the surgeons had theatre
8 commitments?
9 A. Yes.
10 Q. Were you aware of there being any issue, so far as the
11 nurses were concerned, about not readily being able to
12 reach surgeons?
13 A. I don't think so.
14 Q. Let me pull up something for you.
15 THE CHAIRMAN: Let's do it perhaps very concisely this way.
16 A problem was that -- and I think you've already
17 referred to it -- you were not a paediatric surgeon.
18 A. No.
19 THE CHAIRMAN: And most of your patients were not children.
20 A. Yes.
21 THE CHAIRMAN: So most of your time, you were not on Ward 6?
22 A. Yes.
23 THE CHAIRMAN: And the same applied to your surgeon
24 colleagues; isn't that right?
25 A. Yes.

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1 from a paediatrician. If, on the other hand, she formed
2 the view that it was a surgical issue then she would be
3 referring that to a surgeon. Is that what you're
4 saying?
5 A. I agree in emergency situation she can do that. If she
6 is not anticipating any problem then she can call the
7 team who -- which team that patient belongs at that
8 time, and he can deal.
9 THE CHAIRMAN: In an emergency?
10 A. In an emergency situation, if some emergency things are
11 going on and nobody's available, just for example, and
12 then she can ask who is available there in a paediatric
13 ward, if paediatricians are available.
14 THE CHAIRMAN: I just want to make clear to you, the
15 impression that we have received so far from the nurses
16 who have given evidence from the ward is that they
17 would -- if they wanted to contact a doctor for
18 Raychel's care, they would have tried to contact
19 a surgeon. Their first stop was to go to a surgeon
20 because she was a surgical patient. Does that make
21 sense to you?
22 A. Yes. If patient belonged to surgeons, they have to call
23 to the surgeons.
24 THE CHAIRMAN: Okay, thank you. Let's move on.
25 MS ANYADIKE-DANES: Before we were dealing with that

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1 THE CHAIRMAN: So wouldn't that mean that whereas the
2 paediatricians would regularly be in and around Ward 6,
3 the surgeons were not regularly present?
4 A. Not present, yes.
5 THE CHAIRMAN: So that could mean from time to time that the
6 nurses would have difficulty contacting the surgeons
7 because they were elsewhere in the hospital?
8 A. Well, I don't remember that.
9 THE CHAIRMAN: You were here this morning when Mrs Millar
10 was giving evidence?
11 A. When I was there, I don't remember that this practice
12 happened with me or generally, I don't remember.
13 THE CHAIRMAN: It's not blaming you for it, Mr Zafar, and
14 it's not blaming the other surgeons for it, it's
15 a simple proposition, really, that because you were not
16 dedicated to the paediatric unit and most of your
17 patients were elsewhere, it could be sometimes difficult
18 or slow for you to respond to calls from Ward 6.
19 A. That may be the case. It is possible, yes. I can't --
20 I mean, whenever they called, they did call, and I think
21 the surgeons -- they answer [inaudible] the bleep is
22 somewhere.
23 THE CHAIRMAN: They answer it as best they could, but
24 sometimes they just couldn't.
25 A. Sometimes they couldn't. At that time the system was

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1 that the on-call person is not only on call, he is also
2 going to the other assignments, theatre, ward.
3 THE CHAIRMAN: That's the point.
4 A. That's why it's hard sometimes to reach back immediately
5 to --
6 THE CHAIRMAN: Thank you.
7 MS ANYADIKE-DANES: Yes. So the issue was -- or at least
8 the concern was that surgeons were unable to give
9 a commitment to children in Ward 6 unless they are
10 acutely ill, that's the children, and bleeped. That was
11 a specific concern. The reference is 022-097-308. So
12 surgeons are unable to give a commitment to children in
13 Ward 6 unless they, that is the children, are acutely
14 ill and the surgeons are bleeped. That was a concern.
15 Were you aware of that?
16 A. I don't, because this is not a question to me, this is
17 high level, not me.
18 Q. You weren't aware of that being a concern?
19 A. No. I mean, I don't.
20 Q. Where that goes to is the concern that surgeons are
21 responsive in a way, so they respond to an emergency
22 call, if I can put it that way, rather than perhaps
23 being available to engage perhaps in more proactive
24 care. Were you aware of that sort of concern?
25 A. You mean the on-call team?

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1 A. Yes. JHO was available all the time, JHO's duties
2 included at that time only look after ward patients, not
3 emergency patients, not in Accident & Emergency.
4 Q. Yes. The system, if I can put it that way, in order for
5 you and the registrars and consultants to carry out your
6 theatre duties and respond to the needs of your adult
7 patients, the system really depended on those JHOs being
8 responsive to the nurses making preliminary decisions
9 and, if necessary, contacting their more senior
10 colleagues?
11 A. Yes.
12 Q. That's the system?
13 A. That is true.
14 Q. So that system requires them to have, presumably, also
15 easy access to you, because they're only trainees?
16 A. Yes.
17 Q. You're a trainee, but they are pre-reg?
18 A. Yes.
19 Q. And they need supervision, do they not, as pre-reg?
20 A. Supervision?
21 Q. The JHOs would require a degree of supervision too,
22 would they not?
23 A. Yes.
24 Q. They are also not specialists in paediatric surgical
25 care, are they?

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1 Q. Yes.
2 A. On-call team is always on call.
3 THE CHAIRMAN: Sorry, this is isn't just the on-call team.
4 For instance, on Friday 8 June you were on duty.
5 A. Yes.
6 THE CHAIRMAN: Not on-call.
7 A. I was on-call 24 hours.
8 THE CHAIRMAN: But you were in the hospital on duty. That's
9 why you were doing the ward round.
10 A. Yes. I was on-call from morning until next morning and
11 in the hospital.
12 MS ANYADIKE-DANES: But as you've already answered, you
13 wouldn't be necessarily able to commit at any given
14 point in time being able to respond to a child because
15 you had theatre duties and you had your adult patients.
16 A. That is true because during those days, on-call was made
17 like that, on-call is SHO, registrar and JHO, and the
18 consultant. But the plan, it was really by the person
19 who is responsible for that. On-call, okay, if there's
20 some problem, call bleep, but if at the same time you
21 are doing other assignments you have to do that as well.
22 Q. Does that mean that you as an SHO who was qualified and
23 presumably did carry out some surgery were dependent
24 really on the pre-reg doctors being available to the
25 nurses to deal with paediatric surgical patients?

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1 A. No, they are not.
2 Q. So how did the system of supervision work for those JHOs
3 in 2001?
4 A. JHOs were controlled by not SHOs, JHOs were -- I think
5 consultants direct that, they plan their duties and
6 training. I don't know about the other who was
7 responsible for JHOs and how they divided and how they
8 sent them to the wards. I don't know.
9 Q. I might not have put it in a way that you understood it.
10 I don't mean who is directing their overall training and
11 so forth. Obviously all that system in terms of JHOs,
12 SHOs and registrars are under the consultant.
13 I understand that. But the first point of call, I think
14 you have just agreed for the nurses, would be the JHO?
15 A. Yes.
16 Q. The JHO requires a level of supervision?
17 A. Yes.
18 Q. The next person in the chain of seniority, if I can put
19 it that way, is the SHO?
20 A. Yes.
21 Q. That would be you?
22 A. Yes.
23 Q. So what was the system that enabled the SHOs to provide
24 some sort of supervision over what the JHOs were doing?
25 A. That is direct supervision, if he is feeling any

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1 problem, that he can inform to the SHO or direct to the
2 registrar or direct to the consultant.
3 Q. So unless they're actually contacting the SHO or
4 registrar and have managed to contact them, they are
5 actually the person who is dealing face-to-face with the
6 nurse and the paediatric surgical patient?
7 A. Yes, I think so, yes.
8 THE CHAIRMAN: And it's up to them to call for assistance if
9 they want assistance?
10 A. Yes.
11 THE CHAIRMAN: Thank you.
12 MS ANYADIKE-DANES: And up to them to know that something is
13 sufficiently serious or significant that they need to
14 contact someone?
15 A. Yes.
16 Q. So then if we move on more specifically to SHO duties.
17 I know that you say that you hadn't seen the handbook
18 but I am referring to it because it conveniently sets
19 out what Altnagelvin considered to be the SHO duties.
20 We see it at 316-004g-003. It says under the clinical
21 work that you will be responsible directly to the
22 consultant or consultants to whom you are assigned.
23 THE CHAIRMAN: Do you agree that you were responsible
24 directly to the consultant to whom you were assigned?
25 A. I agree that because I have to let him know everything,

