Friday, 1 March 2013

(10.00 am)

(Delay in proceedings)

(10.10 am)

Discussion

MR STITT: Mr Chairman, if I may mention a matter arising out of the questioning of Nurse Noble.

THE CHAIRMAN: Yes.

MR STITT: The witness has been provided with a transcript of the relevant portion, which of course no doubt will be helpful to her, and I anticipate the line of questioning will be mirroring that of Nurse Noble. In anticipation of that, I'm assuming from Mr Wolfe not contradicting what I'm supposing, that that's a reasonable supposition. There is a point which is concerning me and perhaps I can articulate it this way. It's to do with what I'll call the cover-up theory, namely that it was clear to those in June that there were two main problems and that these went on to the attention of the family in September.

THE CHAIRMAN: Yes.

MR STITT: If I may, in order to make a balanced point, if I could ask that the transcript of Wednesday the 27th, page 178 could be put onto the screen.

If you'll bear with me, Mr Chairman, I have to go

through to make my point -- I have to go through a number of entries. I'll do so succinctly, and I've taken the trouble to minimise the references, but it's still necessary to refer to half a dozen or so to get my point.

THE CHAIRMAN: Okay.

MR STITT: If we look at line 21 on page 178, the question from Mr Wolfe to Nurse Noble is:

"The primary failure which you articulate was a failure to ensure that Raychel's electrolyte assessment was carried out in or about the evening of 8 June."

So that's established as the primary failure discussed at the meeting on 12 June. And it's accepted by Nurse Noble that that's the case.

If you go to page 179, if I may ask, can the page just be left unless for some reason anyone has difficulty reading it, rather than highlighting a section. So we've established that in June, the primary problem was electrolytes.

Then at 19, you observe:

"Was it part of that discussion that, apart from Solution No. 18, there was actually too much fluid given to Raychel?"

And that's a questioning of Nurse Noble that she had

indicated earlier, before the extracts which have been provided to the witness, she did say, yes, too much fluid was another problem that was discussed in June. So you quite correctly, sir, asked her to confirm that and she does.

THE CHAIRMAN: Right.

MR STITT: So we have established therefore that there were two problems discussed at the meeting between the doctors and the nurses on 12 June. If we can go forward to page 187. Your observation at line 11:

"So to the extent that Mrs Noble remembers a discussion led by somebody from the anaesthetic side about excessive fluids ..."

We're dealing with the excessive fluids, not the electrolytes:

"... then it is most likely to have come from Dr Nesbitt because he was the only anaesthetist that was there."

We've ruled out Gund and Jamison and, if I may say, that is correct, and your observation is correct, and in time, Dr Nesbitt will confirm that he was the anaesthetist who was discussing these problems.

We then go to page 191. At line 14 you recap quite accurately:

"Sorry, just to make this point. You said to me

a few minutes ago that it was recognised on 12 June that the main mistake which had been made was a failure to monitor the electrolytes."

We've still got the too much fluid as well, but this is a point you're making. She says yes.

"Were Mrs Ferguson and her sister told that in September?"

This is the first reference to September, a meeting Nurse Noble was at.

She says:

"I can't recall. I can't recall."

So this is Nurse Noble dealing with September, able to recall June, but can't recall what was said to the family. We know what the family say because we've read their statements.

THE CHAIRMAN: But we also know what the Trust says because we have the Trust minutes of that meeting.

MR STITT: No, they're not Trust minutes, they are patient advocates, and they're not minutes, they are a note of the meeting. I think they were made by Mrs Doherty. That's not in itself a criticism.

THE CHAIRMAN: Right, sorry, it is the only record of the meeting that we have.

MR STITT: That's correct.

THE CHAIRMAN: Because the Trust has not given us any

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

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

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

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

said". This was at the end of the day, a lady who had been in the witness box probably all day, I think.

THE CHAIRMAN: And the previous day.

MR STITT: And who had also had a difficult time at one point and we rose to allow her to compose herself.

THE CHAIRMAN: Yes.

MR STITT: Then if I may ask you to look at the bottom of the same page at 194.

THE CHAIRMAN: Just before you go to the bottom of the page, you don't skip over the fact that at line 14 I'm recorded as saying that this is subject to the evidence that comes later.

MR STITT: Let me just read that:

"I have to say, subject to the evidence that comes later [which underscores the point I made a moment ago about your general handling of the inquiry, with respect] I think the admissions and facing up to what went wrong should come from the most senior people there and it's difficult to put the responsibility on to somebody like Mrs Noble."

So that's reasonable for the balance.

Then Mr Quinn comes in at line 19:

"I totally agree. I totally agree and the family wouldn't expect this nurse to come out bluntly and say there's mistakes made."

She has already indicated that she doesn't remember. She hasn't been challenged that that was untrue, she was merely saying "I don't remember" because she didn't want to let her colleagues down. That's not a case that's ever been put to her.

Then you say, sir:

"When her more senior colleagues are sitting around and not saying what mistakes are made."

Now, anybody reading that who mightn't know the personae in this inquiry and, more particularly the chairman, might think that senior colleagues sitting around and not saying what mistakes were made was indicative of a state of mind where you, sir, had come to the conclusion that in the light of the Fergusons' statement and the patient record and the light of the first witness on this subject -- the other witnesses haven't touch on the June or September meetings, which is why I'm intervening before this witness gives her evidence and she will be the second, and I anticipate a similar line of questioning with a number of individuals.

THE CHAIRMAN: Yes.

MR STITT: I would like you, sir, if I may -- my point, when I finish it, is that I'm going to ask you to confirm that in fact you haven't reached any concrete or

preliminary view in relation to this matter. And I think it's important that that is clarified because there are two basic points summarising the pages which I have opened. The first is that Nurse Noble does not add to the sum of knowledge as to what was said at the meeting in September. What has happened is she has been used -- notwithstanding the fact she says, and she's not challenged, "I don't recall what was said in September". That is still used as a vehicle for putting to her essentially the conspiracy theory and it's articulated clearly on page 197. Mr Wolfe asks at line 6:

"And at this meeting in September 2001, the family were not given the full story; isn't that right?"

This is a witness who has been in the witness box all day and has said three times already that she can't remember:

"Well, from what I can see, yes. I can't recall the actual meeting itself. I can't recall the exact points of it."

THE CHAIRMAN: But "from what I can see" is from the only written record of the meeting.

MR STITT: We'll come to that, and from what has been put to her as well. It has been put to her as a fait accompli that nobody said anything about electrolytes should have been checked or that there was too much fluid.

Then the question:

"Question: If the record that appears before us is accurate, they weren't told the very things that were admitted among yourselves behind closed doors."

"Answer: Yes."

She's agreeing that if the record is accurate, then that wasn't said, she's not saying that from her own recollection.

THE CHAIRMAN: Yes.

MR STITT: Finally, if I may refer to the next page, 198, at line 5. I have to read into it. This is a question from yourself, sir:

"Can you understand how Mrs Ferguson got the impression that there was a cover-up? Because to put it very, very succinctly, the mistakes which were admitted to internally at the meeting on 12 June were not admitted to externally with the Fergusons on 3 September."

"Answer: Yes."

"THE CHAIRMAN: So if you were sitting there like Mrs Ferguson, you'd think, 'That's a cover-up'."

I go back to line 9, the mistakes which were admitted to internally at the meeting on 12 June were not admitted to externally with the Fergusons on 3 September.

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

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

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

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

he discusses the critical incident meeting on 12 June on page 10.

THE CHAIRMAN: Let me just check if I can find it because the record I'm looking for is the one where he set out who was present. We've discussed just before --

MR QUINN: That's his PSNI statement.

MR STITT: Sir, if you want the actual six-point plan, I can give a reference in the inquiry documents if that would be helpful.

THE CHAIRMAN: Give me one second.