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1 whom you are assigned, that's actually what I was
2 getting at earlier when I was trying to find out who
3 that consultant was. You can see it there, the fourth
4 bullet down:
5 "So far as your clinical work is concerned, you will
6 be responsible directly to the consultant to whom you
7 are assigned."
8 You've agreed with the chairman that you accept that
9 that was the case, but who was the consultant to whom
10 you were assigned?
11 A. I don't remember because there was changing over.
12 I don't remember what was the rota, which rota is going
13 to which consultant and which rota is going to which
14 consultant. I don't remember that. I understand your
15 point, that always assigned with one consultant, but
16 it is not happen -- I don't remember.
17 Q. Okay. Then it goes on at 004, I hope, to talk about the
18 clearly defined chain of responsibility, of which you
19 were a part, and I think you've accepted that?
20 A. Yes.
21 Q. And that part of the responsibility for your actions
22 will ultimately rest on your supervising consultant, and
23 it's important that you liaise closely with him or her.
24 I think it might be 007, sorry.
25 What I wanted to draw your attention to is that it's

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1 what's going on in the ward about his patients.
2 THE CHAIRMAN: Thank you.
3 MS ANYADIKE-DANES: I believe I had given you the wrong
4 place. It should be 006.
5 THE CHAIRMAN: Well, the witness has accepted the point.
6 MS ANYADIKE-DANES: In fairness, so that he sees what I've
7 put to him --
8 THE CHAIRMAN: I think he's accepted the point.
9 MS ANYADIKE-DANES: I think then it goes on to say that even
10 when off duty -- sorry, this is why I wanted to bring it
11 up because I think there's another issue:
12 "Even when off duty, you have a continuing
13 responsibility for the patient under your care."
14 Would you have accepted that? It's the final bullet
15 there. And in your witness statement, you said that you
16 regarded yourself as responsible for the day-to-day care
17 of the inpatients and you assisted in major surgical
18 procedures and, under supervision, performed minor
19 surgical procedures and you assisted with
20 appendicectomies. We don't need to pull it up, your
21 second witness statement at page 4. You also took part,
22 1 in 4 on-call rota. Do you accept all of that?
23 A. Yes.
24 Q. When you answered the chairman there that you were
25 responsible directly to the consultant or consultants to

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1 important that you liaise closely with your consultant.
2 Did you understand that that's what you had to do, you
3 had to be in close touch with your consultant?
4 A. I understand very well. The question is here, we worked
5 with all consultants when we were working here. We have
6 worked with everyone. It was not my ... Of course,
7 always everybody has big desires, but you cannot get all
8 the time. It was not my decision with whom I work, that
9 was the decision by the consultants and how they want to
10 work with us, they did that. It's not mine.
11 Q. I understand that, you didn't choose the consultant you
12 wanted to work with. It was a different point I was
13 asking you about, which is the point about liaising.
14 What did you think your obligations were about liaising
15 with your consultant, keeping in touch with your
16 consultant?
17 A. With whom I worked, I was supposed to be informed about
18 the patients and about everything about his patients.
19 Q. So if we take -- we are going to go to it in detail, but
20 if we take June 8, for example, when you carried out the
21 ward round, you did a post-take ward round involving
22 Raychel and then you went off to do theatre work?
23 A. Yes.
24 Q. And be on call for the rest of the remaining 24 hours,
25 and in fact you ultimately came back, responding to

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1 a call in the early hours of the morning of 9 June. So
2 what I would ask you, though, is, in the scheme of that,
3 what did you consider it necessary or how did you liaise
4 with your consultant over that day?
5 A. Mr Gilliland was on call, I remember.
6 Q. Yes.
7 A. And I also wish, what you are asking me, that I have
8 enough time and sit down and talk to him and about his
9 patient and told him everything, which is not happened.
10 When you are going to go through all the 20, 30
11 patients, and after that you have to go to theatre at
12 9 o'clock or 9.30, it's very difficult to inform about
13 all patients to the consultants. But if there's
14 a potential risky patient, risk is there or some other
15 patient which is requiring consultation by the senior
16 colleagues, I am supposed to be.
17 Q. Yes.
18 A. At that time, that practice was going on in the surgical
19 wards, which we have done.
20 Q. So how you interpreted "liaise" to mean is that if you
21 had a concern about a patient, you would contact the
22 consultant about that?
23 A. Definitely I have to inform him that something is going
24 wrong with the patients and I need a further help or
25 I am going to theatre or going to other assignments and

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1 Q. Yes. You said you thought you did have that specialism
2 in children, in paediatrics, so I'm asking you how you
3 gained it.
4 THE CHAIRMAN: I think he said he's not a specialist in
5 paediatrics.
6 MS ANYADIKE-DANES: "If I'm not a specialist in paediatrics,
7 I'm not going to operate that."
8 I took from that because he was involved in Raychel
9 by himself, at the ward round, that he was regarding
10 himself as being sufficiently specialist to conduct that
11 ward round by himself.
12 A. Well, in here I was a surgical team -- one of the
13 surgical team members. This was a simple round, it was
14 not operation. In Altnagelvin, there was no specialist,
15 general surgeon for paediatrics; right? That's why all
16 surgeons, they have taken part in the paediatrics --
17 their patients. In that regard, I also did that. This
18 is part of my SHO training here that I have to look
19 after surgical -- if there's any surgical patients in
20 paediatric wards, that you have to go and see those
21 patients. Whatever outcome will come from me, that is
22 the consultant assessment that I'm doing right or wrong.
23 Q. Yes. So you regarded yourself as being sufficiently
24 trained, I don't mean that in a pejorative sense --
25 A. Yes.

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1 a senior colleague has to come and see that patient.
2 THE CHAIRMAN: Whereas if a patient is progressing as
3 expected and normally, you don't need to trouble the
4 consultant with information about that patient?
5 A. If the patient is doing well, no problem. Not necessary
6 to let him know that. The next day he will ...
7 THE CHAIRMAN: Okay, thank you.
8 MS ANYADIKE-DANES: You've already accepted that you weren't
9 experienced in dealing with paediatric cases. Were you
10 aware of guidance, this is the good surgical practice
11 guidance, were you aware of guidance that indicated that
12 surgeons should only treat children if they have the
13 appropriate training and ongoing experience in the
14 clinical care of children and their specialty, unless
15 of course there's an emergency. Were you aware of
16 anything like that?
17 A. This is normal ethics. If someone is trained with some
18 specialty, he has to deal with that specialty.
19 Q. Did you regard yourself as having a specialty
20 in relation to children?
21 A. No, I do regard that. I regard that. If I'm not
22 a specialist in paediatrics, I'm not going to operate
23 that.
24 Q. And how did you gain that specialism in children?
25 A. How I did?

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1 Q. -- to carry out a ward round involving a paediatric
2 patient?
3 A. No, I mean, if ... Let's put it that way. Specialist
4 need required for that children, from a surgical input,
5 definitely the senior -- I mean, the surgeon or surgeons
6 can go and see that patient. But it was a simple
7 post-appendicectomy and I mean, I was allowed to go and
8 see and do the round.
9 Q. Well, did you know at the time you started that ward
10 round that it was going to be a simple
11 post-appendicectomy?
12 A. Well, I was just -- I know that appendicectomy was done
13 overnight. And she -- I don't know how she is feeling
14 when I went there. I mean, appendicectomy, what I know,
15 it was normal, there was no problem.
16 Q. Sorry, I didn't mean it quite in that way. Presumably
17 there were other patients -- were there other patients
18 that you saw during that ward round or was it just
19 Raychel?
20 A. No, only Raychel.
21 Q. Oh, so you just came to see Raychel?
22 A. Raychel.
23 Q. And how did you know to come and take that ward round?
24 A. Because I was told that there's one patient
25 post-appendicectomy in Ward 6 you have to go and see.

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1 Q. Who told you to go and do that?
2 A. I don't remember that, in the morning time when we were
3 all together, taking over handovers, and we have gone,
4 the team has gone through the adult patients.
5 THE CHAIRMAN: Sorry, are you told this because there's
6 a gathering of the surgical team?
7 A. Yes.
8 THE CHAIRMAN: And you're asked to go to Ward 6?
9 A. Yes.
10 THE CHAIRMAN: And somebody else is asked to go here and
11 somebody is asked to go there?
12 A. Yes.
13 MS ANYADIKE-DANES: And who would be the person who'd be
14 making that decision as to who went where?
15 A. I mean, the registrar at that time was there.
16 Q. Ah, the surgical --
17 A. Sometimes consultant was there.
18 Q. No, sorry, I mean specifically now, on 8 June who made
19 the decision as to who would go where and, in
20 particular, that you would be going to Ward 6?
21 A. I don't remember that, who made that decision and who
22 directed me to go there, I don't remember that.
23 Q. Can you remember if the registrar was there?
24 A. Must be -- I mean, all registrars -- two, three
25 registrars were there.

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1 these witnesses who are new to this environment.
2 THE CHAIRMAN: Yes.
3 MR CAMPBELL: It's fair to say that she gave evidence over
4 a one-and-a-half day period. The questioning was not
5 unfair, nor was it overbearing, by Mr Wolfe, but it was
6 particularly extended and very searching. Therefore it
7 does place people like Mrs Millar under great strain and
8 perhaps the tribunal could bear that in mind as we move
9 forward through the coming weeks of evidence.
10 THE CHAIRMAN: We will do that, Mr Campbell. Has she been
11 able to go on back home to Derry or wherever she lives?
12 MR CAMPBELL: Ultimately, the decision was taken that she
13 would travel back by car with the same people that she
14 travelled up with.
15 THE CHAIRMAN: I'm glad to hear that.
16 MR CAMPBELL: Although they did take the precaution of going
17 via Belfast in case any deterioration should occur on
18 the journey.
19 THE CHAIRMAN: Okay. Thank you, Mr Campbell.
20 (3.45 pm)
21 (A short break)
22 (4.00 pm)
23 MS ANYADIKE-DANES: Mr Zafar, I want to ask you a little
24 about ward rounds, first in general as to their
25 significance so far as you understood them, and moving

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1 Q. Sorry?
2 A. Two, three registrars were there. It's a gathering.
3 I don't remember how many medical persons were there.
4 I don't remember that, but there was.
5 Q. There were registrars there?
6 A. I think there was, I don't remember exactly.
7 Q. Were there consultants there?
8 A. I don't know, I don't remember that.
9 THE CHAIRMAN: If we're about to get into the ward round,
10 we'll give the stenographer a break for ten minutes and
11 we'll resume at about 3.50/3.55, and continue until
12 5 o'clock or thereabouts.
13 MR CAMPBELL: Mr Chairman, before you rise perhaps I could
14 update you as to some matters that have occurred outside
15 the chamber this afternoon. Shortly after she completed
16 her evidence, Mrs Millar began to feel particularly
17 unwell. She had travelled here in the company of one or
18 two doctors and they thought that the matters were
19 sufficiently serious to call an ambulance on her behalf.
20 THE CHAIRMAN: I'm sorry to hear that, Mr Campbell.
21 MR CAMPBELL: That was done and certain checks were carried
22 out on her. I don't wish to go into the details of
23 those, but suffice to say that she was particularly
24 shaken by the events. And it's not to be overstated,
25 the strain that the giving of evidence does place upon

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1 into the actual ward round that you took. If we can
2 take it in terms of the significance. Firstly, can
3 I ask you what you understood in your practice, at that
4 time, 2001, to be the purpose of a ward round?
5 A. To make sure the patients are doing well, if there's any
6 problem with the patients, deal with that patient
7 accordingly and, if I couldn't deal with that problem
8 and need for advice, I have to call my senior
9 colleagues.
10 Q. Would you accept that they can have a broader purpose,
11 that they can be for refining or maybe sometimes
12 changing a clinical diagnosis; they can have that role?
13 A. It can happen, yes. That was my primary responsibility,
14 that things are going according to what it was, better
15 or bad, or re-diagnose, differential diagnosis.
16 Q. So for example, you would have perhaps an anticipated
17 pathway for a patient's progress and the ward round can
18 be a means of seeing whether the patient is progressing
19 as one might have expected?
20 A. Yes.
21 Q. That would be a purpose?
22 A. Yes.
23 Q. Also what further investigations, if any, need to be
24 made?
25 A. Yes.

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1 Q. Communicating with the patients and relatives?
2 A. Yes, patients or relatives.
3 Q. And also training?
4 A. Yes.
5 Q. That's the purpose of a ward round, isn't it?
6 A. Yes.
7 Q. What I've been reading you from is a very current
8 document, just so that you have it. It's the ward
9 rounds in medicine principles for best practice. As a
10 matter of fact, it was issued only in October of last
11 year by the Royal College of Physicians and the Royal
12 College of Nursing. But those were the principles that
13 they were saying guide ward rounds and you have accepted
14 them all, really, as being important?
15 A. Yes.
16 Q. So if that's an appropriate characterisation, would you
17 accept that a ward round is an important event?
18 A. It is, yes.
19 Q. And in fact, Mr Foster, who's the inquiry's expert
20 surgeon -- you may have read one or other of his
21 reports --
22 A. Yes.
23 Q. He says a post-take round, so not just a normal ward
24 round but the ward round immediately after surgery, he
25 regarded that as essential in the training of junior

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1 Altnagelvin?
2 A. Yes.
3 Q. And in fact, a trainee was supposed to attend
4 a consultant ward round unless there was some very good
5 reason?
6 A. Yes.
7 Q. What determined whether a consultant was going to have
8 a consultant ward round so far as you were aware?
9 A. If the team is led by consultant on the round, that will
10 mean that it's a consultant round.
11 Q. It's automatically a consultant round?
12 A. It is automatically a consultant round.
13 Q. And how do you know whether any particular ward round is
14 going to be a consultant ward round?
15 A. It depends on the consultant.
16 Q. How do you know ahead of time?
17 A. I don't think he can immediately come and start the
18 round, it's a consultant round. It's not -- it depends
19 on why, that I know -- not necessarily that he has to
20 inform me that he is going to come and do his round.
21 Sometimes he can, sometimes ... Because he's a team
22 leader.
23 Q. So in practice, you really had to be there for every
24 ward round unless there was some very good reason why
25 you couldn't be there?

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1 surgeons and medical students and an important part of
2 the day. And he went on to say that continuity of care
3 is only assured if the post-take round is taken up by
4 a team under which the patients have been admitted. We
5 don't need to pull it up, but the reference for it is
6 223-002-010. Would you accept that?
7 A. Yes.
8 Q. Mr Makar, when he gave his evidence, referred to
9 a number of rounds that he had become familiar with at
10 Altnagelvin. He described something called a grand
11 round.
12 A. A grand round, yes.
13 Q. A teaching round?
14 A. Yes.
15 Q. And then, of course, the post-take round. I know that
16 you were only there for six months and you weren't there
17 for six months before you saw Raychel, but would you
18 accept that those were different forms of rounds that
19 happened in Altnagelvin?
20 A. I do accept that different rounds are available and
21 I think they are doing that.
22 Q. Yes. The Altnagelvin junior handbook document refers to
23 something else, which may or may not be one of those
24 things, just by a different name. It talks about
25 consultant ward rounds. Were you aware of those at

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1 A. Yes.
2 Q. And it may be that that ward round turned into
3 a consultant's ward round if the consultant led it?
4 A. It is possible, yes.
5 THE CHAIRMAN: Or, as in Raychel's case, it turns into
6 a split ward round where you're sent off to do the ward
7 round which, in this case, involved seeing one patient
8 in the children's ward. Do I assume that at the same
9 time other surgeons were doing ward rounds with adults?
10 A. I don't remember, Mr Chairman, what they are doing at
11 that time. Either they had -- busy with other
12 assignments, for example to theatre or outpatients
13 outside of the hospital or ... I don't remember that.
14 THE CHAIRMAN: Thank you.
15 MS ANYADIKE-DANES: While you were at Altnagelvin did you
16 know Mr Makar?
17 A. Yes.
18 Q. He gave evidence ahead of you, he was obviously the
19 person who conducted the surgery.
20 A. Yes.
21 Q. And he said there is normally a post-take ward round,
22 there's normally a ward round, in any event it's often
23 led by a consultant, but if the consultant cannot lead
24 it because the consultant is busy or looking at a more
25 urgent case, that ward round will be led by a registrar.