MR WOLFE: Sir, what you're looking for is Dr Fulton's statement, which sets out those who attended the meeting.

THE CHAIRMAN: Yes, and then continues with the six-point plan.

MR WOLFE: Yes. If you go to 095-011-049. If we could have that on screen. The original handwritten action sheet, presumably composed at that meeting, is 095-010-046w, if that could be set up alongside that, please. The plan is then refined and put into a typed form, but it might assist you to see the original version, sir.

THE CHAIRMAN: It's a handwritten document headed "Action sheet 12 June".

MR WOLFE: It's the second entry.

THE CHAIRMAN: The first one is "evidence change to

Hartmann's". And the second is "daily U&E, all post-op". So that's the action plan. And this is a point I'm making, Mr Stitt. This was the action plan agreed on 12 June. Mrs Doherty asked this question on 3 September about checking bloods after the operation. Dr Nesbitt, on this record, is stated as responding by saying that Altnagelvin may have to review procedures.

MR QUINN: If you look at page 52 of the document on the left, 095-011-052, you'll see the start of the six-point plan. It's page 52 of the police statement.

THE CHAIRMAN: It's point 2:

"To detect early hyponatraemia, all post-operative children on IV infusion should have routine electrolyte bloods every 24 hours. Sister Millar would ensure this was done and make the results known to the surgical staff."

So this was to be done with effect from 12 or 13 June.

MR STITT: Yes. It reflects what the six-point plan typed says. This reflects a discussion which took place yesterday with the current witness that it could well have been the following day before the actual tests were done, but that's by the way.

THE CHAIRMAN: Okay.

MR STITT: So here we have, first of all, saying -- I take

the point that it may be necessary to check routine admissions pre-op and post-op. There's no indication there whether that's 24 hours or whether even a more stringent checking of electrolytes might be necessary.

THE CHAIRMAN: If that record is accurate, what Dr Nesbitt doesn't say is, "Well, we have changed the procedures, we changed the procedures within a few days of Raychel's death", and then refer to the second point of the six-point plan. You take me on to the next page.

MR STITT: The top of page 7, the second paragraph.

THE CHAIRMAN: If you bring this up, please. 022-084-221.

MR STITT: The second paragraph:

"Mrs Doherty said Raychel then had her blood checked regularly. Dr McCord said that was when she was in ICU. People are there for more intense monitoring. Dr Nesbitt [Dr Nesbitt being the senior anaesthetist who was sitting around doing nothing and saying nothing at this meeting, according to the earlier reference] said that is something that we might have to do, check blood six hourly. I have never seen this before."

So what Dr Nesbitt is saying is, "I accept entirely that the record does not show they said, "Right, we have actually arranged for 24-hour electrolytes on paediatric patients". But what Dr Nesbitt is saying is, "Yes, we need to look at this and we might have to go to six hour

checks of electrolytes".

That's not somebody -- I'm trying to put this in the balance because this has not been articulated so far -- somebody who is sitting back and trying to cover up a failure to take electrolyte readings on the 8th. That is someone saying, "Yes, our systems need looked at". I appreciate your first point, Mr Chairman, but it's going further than saying, "We may need to review our procedures. We may actually need to do six hourly procedures".

In other words, there was a decision to go for 24 hours and he's going further than that in September and saying, "Look, we might have to go so far as to do these electrolytes every six hours", in answer to a question as to why they were not checked more regularly. Not checked at all, as a matter of fact, in this particular case. The point I'm making in relation to the electrolytes is that this is a conversation which is flowing between Dr McCord, Dr Nesbitt and the family, and they are not saying there's no electrolyte issue, they're saying, "Yes, we're going to have to do something about this". I accept entirely the point, point 2 of the two-point plan was in operation, but --

THE CHAIRMAN: Why not say so?

MR STITT: I can't answer that. But it is still a work in

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

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

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

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

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

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

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

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

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

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

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

The second point is that that note does not show any acceptance that Raychel received too much fluid.

MR STITT: Finishing with the first point, and it's this -- the record does not show Dr Nesbitt saying, "We made a terrible mistake here, we were negligent, we should have done bloods at 3 pm". What it does show is a constructive discussion between the doctors and the family at an early stage, and in my respectful submission to conclude that that could justifiably have led to the family believing it was a cover-up is unreasonable.

THE CHAIRMAN: Okay.

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

and other interested parties, particularly the family.

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

THE CHAIRMAN: I have seen it.

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

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

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

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

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

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

MR STITT: Yes.

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

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

in relation to any alleged cover-up.

THE CHAIRMAN: Well, I have no difficulty at all in doing that. I have heard some evidence, I have not heard all of the evidence, and I think it's also fair to say that what features in Thursday's evidence -- and I made this point at the stage when Mrs Noble became upset.

I specifically acknowledged the concern which I know is held in Altnagelvin that the mistakes which were made in Raychel's case might well not have been made had other hospitals shared lessons which might have been learned from the deaths of the other children. I'm not just talking about the Royal because although we've focused on the Royal in Adam and Claire's cases, there were lessons to be learned when Lucy Crawford died in 2000, which might have been more immediately or at least as immediately directly relevant. So I've acknowledged Altnagelvin's concerns about that explicitly.

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

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

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

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

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

THE CHAIRMAN: Okay, thank you.

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

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

MR STITT: Yes, absolutely.

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

That's point 1.

MR STITT: Could I ask who gave this information?

THE CHAIRMAN: Mrs Burnside.

MR QUINN: She said she was taking a note.

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

MR QUINN: The Trust, as I understand it.

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

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

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

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

on behalf of the family.

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

THE CHAIRMAN: Exactly.

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

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

MR QUINN: That's correct. I want to make a brief point about page 7 that still appears on the screen. Mrs Doherty did ask a number of questions, and I should say that my information at the moment is that -- my instinct was initially that on the second paragraph where it says Mrs Doherty said Raychel then had her blood checked regularly, was more in the form of a question. So that was a sort of open question, discussion type issue. That's why we then see that the ICU is discussed because we know that in ICU the bloods are done on a much more regular basis. So that's how that came about, because there was no suggestion, as we understand it, that the Trust may take bloods every six hours. It was by way of an explanation and the sort of hanging question that the Trust may look at this again. So that's how the family see that issue.

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

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

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

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

MR QUINN: Yes.

THE CHAIRMAN: He says in his statement:

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

MR QUINN: That's correct.

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

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

MR QUINN: Yes.

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

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

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

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

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

will give evidence about that.

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

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

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

MR STITT: Yes.

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

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

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

from anyone in Altnagelvin that it is inaccurate.

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

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

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

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

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

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

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

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

THE CHAIRMAN: Yes, okay. Thank you.

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

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

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

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

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

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

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

MRS ELIZABETH MILLAR (continued)

Questions from MR WOLFE (continued)

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

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

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

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

THE CHAIRMAN: Yes.

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

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

MR WOLFE: It's the opposite.

THE CHAIRMAN: Okay.

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

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

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

A. I would have thought so.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

time is based on their assessment of the amount of vomiting at that point in time. So it is not with the benefit of hindsight that I'm asking you the question. When you think about it now, if these matters had been carefully considered by nursing staff, should you have been prompting the doctor, when he came, to carry out a full review, which would have included raising with him a prompt to consider electrolyte analysis?

A. Yes. Well, probably we should be asking him to assess Raychel for that.

Q. Could I move then to the events of 12 June. You would obviously have heard of the sad loss of Raychel when you returned to work in the following week; is that correct?

A. Yes. I returned -- I went off on Friday evening and I returned on Tuesday morning and I was told about Raychel, which was absolutely devastating for me, for all the staff. I actually couldn't believe it, I didn't actually think we were talking about the right child because I had asked, "Are you sure?", but it was unfortunately what had happened.