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1 A. Yes.
2 Q. And that was the evidence that he gave -- we don't need
3 to pull it up -- in the transcript of 6 February at
4 page 51, starting at line 3. He went on to say that
5 a post-take ward round is usually led by the consultant
6 and that Mr Gilliland in particular was keen to see all
7 his patients, although he admitted that sometimes there
8 could be an emergency and he couldn't do it. His
9 evidence suggested that absent something like that, then
10 Mr Gilliland as the consultant would lead the post-take
11 ward round. Were you familiar with that?
12 A. Again, it's a consultant's desire. I agree, yes, this
13 was.
14 Q. You accept that?
15 A. I accept that. The consultants do lead a round,
16 post-take. It all depends on him, that he likes to go
17 for post-take round or not.
18 Q. Did you know Mr Zawislak?
19 A. Very vaguely.
20 Q. He gave evidence as well. He was the specialist
21 registrar. His evidence was that the following morning,
22 so that's the post-take, would be a ward round. He said
23 that would involve the whole surgical team, including
24 consultants. And he said that he would expect it to be
25 led by a consultant, who would be informed by either the

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1 way, not necessarily typical, but not unusual?
2 A. Not unusual, not typical, but I think at that time some
3 delaying was going on or the senior registrar -- maybe
4 a registrar wants to go to theatre or something.
5 I don't know why I was directed to see that patient.
6 I don't remember that.
7 Q. So you think there might have been a particular reason
8 that day why it happened like that?
9 A. There may be a particular reason, yes, I don't remember.
10 Q. You weren't told, you were simply asked to go and see
11 Raychel?
12 A. Yes.
13 Q. Did you go alone or did a JHO go with you?
14 A. Again, I don't remember. I think a JHO was with me or
15 not, I don't remember that.
16 Q. And what was the plan for when you had done that, when
17 you'd completed that and seen Raychel, what were you
18 then going to do? Would you join the rest of the team
19 on the ward round or --
20 A. There was no ward round at that time, I think they were
21 distributed to the assignments, gone to the theatre or
22 outpatients. It's only 30, 40 minutes you have to
23 complete the round.
24 Q. Sorry, what I meant was what happened to the rest of
25 the -- the other patients who were having post take ward

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1 SHO, houseman from the previous night of his patients.
2 Would you accept that too?
3 A. Yes.
4 Q. So what Mr Makar went on to say is that effectively, if
5 you were having a ward round, there'd be a gathering, as
6 you suggested, all together. If Mr Gilliland couldn't
7 attend, that would become apparent, he would let
8 somebody know, probably the registrar, and it would
9 proceed, and in his view you would start on, I think
10 it's the 9th floor, and work your way down?
11 A. Yes.
12 Q. The suggestion was more or less together, or I presume
13 there are reasons why that can't always happen. In your
14 experience, how did the post-take ward round operate, if
15 I can put it that way?
16 A. It's very difficult to recall. I think the same has
17 happened that all together we have done a round, if the
18 consultant is not available then the registrar takes
19 over and all the way gone through all the patients.
20 Q. So is it more typical for more than one person to be
21 attending the patients?
22 A. More typical, not unusual, but sometimes you have to go
23 alone as well.
24 Q. So the fact that you were asked to go and see
25 a particular patient is, if I can put it to you this

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1 rounds, not paediatric ones necessarily?
2 A. I think that was the reason that maybe they asked me to
3 go and see that patient post-op and they have gone to
4 other patients. Maybe, I don't remember that.
5 Q. So Raychel may have been the only paediatric --
6 A. Yes.
7 Q. -- post-surgical patient?
8 A. Yes. Only one patient.
9 THE CHAIRMAN: I think that's what you said before the
10 break, that you saw Raychel, that was the only child you
11 saw on Ward 6.
12 A. Yes.
13 MS ANYADIKE-DANES: I mean as a post-take. Were there any
14 other surgical patients in Ward 6?
15 A. In paediatric wards, no.
16 Q. Sorry?
17 A. Not in paediatric wards.
18 Q. Sorry? I may not have put it --
19 THE CHAIRMAN: Raychel was the only child he saw on Ward 6
20 that morning.
21 MS ANYADIKE-DANES: I know she was the only child. What
22 I was asking was slightly different, whether she was the
23 only surgical child on Ward 6.
24 A. Only surgical. I remember that I haven't seen any other
25 surgical patient in Ward 6.

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1 Q. Thank you. When would the paediatric surgery or surgery
2 generally typically start? When would theatre start?
3 A. Mostly, early in the morning. I don't remember in
4 Altnagelvin at that time, but I think it would start
5 before 9 some time, or 8 or 9. That is the time of
6 surgery starting. I don't remember the figures.
7 Q. When you'd finished with Raychel, you'd be going on to
8 theatre, typically?
9 A. Maybe, I don't remember where I have gone. I think
10 I have gone in theatre.
11 Q. Yes. Sister Millar gave evidence as to how long she
12 thought your examination or the ward round with Raychel
13 took, and she said between 5 to 10 minutes, I think.
14 And then she thought maybe more like 5 minutes.
15 A. That may be the case, yes.
16 Q. That doesn't seem completely incorrect to you?
17 A. No, no, it's not incorrect. It's maybe the same.
18 Q. Is that a typical period of time? I know that might be
19 very difficult to say. When there are no problems,
20 is that the sort of time that you spend with each
21 patient?
22 A. It depends what kind of surgery is done, what's our
23 issue there, and overnight post-op surgery, how she has
24 gone through. If all questions are straightforward, she
25 was straightforward, I think 5 or 10 minutes is enough.

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1 Dr Zafar. Dr Makar did the surgery, and the post
2 surgery, who is the surgeon, he is always liked to go
3 and see his patient post-operatively. Whenever he
4 likes, he can go and see that patient. Not necessarily
5 the time. Dr Zafar was takeover on call, starting call
6 from morning, and continued until next morning. I was
7 responsible for that 24 hours time, the patients who are
8 there in the hospital in all surgical patients, I was
9 responsible for that.
10 Q. Yes. That's what I was clarifying with you. So you're
11 not meaning to say that Dr Makar had any role in taking
12 the post-take ward round, but as the surgeon who had
13 conducted the surgery it would be natural for him to go
14 and see the patient and, in fact, he had gone to see the
15 patient?
16 A. That is true, because he has done the surgery from last
17 night, and she was considered her [sic] patient, the
18 surgeon.
19 THE CHAIRMAN: Thank you.
20 MS ANYADIKE-DANES: There's one point that I was asked to
21 clarify with you, and I apologise for not having done it
22 before. How often, so far as you can remember, before
23 you took the post-take ward round in Raychel, how often
24 was it that the consultant was not there?
25 A. Again, I don't remember that. If consultants' own wish

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1 If you will say 10 minutes each patient and you have 30
2 patients, 300 minutes you need to go through. If
3 you are considering that each patient should be seen 10
4 minutes, just for example, then if you have 30 patients
5 to go through in the ward, multiply 30 by 10, it's 300
6 minutes. And 300 minutes, how many hours?
7 THE CHAIRMAN: Five.
8 A. Then I cannot go to the surgery, the other assignment,
9 the surgeons will be unhappy with me as well. That was
10 the practice at that time in surgical wards.
11 MS ANYADIKE-DANES: Can I ask you just to perhaps help us
12 with something you said in one of your witness
13 statements. This is to be found at 025/2, page 7. The
14 practice at the time was for the on-call SHO to do the
15 morning ward round. Then you go on to say:
16 "I think that Dr Makar saw Raychel later that
17 morning."
18 It's just under (h). Just so that we're clear about
19 that, because when you were answering the chairman
20 earlier you said that you were the on-call surgical SHO?
21 A. Yes.
22 Q. So you're not in any way suggesting here, are you, that
23 Dr Makar should have been the person to take the ward
24 round, Raychel's post-take ward round?
25 A. Here are two points. One is Dr Makar and one is

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1 and desire, when he likes to go, when he has a free
2 time, he can go and see the patient.
3 Q. Thank you. Earlier today when I was asking you
4 questions, you talked about there being an element of
5 shared care, really, for these surgical paediatric
6 patients on Ward 6. Sister Millar has said that there
7 was a medical ward round, if I can put it that way,
8 going on at round about the time when you were
9 conducting the post-take ward round. And that is not an
10 unusual thing, that the paediatricians do their ward
11 round and the surgeons do their ward round. Were you
12 ever aware of any suggestion that they might combine and
13 you might do shared ward rounds?
14 A. It is their desire, their guidelines, hospital
15 guidelines, not mine. I can't say anything about this.
16 Q. No, no, I'm asking you a different question. Was there
17 any suggestion that there could be an element of
18 multidisciplinary ward round given that the two
19 disciplines sometimes could be involved in the care of
20 the same patient? Was there, so far as you were aware,
21 ever any suggestion of that?
22 A. I don't remember that, any such suggestions.
23 Q. And all the time you were there, that never happened;
24 is that right?
25 A. I haven't seen that. Unless if I have referred

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1 a patient to the paediatricians and the paediatricians
2 came and see that patient, I am available there, I don't
3 remember that.
4 Q. Thank you. When you had previously, before I put to you
5 some of the potential significance of the ward round --
6 when you answered yourself for what you took the purpose
7 of it was, you said to make sure -- the post-take ward
8 round -- the patient was recovering well, their vital
9 signs were okay and their wounds were fine. When you
10 come to do a ward round, what is it that you're doing
11 when you do it yourself so you are not following the
12 registrar or the consultant? What are you doing to try
13 and satisfy yourself as to that objective? What do you
14 actually do with the patient?
15 A. Well, when you come to the patient, you will see the
16 patient, how he is feeling, he or she is feeling,
17 general observation. "General" means how looks like,
18 she is happy, not happy, face is happy or not happy, dry
19 or not dry. Make judgments from that points. And after
20 that, just speak with her in a happy mood and ask her
21 how she is feeling after surgery, politely, and take the
22 history from her. She will say if she is not feeling
23 well.
24 Q. And what do you mean by "take the history from her"?
25 A. How you are, do you feel any pain, do you have a good

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1 helps you.
2 Q. And if it's a paediatric patient you might also ask the
3 parents, I presume?
4 A. If the parents are available, you have to ask,
5 definitely. Parents are more important.
6 Q. Would you want to speak to a parent if --
7 A. I like to, yes.
8 Q. So if a parent's not there, you might ask where they
9 are, are they likely to be available and so on?
10 A. Yes.
11 Q. And apart from your observation and the discussion with
12 the nurse and maybe a conversation that you might have
13 with a parent, what then are you doing about the notes
14 and the charts and so forth? Is that another source of
15 information that you would use?
16 A. That is documentary note. You can get information from
17 the observational chart, what's happening, if it's
18 immediate post-op. Sometimes longer, then there's no
19 chart available, only generally you have to go on
20 clinical evidences, clinical history, biochemical or
21 clinical history. That will give you the results about
22 how she's feeling.
23 Q. But typically, you would want to look at the charts?
24 A. I would like to.
25 Q. And I think you said that you wouldn't necessarily

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1 sleep or not, have you eaten or not. All that questions
2 you have to ask.
3 Q. Do you want to know whether they've gone to the toilet
4 yet?
5 A. Naturally, she has opened her bowel or did she pass her
6 [inaudible] or not. This is important in a general
7 surgery.
8 Q. So those are questions that you would typically ask
9 a patient?
10 A. I do like to ask typically, but you asked me what I do.
11 Q. Yes, exactly. That's what I'm saying.
12 A. If you are asking typically for this patient, you have
13 to put a different question. You are asking me
14 generally?
15 Q. Generally, yes.
16 A. Generally I have told you that I'm doing that way and
17 I look around the patients, what she is doing. As soon
18 as I'll see her -- and after that I will examine her as
19 well if needed. If she is stable, no problem, no need
20 to go and examine her, and ask the sister how she is
21 feeling with her. Sister means nurse, attending nurse.
22 Q. Yes.
23 A. And how she is feeling. She will also give you some
24 history how she was overnight, day, hour before, two
25 hours before, and take from there. That observation

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1 examine a patient unless you had some concern?
2 A. In surgical patients, immediate post-op, if there is
3 something going on or you are not happy with that, if
4 your concerns are there, of course I will examine. If
5 patient is stable, nothing had happened after operation,
6 sitting on the chair or a bed, happy, talking, then
7 there's no point to ask him that, "Okay, I want to
8 listen to this, I want to listen to that". You just
9 have to observe them.
10 Q. Yes. Then if we move to another element of a ward
11 round. When Mr Zawislak was giving his evidence, he
12 talked about it's possible to have a simultaneous ward
13 round and handover. He said that in his transcript of
14 5 February at page 97, starting at line 5. He said that
15 he would expect the post-take ward round to be led by
16 a consultant, who would be informed by either the SHO
17 from the previous night, and it would be, he thought,
18 typically a simultaneous ward round. So the SHO from
19 the previous night would be providing that continuity,
20 if I can put it that way, the handover would be
21 happening all as part of the ward round.
22 A. Yes.
23 Q. When I asked you about handovers, you acknowledged that
24 they were important for quality of care?
25 A. Yes.

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1 Q. In Altnagelvin at that time, would you accept there was
2 any part of a simultaneous ward round and handover
3 occurring or did you --
4 A. Not affecting me, not like that, what you are asking me.
5 Q. Not like that?
6 A. I mean I will not say that, it was not like that
7 handover. I know that patients are there, who are
8 patients operated, I get the information and I'll go
9 through them.
10 Q. So you wouldn't --
11 A. I haven't --
12 Q. Unlike Mr Zawislak, who had some experience of that, you
13 wouldn't have expected necessarily the SHO from the
14 previous evening to be part of that to maintain that
15 continuity?
16 A. I do expect that, that it is part of the -- I mean it
17 will be part of that, but it hasn't happened on that
18 day.
19 Q. Ah, sorry. So that does happen, but it didn't happen on
20 8 June?
21 A. No. I don't remember about that, that there was any
22 formal or informal -- formal handover. Maybe between
23 the JHOs there was a handover, because they got the
24 list, all that patients, where patients are. I mean,
25 mostly they know more than SHO and registrar and the

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1 A. Yes.
2 Q. You were here when Sister Millar was giving her
3 evidence?
4 THE CHAIRMAN: Some of it.
5 MS ANYADIKE-DANES: I'm not quite sure whether it was today
6 or yesterday, maybe I'll stand corrected.
7 THE CHAIRMAN: Sister Millar said today that she was with
8 you when you saw Raychel on the Friday morning.
9 A. Right.
10 THE CHAIRMAN: And as you and she were leaving Raychel,
11 Mr Makar arrived. He went on in to see Raychel for the
12 reasons that you've described because it would be --
13 he had been the surgeon, but you and Sister Millar
14 continued on your way. So her recollection is that
15 although you passed each other, there was no discussion
16 between you about Raychel. First of all, do you have
17 any recollection of that?
18 A. No, I don't remember that. I only know that he came
19 after me, but I don't remember any discussion or
20 anything with me and him, how much was, I don't remember
21 that.
22 MS ANYADIKE-DANES: Sorry, Mr Chairman, she also said it
23 yesterday and we can pull up the transcript in case that
24 assists him. Yesterday's transcript, page 106 and 107.
25 If we can have those side by side. Then I think if you

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1 consultant. They guide them about their patients
2 because they are the -- I mean, who are the first source
3 in the ward, and they are all the time in the ward
4 areas. And that's why maybe they have a handover, but
5 I don't remember myself.
6 Q. You don't remember that ever happening or you don't
7 remember it happening on 8 June?
8 A. It hasn't happened, that, and I don't remember that
9 there was any ward round like that.
10 Q. Yes. If you had appreciated that the SHO from the
11 previous evening was available, would you have wanted to
12 have that kind of discussion?
13 A. Yes.
14 Q. And if they were available, were they prepared to do
15 that?
16 A. It's nice if they are both available and both there,
17 they can discuss all the patients.
18 Q. Thank you. In fairness, in your witness statement, you
19 did say that you couldn't recall if a handover had taken
20 place, and you also said that -- where I'm getting this
21 from is your second inquiry statement at page 7, but we
22 don't need to pull it up. You also said:
23 "Mr Makar didn't discuss the surgery with me
24 personally but I did read his handwritten operation
25 notes."

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1 see starting at line 21 of 106:
2 "As Mr Zafar and I were leaving, he came in the door
3 of the room [that is Mr Makar]. He said he was here to
4 see Raychel."
5 Then if one goes over the page at line 2:
6 "... just outside the door at that stage with
7 Mr Zafar. But they spoke to each other, Mr Zafar and
8 Mr Makar, in passing. They did speak to each other."
9 A. Well, I don't remember that. I have already told that
10 I know that he did surgery, he and I read his
11 handwritten notes. It is a sequence here. If we have
12 spoken, it was not a handover.
13 Q. No.
14 A. I'm just saying that. I mean, handover -- we have
15 spoken, of course. If I have seen him first time,
16 I will say, "How are you?", just a greeting maybe.
17 I don't remember which kind of discussion was there.
18 Q. But would you have wanted to talk to him at all about
19 Raychel?
20 A. No, I mean, I -- if there is something wrong going on
21 with Raychel at that time when I saw her, then
22 definitely I have spoken with him. I have informed to
23 him, "Look, you have operated on this patient, she is
24 not well". I haven't spoken in that regard because she
25 was doing very well at that time.