Q. Now, you were asked to attend a meeting on 12 June, which we understand was termed a critical incident meeting.

A. Yes, that's right.

Q. And if I could turn up your witness statement at WS056/1

at page 6. You set out a narrative on this page, recollecting the events of that meeting. In this context as well, Mrs Millar, you've had an opportunity to review the evidence given by Mrs Noble.

A. Mm-hm, yes.

Q. On Wednesday of this week.

A. Yes.

Q. Picking up your witness statement at page 6 in front of us, the meeting was attended by staff who cared for Raychel, both medical and nursing. You also attended in your role as the senior nurse. So as well as wearing your hat of having cared for Raychel, you were there, if you like, reflecting your seniority in the nursing discipline?

A. Yes, my clinical services manager was there, as far as I remember, Mrs Doherty, Margaret Doherty, as well.

Q. And you say that following the meeting, an action plan was agreed. Would it be possible to have that up on the screen side by side? It's 022-108-334.

You might know from your reading of the papers that this action plan appears in various forms. There's a handwritten version, there's various clean versions. This is the one referred to by the witness in her witness statement. There is no particular point of accuracy or difference that I'm going to probe, it just

happens to be the version she refers to.

That action plan was agreed at this meeting, Mrs Millar; is that right?

A. Yes. Yes, there were two points for me to implement.

Q. We can see them there. At number 2 you were going to be asked to arrange daily U&E on all post-operative children receiving IV infusion. And at number 4, emphasis was now being given to measuring and recording all urinary output while IV infusion progress was in place?

A. Yes.

Q. At the meeting, plainly the events leading to Raychel's collapse and ultimate death were discussed; isn't that right?

A. Yes. I do not have a clear recollection of the meeting, but yes, I was given a transcript of Nurse Noble's witness statement -- at least her ...

THE CHAIRMAN: Her evidence.

A. Her evidence during the week. There are parts of it that, yes, I do remember, but there is a large part of it that I just don't remember. I want to emphasise that, that I came into the meeting that day, I had just been told that morning that Raychel had died, and my mind was on what had happened. As nurses -- I was very much looking at, "Had we fallen down?" We know now yes.

But that was my main thought going into the meeting. Plus I was very upset, and also I had very strong views on certain things that had upset me as well.

MR WOLFE: We'll take all of that as the baseline. Can I ask you this, had you ever had to attend such a meeting before?

A. I cannot remember, but at that stage when Raychel died we had set up risk management meetings in the hospital within paediatrics. As far as I'm right, it was around that time or shortly before it. So if there was an uneventful [sic] event that happened, we would have got together to discuss the events leading up to whatever the event was and to see whether there was something we could learn from it to prevent it happening again.

Q. Can I suggest to you that meetings like this are, happily, comparatively rare in your working experience?

A. Yes.

Q. And therefore, while you may not remember every fine detail of this meeting, you must remember broad things that emerged.

A. Yes, I do remember some main points.

THE CHAIRMAN: Can I ask you, Mrs Millar, what were the things that had upset you, which you had strong views on?

A. Well, when I returned to hear that Raychel had died,

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

THE CHAIRMAN: In what way?

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

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

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

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

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

A. And actually, until I read Nurse Noble's transcript last night, I had actually forgotten what I had said. What I'm telling you now maybe is not exactly what I said, but I did give a very -- I just felt ... Yes, the main thing I said was, I used the word "responsibility". I remember that. I said that I thought it was totally unfair that the nurses had such responsibility for the surgical children. I felt it was unfair. I felt that we had to be the lead all the time in looking after the surgical children. We are nurses, we're not doctors, and whilst we do our very best, I don't think we should be prompting doctors. We would now maybe, but 12 years ago ... Or I don't think we should be telling a doctor to do electrolytes. It's different now, we're more knowledgeable, we've had quite a bit of education. But in those days, really we were leading the care, I feel, in looking after children. And my nurses --

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

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

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

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

A. Yes.

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

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

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

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

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

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

THE CHAIRMAN: Would that be the same anywhere else?

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

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

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

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

work under you know you're concerned, if you express that view to the paediatric consultants then they know you are concerned. Had you expressed that view to anyone in the surgeons' hierarchy, any consultant surgeons? Because they might -- it seems to me, maybe this is wrong, but that might be the very person to speak to about it.

A. Yes.

THE CHAIRMAN: Because ultimately, the consultant surgeon is responsible for the registrar and on down.

A. I may have -- I wouldn't have found the surgeons ... They're all very good people I'm sure, and very hard working, but I wouldn't have had the relationship with them that I would have had with the paediatric consultants. Surgeons are different to physicians.

THE CHAIRMAN: Okay. To put it bluntly, did it take Raychel's death to lead to some sort of sea change in Ward 6?

A. Well, it did, obviously there were changes after Raychel died. But I think prior to Raychel dying, I think -- one of my main problems was that ... And I think this was before Raychel died, that you would have liked the children to be reviewed early in the morning so that you could plan your day. And also, if there were children to be discharged, that we could get them discharged and

that the parents weren't waiting all day. That was a big problem. I'm not sure exactly when, but it was before Raychel died. I think that I had --

THE CHAIRMAN: Sorry, that's the surgical ward round you're talking about?

A. Yes.

THE CHAIRMAN: So although it happened to be reasonably early with Raychel on the Friday, that wasn't typical? The surgical ward --

A. I think I conveyed that to the surgeons and they had decided that -- at least they then said that they would try to do the children's ward first. Now, as far as I remember, that was before Raychel died. So then the plan was that they would come up every morning, they'd see the children first before going to the adult wards. So that was a concern I had. That helped, that did help in the planning of care for the surgical children.

THE CHAIRMAN: Right. Okay, so that was something which you -- we got on to that because you'd said you had strong views on things which had upset you. This was what you expressed at that meeting on 12 June?

A. I did.

THE CHAIRMAN: Is there anything else in particular that you can recall, either from your own memory or from what Mrs Noble remembers?

A. You mean about the ...

THE CHAIRMAN: About the meeting on 12 June or what you said at it. I think we've got a pretty good picture of the meeting on 12 June, and as I said previously, it stands in very favourable contrast to what had happened after the deaths of the other children that we've looked at.

A. Well, there was very open discussion about what had happened. As I say, I can't remember exactly, but the main thing that I remember out of it was there was a big discussion around the fluid, the Solution No. 18, what were we to do. I think Dr Nesbitt may have got some initial information on the Monday, I wasn't working on the Monday. There was a lot of discussion around, do we put the children on Hartmann's, the surgical children. At the end of the meeting, it was decided, no, he would enquire around other hospitals and see, but at the moment, no, to leave Solution No. 18 for the surgical children and as here, there were two points that I had to implement. The daily electrolytes on all children receiving intravenous fluids and how I would do that, I had to inform staff, and I had to document in our treatment communication book the electrolytes. And also -- oh yes, it was recognised at the meeting that -- and that was my main concern at that meeting, was our failure in the documentation. Because that, you know,

was a nursing issue.

THE CHAIRMAN: You said it was your main concern, but the lack of support from surgeons and the nurses having to take a lead would surely be at least as big as that?

A. Oh it would, yes.

THE CHAIRMAN: Thank you.

MR WOLFE: You said, Mrs Millar, that one of your concerns was really 12 or 13 years ago it shouldn't have been the nurses prompting the surgeons to do electrolytes. Now, plainly, at this meeting, the issue of the need to arrange daily urea and electrolytes on all post-operative children on IV fluids emerged as a major theme. Can I ask you if you can assist us on this. Presumably it emerged as a major them because it was recognised that one of the cardinal errors in the care of Raychel was the failure to assess her electrolytes in a timely fashion.

A. Yes. My recollection of the meeting was that the main issue that was discussed that day was the fluid. That was the main issue. There was a long, long discussion about the appropriateness of the fluid, because I think when Raychel was taken to the Royal, one of my nurses accompanied Raychel. And a nurse in the intensive care in the Children's in Belfast said when Raychel arrived and there was handover, that she was on the wrong fluid.

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

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

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

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

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

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

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

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

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

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

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

A. He did, yes.

THE CHAIRMAN: And a nurse.

A. A nurse, and an anaesthetist probably.

MR WOLFE: So if we can --

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

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

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

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

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

A. Yes.

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

A. Yes.

Q. The failure to do electrolytes was an error?

A. Yes.

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

A. Yes, I do.

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

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

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

A. Can you repeat that, please?

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

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

to say Raychel had vomited, I said could she get a doctor. And I think I said yesterday in my evidence that I understood that would be Dr Makar or Dr Zafar. But I didn't know that she actually wasn't able to contact them. So when I returned over to the ward, after ringing her to say, "Have you got a doctor?", she said no, and I thought, "Right, I'll go over and see if I can get somebody", but then I saw Dr Devlin on the ward and asked Nurse McAuley to ask him. But it would have been preferable for a more senior doctor, yes, to have seen Raychel.

Q. You attended the meeting on 3 September with the Ferguson family. What was your understanding of the purpose of that meeting?

A. I was asked to attend the meeting by Mrs Burnside, she had sent out a message via, I'm not sure who, probably my clinical services manager that the nurses involved with Raychel should attend a meeting with Mr and Mrs Ferguson. I didn't know -- I mean, I didn't know what the meeting was for, but I presumed it was to meet with the family and talk to them and answer any questions they might have. That was my understanding.

Q. You would have appreciated at that time that the Fergusons were going through the agony of the grief of losing their daughter and that this meeting was designed

presumably to give them a full and accurate account of the events leading to that death?

A. Yes.

Q. You would have known that to have been the purpose?

A. I would.

Q. Now --

A. Well, I understood the meeting was to explain what had happened to Raychel. I didn't know -- I mean, I had no idea, I'd never been to a meeting like this before in all my, at this stage, 36 years of nursing, so I didn't know. I went in and sat down. Nobody said to me, "You're to take part, you're not to take part". I mean, I ... I can't describe to you how I felt that day. I'd only been told that morning that Raychel had died. Sorry, it wasn't --

Q. This is the September meeting.

THE CHAIRMAN: We're talking about the end of the summer, really, 3 September.

A. Yes, sorry about that. I'd only come back that morning, as I say, and ... I was very upset.

MR WOLFE: Yes. Can I bring you to your input to the meeting, 095-010-046k, please.

THE CHAIRMAN: Just as we start this, how much of this meeting with the family on 3 September do you remember? You've told me that you have very little detailed

recollection of the 12 June meeting.

A. I do remember parts of this meeting. I had a better recollection of this meeting than I did of the critical incident meeting.

THE CHAIRMAN: Thank you.

A. I haven't full -- I cannot remember the exact conversations.

THE CHAIRMAN: Of course.

A. But I have some idea.

THE CHAIRMAN: And have you had a chance to look at the note of the meeting? There's a 10-page record of this meeting of 3 September.

A. Of Nurse Noble's ...

THE CHAIRMAN: No, the 3 September. We have a 10-page note of it, which was taken by the patient's advocate, Mrs Doherty.

A. No, I didn't get that, no.

MR WOLFE: Well, let me take you to the parts of that meeting where you made some input. You can see on the screen in front of you, two-thirds of the way down the page:

"Sister Millar said she was on duty on Friday evening. She went off at 6 o'clock. Raychel was walking out to the toilet and did not appear to be in pain. She was walking well."

That relates to your observations that you've told us about in the late morning/early afternoon.

A. Yes.

Q. "Sister Millar remarked to Raychel's dad how well Raychel was doing. Sister Millar had been aware that Raychel had vomited at around 9 am but she did not see the vomit. Sister Millar did not consider this unusual as lots of children vomit. She had no major worries regarding Raychel but asked the doctor to give her something for the vomiting. When Sister Millar went off at 6 pm, the doctor was giving Raychel Zofran."

That is the first recorded input into the meeting from you. I think there's a second one at page o, please. "Sister Millar said she came back from days off and was absolutely devastated when she heard. She said she had been nursing for over 30 years and had never seen anything like this happen. There would be some children that you worried about but there was nothing about Raychel that caused her concern."

Now, plainly, Mrs Millar, arising out of the events of the critical incident meeting in June you and your colleagues were coming to this meeting, having admitted to yourselves behind closed doors that certain mistakes had occurred. Is that a fair synopsis?

MR STITT: I'm sorry, Mr Chairman, I don't know where the

expression "behind closed doors" comes from. It doesn't add to the sum of knowledge in this case and it is pejorative.

THE CHAIRMAN: An internal meeting within the Royal.

MR STITT: Yes. With respect, that would be a preferable way to phrase it.

MR WOLFE: Very well. I don't believe it to be pejorative, but I --

MR STITT: And it's something that was taken up two days ago.

THE CHAIRMAN: Mr Wolfe was saying that there had been an internal meeting on 12 June, at which people had faced up to the fact that mistakes had been made in Raychel's case and those mistakes -- mistakes had been made in Raychel's case, you had also made, as I now understand, some general points about the care of children on the surgical side, and that led to change.

A. Yes.

THE CHAIRMAN: I think Mr Wolfe, you can pick it up there.

MR WOLFE: Yes. In terms of what you said at the meeting, Mrs Millar, we have some of what you said in front of us, where you expressed that there was no concern. Is it fair to say that you didn't articulate to Mrs Ferguson at this September meeting the fact that the Trust recognised that the fluid rate was excessive in

Raychel's case?

A. As I've said to you, I cannot remember the volume of fluid being discussed at the meeting on 12 June. I have no clear recollection of that.

Q. Okay, so the answer to this question is, no, you didn't articulate to Mrs Ferguson that there was an excess of fluid.

A. No.

Q. The second point is this. There has been a recognition at the June meeting that there was an error in failing to carry out an electrolyte assay in Raychel's case. And you've indicated this morning that one should have been -- there was a recognition that one should have been carried out because of the severe vomiting experienced by Raychel.

Now, did you personally articulate that account to Mrs Ferguson at the September meeting?

A. No, not that I can recall. I thought or my recollection is that Dr Nesbitt did or he ... I cannot remember exactly what he said, but I know that he did mention the fluids and the appropriateness of the fluids and the fact that we had learnt from the events around Raychel's death. He tried to explain or he did explain to Mrs Ferguson what the fluid would have done, you know, the low sodium he thought was the main problem. But as

far as I remember, he did mention the electrolytes that we had learnt lessons from Raychel's death and we would now be -- we had changed our practice as far as I remember.

Q. Was it said in plain terms to Mrs Ferguson that: we have changed our practice because we recognise that we made an error in Raychel's case?

A. Yes, I think that was said.

Q. And who said that?

A. Dr Nesbitt, as far as I remember. He explained, you know, the problem with the fluid or the problem and the different events leading up to Raychel's death. There was explanation around the fluid and, as far as I remember, there was mention of the electrolytes.

Q. There's no doubt there was mention of the electrolytes. Let me bring you to that. If you would go back to page n within this sequence of documents.

THE CHAIRMAN: I think you might want n and o together, Mr Wolfe.

MR WOLFE: Yes.

Working off the left-hand page, first of all, Mrs Doherty appears to introduce the issue of sodium levels. Do you see that, halfway down the page? She asks --

THE CHAIRMAN: Mrs Doherty asked what her Raychel's sodium

levels.

A. Yes.

MR WOLFE: "What is routine? What checks do you do?"

Dr McCord said:

"Bloods are checked routinely on admission. 36 hours prior to this, Raychel's bloods were normal."

And we know that her serum sodium at admission was 137.