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1 Q. So you wouldn't have seen any need to have
2 a conversation with him about Raychel?
3 A. Well, if there are some concerns definitely I have told
4 the operating surgeon, not only him, the consultant
5 registrar as well, that she is not well.
6 Q. Yes. Then let's move into your actual conduct of the
7 ward round. If I can ask you first -- as you mentioned
8 in generality, you mentioned what you would typically
9 do, and let's come to what you actually did with
10 Raychel. Can I ask you if you have much recollection of
11 this ward round?
12 A. Mm-hm.
13 Q. Do you? Do you have a clear recollection of this ward
14 round?
15 A. I remember because I -- what I have written there,
16 I remember that. It's going on, that -- the same
17 I remember.
18 Q. I understand. What you said in your inquiry witness
19 statement, the first one at page 2 of it, was that on
20 8 June you conducted a morning ward round in Ward 6, you
21 saw Raychel Ferguson:
22 "She didn't complain about nausea or vomit and the
23 ward staff did not mention any vomiting earlier that
24 morning and I have no recollection or knowledge of any
25 vomit at 8 o'clock."

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1 Q. You say that in your second witness statement for the
2 inquiry. What I'm trying to find out is actually what
3 observation charts you looked at.
4 A. There's a different observation chart? I don't remember
5 that. There was only supposed to be one chart.
6 Q. Well, would you have wanted to look at anything other
7 than just the observation charts?
8 A. No, observation chart consists of everything.
9 Temperature(?), blood pressure, everything there.
10 Q. Okay. For example, if we start with the top, would you
11 have wanted to look at the original A&E note of her
12 admission and the observation sheet?
13 A. No, I didn't.
14 Q. No. Would you have wanted to?
15 A. No. What for?
16 Q. Well, it might have told you something of her condition
17 when she came in and something of what they thought the
18 problems were.
19 A. That was appendicitis, they told that, she was not
20 feeling well, and she was operated. I have to look
21 after her post-op care, that she was doing well or not
22 at that time after operation, not to look on that
23 what was -- initially what happened. The symptom was
24 clearly that was told me, that she came with acute
25 abdominal ... That was the information which I had.

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1 A. Yes.
2 Q. When you came to do that ward round, you had been asked
3 can you go and do a post-take ward round with Raychel,
4 presumably you were told she had had an appendicectomy
5 the previous evening. Had the JHO gathered Raychel's
6 notes and records together or was that something that
7 was provided to you at her bedside by Sister Millar?
8 A. I don't remember that, what was there, but it was there,
9 something.
10 Q. Her notes would have been there?
11 A. I think, yes. Because in the notes I wrote that, the
12 notes were there.
13 Q. At that stage when you've got her notes available to
14 you, what are you wanting to look for particularly at
15 that stage?
16 A. I mean, how she is.
17 Q. In her notes.
18 A. No, not in her notes. I mean --
19 Q. That's what I'm asking you.
20 A. In her notes I read that because I wanted to see how the
21 operation was going at that time. That's what the main
22 thing was.
23 Q. You say that you looked at the patient's observation
24 charts and that you had information from the ward nurse.
25 A. Yes.

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1 Q. If you were to look at that observation sheet, the first
2 one, let's pull it up, 020-016-031. That's an
3 observation chart. That's an observation chart that
4 starts at her admission, more or less, on 7 June. If
5 you'd looked at that, you'd have seen that the results
6 of microbiology on her urine indicated that she had
7 protein plus 1?
8 A. I haven't seen that.
9 Q. I'm saying, had you seen it, you'd have seen that. You
10 would also have seen on this observation chart that she
11 had complained of pain on urination, at least that is
12 recorded, and that might have indicated to you that
13 maybe there's some infection there and maybe we should
14 see whether that has resolved itself. You might have
15 learnt that if you'd seen that observation chart.
16 A. I understand that, but at that time my priority was to
17 how she is feeling after operation.
18 Q. Yes.
19 A. How she is feeling, is she recovering or not. I was
20 looking after that side more than this. This was for me
21 at that time not a sequence -- have some importance at
22 that time was the post-op period that she is okay, she
23 is fine or not. That I was considering more than
24 everything for her.
25 Q. But if you didn't look at this, you wouldn't know that

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1 there might have been an issue as to whether she had any
2 kind of infection, which might be something that could
3 be treated --

4 A. No, that was --

5 Q. Sorry, bear with me a minute. Even though the surgery
6 for her appendicectomy was successful, there may have
7 been something else that I should check to see if that
8 has been resolved.

9 MR STITT: Mr Chairman, if I may interrupt. This is
10 developing, if I may say so, an air of unreality. We're
11 now dealing with a note from the night before where it's
12 now being suggested for the first time that there should
13 have been some attempt to actually go down a road of
14 treating an infection. We know that Mr Zafar was not
15 there the night before, we've had all this with
16 Mr Makar, and we've been down this road about the
17 infection. This is the man who turns up the next
18 morning to the ward round.

19 And then, when we look at the appropriate
20 independent expert that the inquiry has retained,
21 Mr Scott-Jupp, the paediatrician, he says at
22 section 3(c) of his report that basically he has got no
23 criticism whatsoever, even the rather short notes that
24 this witness made during the ward round. So even if
25 these questions were dealing with the ward round itself

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1 respect, to ask this witness about why there was not
2 some investigation the night before when he hasn't even
3 come on the scene --

4 THE CHAIRMAN: He's not being asked why there wasn't any
5 further investigation the night before, he's being
6 quizzed to some extent about the extent to which he
7 thought it necessary to look at the full observation
8 sheets and what he might have gained or added to his
9 knowledge had he done so.

10 MR STITT: I stand corrected. That's exactly the point.
11 I apologise for that. That having been said, the very
12 person who should be in the best position to comment
13 upon good or poor paediatric practice is Dr Scott-Jupp,
14 who gives this witness a clean bill of health.

15 THE CHAIRMAN: I'm not losing sight of Dr Scott-Jupp; okay?
16 I accept entirely that his view will be one which the
17 Trust will urge on me because he comes from one of the
18 comparable fields. But I do find it a bit curious that
19 I should restrict the questioning of a surgeon to a view
20 given by a paediatrician when in fact it was then the
21 Western Trust itself which decided to get a further
22 surgeon's view.

23 MR STITT: I understand that point.

24 THE CHAIRMAN: So I'm not going to cut off this line of
25 questioning, but I accept entirely your point that

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1 and the note, I would be saying that the paediatrician
2 who deals with children says this treatment was
3 satisfactory. But to try and go back to the night
4 before, before this gentleman even came on the scene, is
5 not realistic.

6 THE CHAIRMAN: Sorry, that's not quite the only view on
7 this, sure it isn't. Dr Scott-Jupp does not have the
8 only view on this.

9 MR STITT: No.

10 THE CHAIRMAN: I accept that he is generally less critical,
11 but Mr Foster has a slightly different view.

12 MR STITT: I understand that.

13 THE CHAIRMAN: And Mr Foster is a surgeon. So what you're
14 doing here, with respect, Mr Stitt, is you're suggesting
15 that we go only by what Dr Scott-Jupp has said and not
16 by what Mr Foster has said.

17 MR STITT: I'm saying, sir, because Mr Scott-Jupp is
18 a paediatrician, he is commenting specifically on the
19 good, proper treatment of children. Mr Foster is not
20 a paediatrician, he's a surgeon, a general surgeon, who
21 comments upon surgical matters, and we're very alive to
22 what he says, particularly when it comes to the
23 operation the night before, that maybe there should have
24 been a "wait and see", maybe the proteinuria should have
25 been noted, et cetera. But with the greatest of

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1 Dr Scott-Jupp is rather less critical on this issue and
2 less critical generally than Mr Foster and Mr Orr are.

3 MR STITT: Yes. My point was that this is not an expert who
4 has been retained by any party, he's an expert to the
5 tribunal.

6 THE CHAIRMAN: Absolutely.

7 MR STITT: And he is an expert in children's care.

8 THE CHAIRMAN: Yes.

9 MS ANYADIKE-DANES: Mr Chairman, just to give you that
10 reference from Mr Foster's report. It's 223-002-010.
11 He says there's no evidence for instance that he noted,
12 he being Mr Zafar, or had brought to his attention the
13 abnormal urine tests. He says that in the context of
14 perhaps there being a bit of a pressure of time, but in
15 any event what he's flagging up is that there was an
16 abnormal urine test and it might have been something
17 that could have been brought to your attention, and
18 therefore it might have been something that could have
19 been considered, and that's the reason I was exploring
20 it with you.