"Mrs Doherty asked if they should not have been checked after the operation. Dr Nesbitt said they may have to review procedures. It may be necessary to check routine admissions pre-op and post-op. The reason why they are not done routinely is that it requires a needle into the vein to take the blood. At 3.30 am Raychel's sodium was down."

Now, I can stand corrected, but that is the most involved or detailed passage dealing with the issue of blood tests.

THE CHAIRMAN: I think Mr Stitt might invite you to take the witness to the top of page 7 where Mrs Doherty said, four lines down:

"Raychel then had her blood checked regularly. Dr McCord said that was when she was in ICU. Dr Nesbitt said that is something that we might have to do, check bloods six hourly, I have never seen this before."

MR WOLFE: That's right. For completeness, that's right. On the left-hand side, Mrs Doherty is asking specific questions about Raychel's specific case. Leaving aside the record, Mrs Millar, are you saying that Dr Nesbitt said more at the meeting than what I have just read to you, on the basis of your memory?

A. No, I can't remember anything ... I can't remember. I mean, Dr Nesbitt said there they may have to review procedures.

Q. Yes.

A. But there was already -- the procedures had been changed at this stage.

Q. Of course.

A. The electrolytes were being done 12 hours, they were being done preoperatively, intraoperatively and 12 hours.

Q. That's the point, isn't it, Mrs Millar? This record -- and no doubt everybody who was at that meeting will have an opportunity to comment on aspects of it that they remember and which might concern them. But that record suggests that this issue about electrolyte analysis was something that the hospital was considering reviewing as opposed to something that they had reviewed and changed based on a mistake in Raychel's case. Do you see the distinction?

A. Yes, I do. That was already in place.

Q. And you can't help us any more in terms of your memory as opposed to this or as compared to this record?

A. You mean in what was said?

Q. Well, your memory, you tell us, broadly, is that the issue of electrolytes was addressed at the meeting through Dr Nesbitt. I'm bringing you to portions of the record that have Dr Nesbitt dealing with this issue.

A. Well, I think in his explanation about the fluid -- I mean, I cannot remember fully, but I think in his explanation about the fluid to Mrs Ferguson he did say, as far as I can remember, that Raychel should have had an electrolytes done. That's as far as I can remember.

Q. Because if that was said in that way, that would be an important thing to say because, if I can explain it in this way, Mrs Millar, notwithstanding that Raychel was being given Solution No. 18, she had been vomiting through large parts of the day. You have accepted that the vomiting was severe and that electrolytes were justified by at least 9 o'clock. Now, if electrolytes had been done, the expert evidence appears to be that that would have identified a biochemical imbalance that could have been addressed and Raychel's life potentially would have been saved.

In terms of the narrative that was revealed to the

parent at this meeting, do you have a recollection of anything like that being said?

A. Well, I do remember that ... As far as I can remember, Dr Nesbitt was very open in explaining that there was a fault on the care of Raychel. As far as I remember, that came across to ... He was very open and honest. That was my impression of the meeting.

Q. In terms of the fault that he accepted or admitted to at that meeting, what did he say, what was the fault?

A. I can't -- well, I cannot remember exactly, but it was around the --

THE CHAIRMAN: I think Mrs Millar has already said, "I think Dr Nesbitt said that Raychel should have had her electrolytes done". Mrs Millar is remembering something which is not perhaps spelt out in the same way or detailed in the same way on the transcript, but her recollection maybe goes beyond -- not the transcript, the record. Mrs Millar's recollection goes somewhat beyond that and her recollection is that Raychel, according to Dr Nesbitt, should have had her electrolytes done. You think he was very open and that there was a fault in Raychel's care?

A. Yes. I thought he was very honest and open at that meeting, and I was ... I didn't have great input into the meeting, but he was very, very sympathetic and there

was an apology, he apologised to the family. I thought his explanation of what had happened was very sympathetic and I thought he did his best to explain it in simple terms that the family would understand. But I cannot remember exactly what he said. I felt he had made a good effort to try to get through to the family.

MR WOLFE: Just to be clear, you said you don't have a clear recollection of what he said.

A. Not of his exact words.

Q. But in terms of him saying to the family that there ought to have been electrolyte testing, did he say that on your best recollection?

A. He may have said that, you know, that monitoring of her IV fluids -- it may have been in that context. But I did ... At least I did think he did bring up the issue of the electrolytes.

Q. He clearly did on this account. But what is apparently missing from this account is relating the omission to carry out electrolytes in Raychel's case to the decision to consider reviewing electrolytes.

A. You're asking ...

THE CHAIRMAN: Sorry, let me try to put it more simply, just to bring this to a head, because there's a limit to the amount of times we'll go over this. If you look at the left-hand side of the screen, page n -- could you take

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

If you go to the fourth paragraph down, one line: "Mrs Doherty asked if they should not have been checked after the operation."

Right?

A. Yes.

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

A. Sorry, I ...

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

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

A. Yes.

THE CHAIRMAN: Thank you.

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

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

I could say, if I may add, that it -- as I said, it was a very difficult meeting and I have personally -- I just felt there were too many people in the room. I ... I said what I said, and I accept that, you know, that ... that Raychel was, you know, deteriorating earlier than we as nurses recognised. I accept that.

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

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

to be learned there about how many people come in?

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

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

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

That's the list of people, Mrs Millar.

MR WOLFE: There are 12 people there, sir.

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

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

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

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

MR STITT: May I intervene from a Trust perspective?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE CHAIRMAN: Okay. Mr Quinn, have you anything?

MR QUINN: Just on that point, I think it was Mrs Doherty, the sister, who asked most of the questions.

THE CHAIRMAN: Is that K Doherty?

MR QUINN: Yes. If you look at the first line:

"Mrs K Doherty said she would ask the questions."

That's the recollection of the family.

THE CHAIRMAN: You're quite right, yes.

MR QUINN: I have no questions on this issue.

MR CAMPBELL: Mr Chairman, I have no questions, but the point you asked about earlier, the identity of the nurse who accompanied the transfer. The name that I have gathered is Margaret Dooher. I'm unclear as to the spelling of the surname, but apparently the name does appear on a patient transfer sheet.

THE CHAIRMAN: We'll take it as the Tyrone Dooher, which is double O.

A. She's the intensive care nurse.

THE CHAIRMAN: Thank you very much.

I think Mr Campbell gets the last shot if he has anything. Mr Stitt, do you have anything for this witness?

MR STITT: No, sir.

MR CAMPBELL: Nothing, sir.

THE CHAIRMAN: Mrs Millar, thank you very much for your

time. Unless there's anything else you want to say, you are now free to leave.

A. Thank you. No, I've got nothing.

(The witness withdrew)

THE CHAIRMAN: Ladies and gentlemen, it's coming on 12.40. We've got a doctor who's travelled from England to give evidence today and his evidence will be finished today. I'm in your hands about what you want to do. We started just after 10. Do you want to stop for lunch now and start at 1.30? We're going to have to break for ten minutes for the stenographer. Maybe we'll run the two into one, take an early lunch, start at 1.30 and we will hear Mr Zafar's evidence from 1.30. Okay?

(12.40 pm)

(The Short Adjournment)

(1.30 pm)

THE CHAIRMAN: Mr Stitt, just before we start with the next witness, can I flag up to you that I want to raise with you now and the other parties a letter which we received yesterday, signed by Ms Beggs, which I think has been distributed. 316-048-001. I have a number of concerns about this, but the main one is that in the second paragraph the Trust -- I presume the "we claim" is a reference to the Western Trust, is it?

MR STITT: Yes.

THE CHAIRMAN: The Western Trust is claiming privilege in relation to the contents of the DLS inquest file. You may not know this because you weren't --

MR STITT: Sorry, I must correct an earlier answer. The "we" is the DLS.

THE CHAIRMAN: The DLS is the solicitor to the trusts, so any claim for privilege is made on behalf of the Trust -- of the client.

MR STITT: Yes. It's been made by the DLS on behalf of the Western Trust.

THE CHAIRMAN: Yes. So it's the Trust's claim for privilege.

MR STITT: Yes.

THE CHAIRMAN: The reason I'm raising it is that we had a very unhappy experience last June about a document which was found in the Brangam Bagnall inquest file in relation to Adam's inquest. That led to the inquiry being adjourned late in June and it led to an exchange of correspondence between myself and Mr Maginness. Mr Maginness wrote to me in -- I'm raising this now and we can give you the list of correspondence, but Mr Maginness wrote to me in July last year to say that the various trusts were taking instructions or were requiring advices from senior counsel, particularly in relation to legal professional privilege before they

could confirm instructions.

I acknowledged that. So having been told last July that the Western Trust and the other trusts were considering a claim for privilege, I now find that a claim for privilege is made on 20 February, more than six months later, and during the hearing. That's one point.

The second point is that there was an earlier issue about privilege in Raychel's case, which straddled the break between 2005 and 2009, and the Trust did not pursue a claim for privilege or, alternatively, waive privilege in relation to the reports of Dr Warde and Dr Jenkins, which is how the inquiry comes to hold Dr Warde's report. So it now seems to me that the Trust is being selective or may be selective in the documents for which it is claiming privilege.

That is an issue which I may require submissions on next week, about whether you can partially waive privilege and partially retain a claim for privilege. It seems to me at first blush that it would clearly be inappropriate for a party to say, "We'll give you some documents for which we can claim privilege, but we're not going to give you other documents", because on that scenario that party has an opportunity to skew the evidence by giving some and withholding others. I'm

raising this now and I also presume that the representatives of the Ferguson family might want to consider this point about a claim for privilege, so I don't want to pursue it now.

MR STITT: I'm not going to give a detailed submission because clearly I haven't had chance to prepare it, but might I just respond by saying at the outset any file has got a range of documents in it.

THE CHAIRMAN: Yes.

MR STITT: Those which are more privileged than others, so to speak, maybe they might be direct legal advice or they might be peripheral documents. In this particular case what has happened is that the solicitor to the inquiry, Ms Dillon, has specifically asked for an earlier document. A full search was made of the trust's file, as in the file held by Ms Brown, and no document was found there; the reason being the original statement of Mr Zafar was a draft statement, which then became the final statement, and my instructions are that at that time Ms Brown's universal practice was to destroy any draft document and keep a final document.

That meant that in an effort to try to respond to the questions which were being raised, a further search was made, and this time inside the DLS file, into the inquiry, and the letter was there. I obviously will

take time to prepare a full argument, if necessary. If privilege is claimed, that privilege, in my respectful submission, can be waived in terms of an individual document. If it's specifically indicated that that document -- I understand the public perception, perhaps, but by the same token this has arisen because of a specific reference to a specific document.

THE CHAIRMAN: Yes.

MR STITT: This isn't the Trust saying, "We're going to pull out certain sweets in the bag, you can have those ones and we're keeping the others". We have been asked for a document and we're providing it.

THE CHAIRMAN: Apart from that, you are asserting a claim for privilege over other contents of the file and I note that that is not what the Belfast Trust did in relation to the Adam inquest file. There is the appearance at least of an unfortunate different approach being taken by different trusts over equivalent documents, namely inquest files. That's another matter.

I also am interested in your reference to Ms Brown's practice of having documents and destroying them and keeping file documents. I think as part of this, I will be looking for a list of the contents of the inquest file for which privilege is claimed. I would also like a list of any documents contained in files which are in

the possession of Ms Brown, which are effectively files which are in the possession of the Trust, since she's a Trust employee.

MR STITT: Yes.

THE CHAIRMAN: We'll revisit this next week. Is that okay, Mr Coyle?

MR COYLE: Naturally, on behalf of the Ferguson family, we're wary of the manner that this document has become available, given the debacle over the Warde/Jenkins reports to which you have alluded and the wariness of the family pertaining to the information withheld. If it is the case, listening to my learned friend, that perhaps Ms Dillon, on your direction or on your counsel's direction, asks for another document, is it going to be dealt with on an incremental basis, or will that problem have to be addressed on a continuing basis as against the perspective and the healthier perspective, in our view, of the Belfast Trust? So if there is the assertion of privilege, sir, we would invite you to set a timetable to have it properly argued out with skeleton arguments to give you maximum assistance, and your counsel.

THE CHAIRMAN: I'd like to see what the -- I mean, at the moment we have a claim for privilege for a file.

MR COYLE: Yes.

THE CHAIRMAN: We don't know what's in the file. It's probably more helpful to know what's in the file before we start considering a claim for privilege.

MR COYLE: Yes. An itemised account might be of more assistance. But these are all documents, rather like the Warde/Jenkins reports, sir, all generated at public expense, and one wonders what interest is being protected.

THE CHAIRMAN: It's Friday afternoon now, Mr Stitt. Would it be possible to have a list of documents for Tuesday morning?

MR STITT: I think it would be, yes.

THE CHAIRMAN: Thank you.

MR STITT: I would respectfully suggest that that is an appropriate way forward.

THE CHAIRMAN: The starting point is I have to recognise that under the powers that we looked at a couple of weeks ago on another issue, you have the same right, your clients have the same right to claim privilege as they do in the High Court. So that's the point, it then becomes a matter of what they're claiming privilege for and whether they decide to pursue their claim for privilege or to maintain it.

Ms Anyadike-Danes?

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

Mr Zafar, please.

MR MUHAMMAD ZAFAR (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good afternoon, Mr Zafar.

A. Hello.

Q. Can I first confirm that you have a copy of your CV there?

A. It is here.

Q. Thank you. You have made a number of statements, two of which were for the inquiry. You made a statement for the Trust, which I'm going to ask you something about, on 3 April 2002. You had a deposition for the coroner, which seems to be dated 5 February 2003, and I'm going to ask you something about that as well. Then you had two statements for the inquiry. The series reference for them is 025. Your first is dated 13 January of last year, the second is dated 15 November of last year.

Subject to anything that you say now in your oral hearing, do you adopt as accurate those statements?

A. Well, I need to see the statements. Can we put them forward, please?

Q. Let's start with the easiest one, which is your very first one, 021-059-143.

A. I can't see on the computer.

Q. It should come up.

THE CHAIRMAN: It'll come up in one moment. The reason why you're being asked these questions, Mr Zafar, is what we are confirming is that -- and we do this with every witness as he or she starts. You have made statements to the inquiry and what we want to check is that we can proceed on the basis that you are standing over that statement. Sometimes a witness says that actually, in looking through it, they want to change this or want to correct that. But what we want to confirm is that we can proceed on the basis that you stand over those statements and the questioning which you will then encounter this afternoon will be based on the contents of those statements being accurate.

A. Fine.

THE CHAIRMAN: Do you understand?

A. That's fine.

THE CHAIRMAN: In that event, can I take it that you stand over the various statements that you have made before?

A. Yes.

THE CHAIRMAN: Right. At this point, you have no changes or additions that you want to make to them?

A. Only one statement, I think, the timing about this, I am just worried about.

MS ANYADIKE-DANES: Perhaps we can enlarge that a little bit in ease of you.

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

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

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

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

dates was a very fresh memory, it was not 12 years back, it was within six months, I think, when I was moved from here and I thought that that happened and I have written. Then I have checked my notes, it was only one line notes, which was also saying many things as surgical notes. It is there, everything. And I have taken from there what I have done. That's why I have pointed out that the time is not correct.