21 THE CHAIRMAN: Yes. I think it's a point to make concisely
22 because in the scale of things that particular query
23 raised by Mr Foster is a limited one.

24 MS ANYADIKE-DANES: Yes. Thank you, Mr Chairman. I simply
25 did it for that purpose, to ask about that, and he has

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1 given his answer.
2 Then you could have looked, because it was available
3 for you to do, at Mr Makar's clinical note. In fact,
4 I think you said you did look at his clinical note?
5 A. Yes.
6 Q. Because it was from his clinical note that you took what
7 had happened and didn't feel the need to discuss matters
8 with him; would that be right?
9 A. Yes.
10 Q. Because effectively he had written it down?
11 A. The reason was that, she was feeling well and she was
12 not showing me any unhappiness where I had to speak with
13 him and let him know.
14 Q. And if you'd looked at that -- in fact, you said you
15 looked at it. It's at 020-007-011. Apart from
16 describing what had happened, it tells you or would have
17 told you that her sodium level was 137, which is normal,
18 and that she had been put on IV fluids. And that's what
19 you would have learnt from looking at that immediate
20 note. In fact, you see that at 012.
21 THE CHAIRMAN: That's right.
22 MS ANYADIKE-DANES: Thank you.
23 Then you could also have looked at the prescription
24 sheet. Once you'd seen that she had been put on IV
25 fluids, you could have looked at the prescription sheet

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1 A. Yes.
2 THE CHAIRMAN: Right. Having said that, I understand that's
3 your position, but you were being asked perhaps
4 a slightly different but related question. Did you
5 notice or did you observe the rate at which she was
6 obtaining fluid? That's the first point. Did you?
7 This sheet in front of you, did you see that?
8 A. No. Well, I understand that, but at that time I have
9 taken a decision to reduce the fluid. That is why
10 I haven't gone too much attention towards that side, how
11 much is going on, when I have decided, I told that, and
12 my decision was, okay, start sips as soon as she was
13 tolerating, just stop -- I mean reduce the fluid and
14 stop it.
15 THE CHAIRMAN: So can I take it in this way? From looking
16 at the records, you understood that she had had
17 a straightforward appendicectomy, which had gone well?
18 A. Yes.
19 THE CHAIRMAN: When you came along to see her on the Friday
20 morning, you spoke to her and observed her and she
21 seemed well. And Sister Millar, who was with you,
22 seemed to have the same view, that she was well.
23 There's a separate point about that, about a vomit, but
24 in general Sister Millar was not overly concerned about
25 Raychel's condition.

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1 to see what she had been put on, because that would have
2 told you something -- it would have told you her fluid
3 regime. And if you had gone to her prescription sheet,
4 which is at 020-021-040, that would have told you that
5 she had been put on Solution No. 18, which is a solution
6 that you say you hadn't particularly been familiar with
7 before you came to Altnagelvin. You'd have seen that
8 the rate was 80 ml an hour and you'd have seen that it
9 was erected at 10.15 on the evening of 7 June. If you
10 had seen that rate at 80 ml an hour, would you have
11 thought that that was a little high, maybe, a little
12 excessive?
13 A. What was my decision at that time, I just started sips
14 and I asked to reduce the fluid.
15 Q. Sorry, it's a different question. If you had seen --
16 THE CHAIRMAN: The witness is allowed to answer it in this
17 way and we can go back to the point. But the witness is
18 quite entitled to answer this point in the way that
19 he was answering it.
20 Your position is that having seen Raychel, you
21 decided that she should start sipping fluids and that,
22 as the day went on, the intravenous fluids should be
23 reduced?
24 A. Yes.
25 THE CHAIRMAN: And then discontinued?

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1 A. Yes.
2 THE CHAIRMAN: Is that why you say that you thought things
3 appeared to me to be quite normal and, since they seemed
4 to be normal, I thought she should start sipping fluids
5 as the day went on and that the intravenous fluids
6 should be reduced and then stopped, and you say that
7 that advice was given because you were satisfied about
8 her condition?
9 A. Condition, yes.
10 THE CHAIRMAN: Okay. So the rate at which she was receiving
11 fluid did not seem to you to be an issue of any
12 importance?
13 A. The reason was only that, at that time my attention is
14 gone that she is going to stop the fluid, IV, and there
15 will be no more fluid and she will be okay.
16 THE CHAIRMAN: Does that mean that the rate at which she was
17 receiving fluid did not seem at that point to you to be
18 anything significant?
19 A. No, I understand she is getting more fluid.
20 I understand that.
21 MS ANYADIKE-DANES: Sorry, did you --
22 A. At that time, her general condition was not that --
23 I mean ...
24 THE CHAIRMAN: When you say that you knew she was getting
25 more fluid, do you mean that on that morning, on that

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1 Friday morning, you realised that she was getting more
2 fluid than she ought to have been receiving?
3 A. No, no, I didn't mean that. When I saw her, she was
4 okay and she had had no problems. She was
5 straightforward, going towards progress. And I have
6 stopped her fluid. I didn't take care about other
7 things at that time.
8 THE CHAIRMAN: Can I ask, did you also regard it as not
9 being an issue about the type of fluid she was
10 receiving? Did it occur to you that the type of fluid
11 she was receiving mattered?
12 A. Well, at that time I have stopped the fluid. That's why
13 I haven't thought which type of fluid she was taking.
14 That was my attention.
15 THE CHAIRMAN: Your intention was to stop the fluid, so if
16 you were stopping the fluid you weren't worried that it
17 was Solution No. 18 rather than Hartmann's or other --
18 A. When I saw her, if some other symptoms she has shown,
19 then I have gone towards that -- I have to do further
20 actions and I have to check bloods, et cetera.
21 MS ANYADIKE-DANES: Did you think that 80 ml an hour was
22 a rather high level for Raychel, a child of about
23 25 kilograms?
24 A. That was calculated by them, by the paediatricians, I am
25 sure.

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1 MS ANYADIKE-DANES: Sorry, can I perhaps approach it in this
2 way. You noticed that she was on 80 ml an hour, you
3 said you'd noticed that.
4 A. No, this -- the observation chart was there, 80 ml.
5 Q. The observation chart is there, she's on 80 ml an hour,
6 exactly. This prescription dates back from at least
7 10.15 on 7 June.
8 A. Yes.
9 Q. And if you'd looked at it, you'd have seen there is
10 another prescription which has been struck through and
11 there is no other prescription. Well, you can see
12 there's no other prescription for fluids. That's
13 correct, isn't it? The only prescription for fluids is
14 this one at 80 ml an hour, which was erected at 10.15.
15 A. I don't remember that. I don't know this.
16 Q. No, on this sheet, that is the only prescription for
17 fluids?
18 A. Yes.
19 Q. Then if you look at her actual fluid balance chart,
20 which you said was there, if we go to 020-020-039, this
21 is what was opened at 22.15, 10.15, to correlate with
22 the prescriptions, the signed time when it was erected.
23 It says 80 ml an hour. And then you can see there's the
24 amount down there and the total, and that amount is
25 being given fairly consistently until there's a break,

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1 Q. Actually, no, it wasn't calculated by the
2 paediatricians, it was calculated by Mr Makar.
3 A. If he has calculated, he has calculated the formula.
4 THE CHAIRMAN: There's a fundamental point. Do you remember
5 noticing that she was receiving 80 ml an hour?
6 A. It was there on 80 ml, yes.
7 THE CHAIRMAN: And do you remember noting that that was the
8 rate?
9 A. I think that was the rate.
10 THE CHAIRMAN: Sorry, that was the rate?
11 A. Yes.
12 THE CHAIRMAN: What I'm asking you is if, on your
13 observations, it registered with you that that was the
14 rate.
15 A. No, I mean, that was the rate. But the question is if
16 she was in a paediatric -- my understanding was that
17 rate is calculated by the specialist, by her age and
18 body weight.
19 THE CHAIRMAN: Well, did you realise that it was the
20 preoperative rate that she was receiving? Sorry, let me
21 make it clear. Did you realise that the rate she was
22 receiving was the rate which had been prescribed for her
23 preoperatively and that she had been put back on to that
24 same rate post-operatively?
25 A. I don't remember that, about this, no, sorry.