Q. Yes. Just bear with me a moment. Are you saying that you asked for a copy of the surgical notes to assist you in providing --

A. I did.

Q. -- the statement.

A. Yes.

Q. You did?

A. They sent me, yes.

Q. And they sent you that?

A. They sent me, yes.

Q. Did they send you anything else?

A. Notes only.

Q. So the information that we see here, your only source would be from those surgical notes --

A. Notes, yes.

Q. -- apart from what you independently remembered?

A. Yes.

Q. Now, Raychel died on 10 June 2001.

A. Yes.

Q. You actually would have had an involvement with her on 8 June 2001?

A. Yes.

Q. And this is now an exchange coming, when it starts off, some time in 2002. How clear a recollection did you have of events?

A. Would you mind to repeat it again, please?

THE CHAIRMAN: Given that Raychel had been treated and had died in June 2001, how clear was your recollection of events in April 2002 when you were preparing this note?

A. Yes, I remembered that. That's why I'm saying that the timing was -- I don't remember timings, chairman, and I have already pointed out that the time is not correct. The rest of things, it was right.

MS ANYADIKE-DANES: Does that mean that you're answering the chairman that you had a very clear recollection of what happened?

A. At that time.

Q. In April 2002?

A. In April 2002.

Q. If that's so, why did you put an incorrect time if you had a very clear recollection of it?

A. I don't know. I'm telling you that I don't remember

that timing because early morning time, we start from different -- you can stay early morning from 12 o'clock until morning, 9 o'clock. I don't remember that time. It's exactly the facts because I don't remember. I just approximately write that because there was nothing in the notes documented, what time, what happened after me.

Q. Okay. Then let's go to your curriculum vitae. It starts at 317-010-001, but perhaps if we could put up 002, which is your academic record. You qualified in 1985. That's right, isn't it?

A. True.

Q. And you worked in Russia --

A. Not worked, studied.

Q. I beg your pardon. You studied in Russia?

A. Yes.

Q. Maybe if we can pull up the next page, 003, alongside that. Right down at the bottom, can you see 1984/85, "house surgeon, general surgery". That was not a working position; is that right?

A. House surgeon at that time was considered as an FY1, that's a training point.

Q. So that was a trainee?

A. Yes.

Q. And then we see, 1985 to 1987, you were a registrar?

A. Yes.

Q. In general surgery?

A. General surgery.

Q. Yes. Then in fact, you carried on being a registrar in cardio or cardiovascular, cardiothoracic discipline for right up until 1998; is that right?

A. Yes.

Q. During that period of time, you had quite a significant period of time in England working as a registrar in the cardiothoracic discipline?

A. Yes.

Q. And you first came to England in 1993. You carried on working there for a period of three years until 1996; is that right?

A. That's right.

Q. And then you had a year in Pakistan when you were still working at the level of registrar?

A. Yes.

Q. In cardiac surgery?

A. Yes.

Q. Then you came back to Wythenshawe, which is a hospital where you'd worked as a registrar previously, as an SHO in general surgery. What brought about that?

A. Right. I want to clarify first that my qualification name is MD, which is a 6 to 7-year programme in Russia.

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

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

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

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

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

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

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

A. Yes.

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

A. Mm.

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

A. I was able to sit in the exam.

Q. Sorry?

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

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

A. Yes.

Q. Thank you. At each of those positions, I think you were three years in Wythenshawe as a senior house officer. Then you were just six months, I think, in Altnagelvin and two years or thereabouts at Derryford. Why did you come to Altnagelvin for the six-month period, can I ask?

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

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

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

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

A. Yes.

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

A. It is involved.

Q. Yes, that was involved?

A. It is involved.

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

A. Adults.

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

A. Yes.

Q. You also say that you participated in journal clubs. That's the final bullet in that middle section. What is a journal club for a surgeon?

A. Teaching.

Q. Who is teaching?

A. Consultant.

Q. The consultant is teaching you?

A. Not only me, it's generally.

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

A. Teaching session.

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

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

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

A. Yes. In different hospitals, different names.

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

A. No.

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

A. Yes.

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

A. Yes.

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

A. Six months, yes. Nearly, yes.

Q. Just while we're dealing with your level of understanding of matters, if I can ask you this. You were asked about NCEPOD and whether you were aware

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

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

And you say you were aware of that.

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

Q. But you were aware of the point?

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

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

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

Q. I beg your pardon?

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

THE CHAIRMAN: It didn't arise?

A. No, it didn't arise.

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

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

Q. Did it arise for you in Altnagelvin?

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

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

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

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

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

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

THE CHAIRMAN: What is it now?

A. Now consultant knows or consultant comes himself.

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

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

Q. That means you can't remember?

A. It is, yes.

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

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

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

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

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

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

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

If you look at that, what you're being asked about is whether you understood that to be important, communicating with the staff, and if you make any changes in management, not only are they verbally passed on to the nurses but they're also documented in the notes. Did you know that?

A. They are important. No one has told me that I have to do notes that way.

THE CHAIRMAN: No one has told you that. For instance, in your hospital experience, before you came to Altnagelvin, if you directed changes in the management of a patient did you record those or have them recorded in the medical notes and records?

A. Mr Chairman, it needs to be recorded, but sometimes when you are in an early ward round and you will see something is not going on with the patient, the patient is stable, then not necessarily that you have to write immediately everything about that A to Z, but you have to write particular things which are needed.

THE CHAIRMAN: If everything is stable and you're not recommending any change, then it may not be very important to record that in the notes?

A. Yes.

THE CHAIRMAN: But if you are recommending a change in the treatment of a patient then that is to go in the notes?

A. No, it is important that -- I mean, writing is important, but at that time, what we are talking, if we are talking at present --

THE CHAIRMAN: We're talking about 2001.

A. At that time I agreed that, this is written, notes there, there are documents, but I didn't feel that someone has followed that notes.

THE CHAIRMAN: Sorry, you didn't feel?

A. Someone has followed that direction.

THE CHAIRMAN: You didn't feel it was necessary?

A. No, it is necessary, it was necessary, I agree that.

THE CHAIRMAN: Okay. Was it also necessary that if you had a discussion with the mother or father which informed you of anything of significance, that that should go into the notes and that should also be mentioned to the nursing staff?

A. Again, I am just saying that when I have to go through 20, 30 patients and go through all that, and immediately I have to reach in time the theatre when theatre is starting already exact time, and the surgeon needs a hand there, then it's very hard to complete everything.

THE CHAIRMAN: I understand that, I know that it's not always possible to do it. But as a standard to try to achieve, do you agree that in 2001, if you had

a discussion with a parent which revealed anything, any worries or any significant concerns, that according to these standards, two things were to happen. That was to be recorded in the notes and it was also to be mentioned by the doctor to the nurses. Was that the standard that you aimed for if you could?

A. No, that could be -- I mean, I agree that standard should be there.

THE CHAIRMAN: Thank you.

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

Can we stay in that same document and go to 017? 316-004g-017. Can you see the first bullet:

"All entries in case notes must be timed and dated."

A. Yes.

Q. As we have said, irrespective of whether you saw this document, did you appreciate that you should time an entry?

A. Yes, I agree that.

Q. If we follow the way down along the lines as the chairman was taking you, you can see that there is a bullet that starts "regular notes":

"Regular notes after admission should be made including the progress of the patient and how the results of investigations have confirmed or altered the differential diagnosis."

And then the next bullet along after the use of ancillary services:

"A record should be made of the content of discussions with the patient and relatives."

And so on.

So that is what Altnagelvin wanted at the time. If I pause there and ask you, when you first arrived at Altnagelvin as an SHO, was there a consultant who essentially was accompanying you for a period of time to show you how Altnagelvin did things and also to assess your performance? Did you have anything like that?

A. No, how much I recall, no. I haven't seen that.

Q. Nobody assessed your performance?

A. No.

THE CHAIRMAN: For your first couple of weeks, let's say, Mr Zafar, would you have been working side by side with a consultant or a registrar?

A. Yes.

THE CHAIRMAN: Whereas, after that, did you work more on your own?