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1 you can see the break from midnight to 2 am is the break
2 for theatre. Yes?
3 A. Yes.
4 Q. You can see that?
5 A. Yes.
6 Q. And then alongside you can see under "oral" that she's
7 fasting and you can see the signatures for those who
8 have signed for that fluid. So you can see from this
9 chart that from when she started with the exception of
10 when she was in theatre, she was given this fluid, both
11 before theatre and after theatre, up until this chart
12 goes to 7 o'clock in the morning. And then I will pull
13 up in a minute, because I'm going to talk about
14 something else -- I'll pull it up now. 020-018-037.
15 MR STITT: Just before it comes up, I want to come back to
16 this point and put it in a balanced way. We're dealing
17 with a fluid chart the night before and I know it's
18 predicated on an answer, "Yes, I would have seen the
19 fluid charts", I accept that. No one in this inquiry
20 thus far, that I'm aware of, is making the case that
21 Raychel had suffered in any way physiologically by the
22 fluid from the end of the operation through until
23 8 o'clock in the morning, even if it was too much, even
24 if it was 15 ml per hour by the number of hours, six
25 hours, post-operatively, maybe eight hours. No one is

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1 saying that that has had any aetiological effect in what
2 was to happen later in the day. It's the vomiting and
3 the continuation of the fluid. When in fact, as you've
4 asked me to do, to balance this, I look at Mr Foster at
5 7.2 -- and I will read one sentence:

6 "Dr Zafar does not tell us what his continuing
7 observations ..."

8 If you could pull up 223-002-010. It's the first
9 paragraph under "Comment":

10 "Clearly, there was no senior ward round on the
11 morning of 8 June by anyone else above SHO level.
12 Dr Zafar does not tell us what his 'continued
13 observations' should be, although there is no doubt that
14 on the morning of June 8 Raychel would have been well
15 and there would have been little cause for concern."

16 Then he goes on to the fact there may have been a
17 time constraint and possibly looking at the urine, which
18 in fact Ms Anyadike-Danes had quite properly referred to
19 because it's in this report. That having been said,
20 this line of questioning is, I respectfully suggest,
21 dealing with the amount of fluid up until 8 am. It's
22 clear that all the evidence is that Raychel would have
23 been fine at that time.

24 THE CHAIRMAN: As he found her.

25 MR STITT: Yes.

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1 allow, that's the area that I'm going to get into. I'm
2 not saying that -- I'm not running a line about anything
3 in particular, I'm just asking this witness some
4 questions in those areas.

5 MR STITT: It's clear from the answers that the witness has
6 given that he found Raychel to be as he would expect her
7 after the operation, which had been uncomplicated. He
8 then is indicating that he would have indicated and
9 expected that she would have gone on to oral fluids.
10 That's where he is.

11 MS ANYADIKE-DANES: Yes. Then my next line of questioning
12 to him is what he understood about the practice of who
13 had responsibility for fluid management matters and also
14 what the actual practice was for fluid prescription in
15 Ward 6 for post-surgical patients. That's where I'm
16 next getting to. I'm asking him about that because
17 there is such a difference in view amongst all the
18 specialties on those matters and he is a surgeon who was
19 working in Altnagelvin and therefore, Mr Chairman, with
20 respect, I think it's relevant to know what he
21 understood the practice was.

22 THE CHAIRMAN: Well, there are two points. First of all,
23 there can be no doubt that Mr Zafar could have reviewed
24 the fluid regime if he had wanted to and if he had felt
25 it necessary to. I think, Mr Stitt, he had the

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1 MS ANYADIKE-DANES: Mr Chairman, that is not the purpose of
2 this. If I might be allowed just to develop the point,
3 the purpose that I'm getting at is that at the post-take
4 ward round was an opportunity to review the fluid regime
5 that Raychel had had and take a view in relation to that
6 and all the other factors as to what to happen. This
7 witness is saying that in fact what he advised should
8 happen is that her fluids should be stopped altogether.
9 But there is an issue about that, so I'm trying to tease
10 out what the information was and therefore what the
11 judgment might be as to what should happen in terms of
12 her fluid regime going forward for the rest of the day.
13 That is what I am trying to tease out with this witness
14 statement. One of the things that we have been advised
15 is that a post-take ward round provides an opportunity
16 to review what has happened, take stock, and give
17 directions and guidance for such things as fluid regime.
18 That is one thing I want to explore with this witness.

19 The other thing I want to ask this witness is the
20 difficult question that we've had with all the different
21 disciplines as to their respective roles and what they
22 understood about the practice about who had
23 responsibility for fluid management regime and what the
24 fluid management practice was on Ward 6 in relation to
25 post-surgical patients. If my learned friend would

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1 opportunity to do it but he clearly wasn't concerned
2 about Raychel's condition because the operation appeared
3 to have gone well, according to the notes, and he found
4 her reasonably well, according to the notes. That's one
5 point.

6 The second point is more relevant, which is about
7 the disagreement or lack of clarity about who took
8 responsibility for fluid management.

9 MR STITT: While we're going through a list of the various
10 fluids that were going from 10 o'clock, 11 o'clock,
11 2 o'clock in the morning, if there's an issue about
12 actual responsibility for fluid levels, then let's put
13 it to the witness.

14 MS ANYADIKE-DANES: Well, with a little latitude,
15 Mr Chairman, I'd like to ask the question in the way
16 that I wish to because there is a reason why I show him
17 a fluid balance sheet that goes from 10.15 through to
18 7 o'clock in the morning, because that exposes the fact
19 that there appears to be no fresh prescription and that
20 the same rate continues on, and that allows me to get
21 into the area that I want to in asking him in that way.

22 THE CHAIRMAN: I think maybe Mr Stitt's concern is that
23 we can get to the point more directly because there's no
24 dispute about the fact that the fluid regime from the
25 night before was continuing the following morning.

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1 MS ANYADIKE-DANES: But I'm going to ask him whether he
 2 would be surprised at that because Mr Makar has given
 3 his evidence about that, about what --
 4 THE CHAIRMAN: Yes. Well, let's see if we can get these
 5 points resolved before we break for the day.
 6 MS ANYADIKE-DANES: That area, Mr Chairman, I would rather
 7 not deal with in a very short way because what the
 8 practice was, who knew what, requires me to not only ask
 9 this witness those sorts of questions, but also put to
 10 him what the others have said. Some of those others are
 11 his colleagues in the surgical discipline, which is
 12 Mr Zawislak, Mr Makar and Mr Gilliland, as well as
 13 others who are from different specialties that also had
 14 the care of Raychel. That is a very important point and
 15 I would rather not deal with that point too summarily,
 16 if I can put it that way.
 17 THE CHAIRMAN: The point will wait until Mr Zafar's evidence
 18 resumes, but I don't think it is necessary to go through
 19 what each other person says in order to explore the
 20 issue. We don't need to put to this witness or to any
 21 other witness what every other witness says in the area,
 22 and that will not happen.
 23 MS ANYADIKE-DANES: No, Mr Chairman, with respect, I don't
 24 intend to do that. But I have provided a schedule of
 25 how I hope to go through this witness with his evidence.

1 doing it down the line by video link.
 2 MR STITT: I agree with that.
 3 THE CHAIRMAN: I'll rise and we'll resume on Monday morning
 4 at 10 o'clock. We have two nurses on Monday,
 5 Nurse Bryce and Nurse Patterson. Thank you very much.
 6 (5.05 pm)
 7 (The hearing adjourned until 10.00 on Monday 4 March 2013)
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1 There is a logic to it and I will try and deal with it
 2 as succinctly as possible, but there are reasons why one
 3 puts the questions.
 4 THE CHAIRMAN: Thank you.
 5 Mr Zafar, I'm afraid we're not going to finish your
 6 evidence this afternoon. If necessary, we can ask you
 7 to resume your evidence on a date to be arranged by
 8 video link. But that becomes difficult because on the
 9 video link we don't have the facility to put up in front
 10 of you the various documents to which we're referring,
 11 the documents which come up on the screen. It's much
 12 easier for you to give your evidence if you can see the
 13 documents in the same way as you've seen the documents
 14 this afternoon. I think it's correct that you're not
 15 available next Monday or Tuesday. What I would like to
 16 be explored after I rise now is whether there is some
 17 half day next week, Mr Stitt, when Mr Zafar could come
 18 back on either Wednesday or Thursday. If you could
 19 explore the various options about dates and liaise with
 20 Ms Anyadike-Danes about that.
 21 MR STITT: Yes, we'll work through that, obviously the
 22 sooner the better.
 23 THE CHAIRMAN: That's certainly right. The other issue
 24 is that, if at all possible, I would prefer him to be
 25 here because I think it is easier to be here rather than

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