A. I have taken rounds myself, initially -- I mean, rounds also depends, sometimes only one person is going, sometimes altogether a team is going. It depends again on the situation and what you're doing in the morning time. These are the notes which are from the induction

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

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

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

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

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

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

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

to the child's parents the condition of the child, what you're proposing for the child, in a way they can understand; you would accept that?
A. Yes.
Q. In fact, one sees it also reflected in the GMC guidance, but I'm not going to take you to that. Although what the guidance goes on to say is that it's important that you provide patients with information or those with parental responsibility, and that you make sure that the patients have understood your role in relation to them. I'm not going to pull it up now, but let me give the reference. The part about ensuring that you provide information to patients or those with parental responsibility can be found at 315-002-007. The part about making sure that patients understand your role can be found at 315-002-012.
Would you accept that, that it's important that the patient or the patient's parents, if the patient is a child, understand your role in the chain of responsibility, if I can put it that way?
A. Yes.
Q. And how it is that you are having the care of their child?
A. Yes.
Q. You would accept that?

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

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

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

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

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

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

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

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

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

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

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

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

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

And after that, act on that, you need to continue that fluid or you need to stop that fluid according to the blood results, according to the advice of the paediatricians, as well as speak with my own senior, "Look, this is happening, I'm doing this, this, this". And then wait from him, what he wants me to do further.

Q. A little while ago I'd asked you whether -- at least to have you confirm that you were familiar before you came to Altnagelvin in prescribing fluids, both preoperatively and post-operatively, and you said yes, you were. Can I ask you what fluids you were familiar with or used to prescribing?

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

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

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

Altnagelvin, I don't know.

Q. You mean --

A. About 18 Solution.

Q. You didn't know about that solution?

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

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

A. No. You mean here in Altnagelvin?

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

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

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

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

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

A. 18 Solution?

Q. Yes.

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

Q. Thank you.

THE CHAIRMAN: Were you familiar with Hartmann's?

A. Yes. In England they use that.

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

A. I think, yes.

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

A. Yes.

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

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

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

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

A. Yes.

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

A. All patients?

Q. Yes, in general.

A. In paediatric wards?

Q. In Ward 6.

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

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

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

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

I can't recall all that, really. I understand -- the surgical patients belong to surgeons and the medical patients belong to medics. But at the same time, I think the prescribing things belonged to them. The reason was only that mostly the surgeons, most of the surgeons, they are working on the surgical side, adult surgery, and the paediatricians know how much -- there's a difference between writing drug charts as well as fluids, according to the body weight, according to the formulas. That's why that was understanding that the paediatrician will take over that and write that. I don't remember exactly, but I understand that.

Q. Let me help you by pulling up your witness statement, which is actually why I was asking you that question. It's witness statement 025/2, page 18. In there you say:

"Paediatrics take care of surgical patients on paediatric ward."

It's right up at the top. If we pull page 17 up alongside it, we can see what the question was, question 19:

"Clarify whether there were any arrangements in place in 2001 to allow members of the surgical team in Altnagelvin to obtain paediatric medical advice or assistance for the care of a surgical patient."

And the answer to that from you was:

"Paediatrics take care of surgical patients on paediatric ward."

I wonder if you could help us by explaining what you meant when you wrote that.

A. Its meaning is that if there is a medical problem with the surgical patients, then at that time the paediatricians will take over and look after them.

Q. And what would you mean by a medical problem?

A. Surgical problem means wounds, [inaudible], any pains et cetera. Surgical problems is after surgery; right? And after surgical, if some medical problems come, other problems on the abdominal side or distension or et cetera maybe, it's better to be consulted with the paediatrics and the paediatrics can take over that.

Q. So if I may understand you, if for example the wound wasn't healing very nicely, would you regard that as being a surgical problem?

A. Very nicely? You mean ...

Q. It wasn't healing well.

A. It is a surgical problem. The surgeons have to look after the wound.

Q. If that's the surgical end on the spectrum of problems, what would you say is a medical problem?

A. Just writing, looking after dehydration or something,

give a fluid or prescribing some drugs or ... They can write that at that time.

Q. So that would mean that the fluid management --

A. Fluid management, yes.

Q. You would regard that as a medical problem?

A. A medical problem. It's not a problem --

Q. Yes, a medical issue.

A. Yes.

Q. So if I understand --

A. Sorry, it's also considering that they are paediatrics, that's why I'm saying that. If they are in the adult side, in the adult ward, of course surgeons they have done that.

Q. So this is particular because these are general surgeons, not specialist paediatric surgeons, with their patients who are on the paediatric ward. So if there were issues like fluid management, that is something that you would be requiring the assistance of a paediatrician --

A. Paediatricians.

Q. And you would expect them to be managing that aspect of their care; is that correct?

A. Yes.

THE CHAIRMAN: Then let's go back to page 6 of the same statement, WS025/2, page 6. You were asked, Mr Zafar,

at question 4:

"On 8 June 2001 I conducted the morning ward round."

The question is:

"What were the arrangements for post-operative management of children at that time?"

You said:

"The junior surgical team was responsible for doing ward round for post-operative patients as well as providing further care."

A. Yes.

THE CHAIRMAN: That's why you did the ward round on the morning of 8 June, because Raychel was a post-operative paediatric patient.

A. Yes.

THE CHAIRMAN: And when I read that on and it says:

"As well as providing further care ..."

The further care that you would provide does not include fluid management; is that right?

A. Here is a surgical -- I mean, as she was first post-op after appendicectomy, the surgeons are required to see her and look after her surgical side, if there are any other issues could be addressed and direct her accordingly. That's what I'm saying here, the junior surgical team, SHO, because the question was put in that way, who is going to do rounds or look after that

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

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

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

paediatric surgical patients on that ward? By that I mean, between the surgeons and the paediatricians.
A. I don't remember that.
Q. But you have described effectively an element of shared care?
A. Sorry, yes.
Q. With the paediatricians, albeit being invited by the surgeons, but the paediatricians contributing in part in certain circumstances to the child's care.
A. Yes.
Q. So there's an element of shared care is what I was saying.
A. Yes.
Q. Which is something that wouldn't happen on an adult surgical ward?
A. It's not happening there because -- I mean, they have separate wards and they are separate specialists. Medical ward is a medical ward and in a surgical ward they are fully equipped and surgeons are available there.
Q. Yes. The other reason why there might be an element of shared care is because, as you've already said, the surgeons are really busy and needing to get into the theatre to perform surgery.
A. That's true, yes.

Q. So they're not always perhaps as accessible as a paediatrician might be. Would that be fair?
A. Yes.
Q. If I can pull up 025/2, page 11. It's question 6(f). We're still in this sort of area. The question was:

"In what kinds of circumstances was the nursing team expected to contact the surgical team in relation to the condition of a post-surgical patient who was being kept under observation?"

Which is the same sort of question as the chairman was asking you. This is what you said:

"If there were any issues about Raychel's [so you are now zooming in specifically on Raychel, not generically] surgical condition and general medical condition, she should have been seen by paediatricians. The surgical team should be contacted if there were any surgical issues such as wound problems or abdominal pain/distension. For general medical issues, sometimes the paediatric team would be contacted."

That seems to suggest not that the nurses would contact the surgeons, who would then relay that to their paediatric colleagues, but rather that the nurses seem to be exercising a judgment, as I think you have described it. "If it's a medical issue, we'll contact the paediatricians. If it's a surgical issue, we'll

contact the surgeons". Is that correct, is that what you meant to convey?
A. Yes. Here again, I have -- previously I've explained that. If there's some medical problems going on -- just in Raychel's condition, she was vomiting. It could be seen at that time paediatricians. Paediatricians are available all the time there in the ward.
Q. Sorry, Mr Zafar, let's just be clear about it. The point that I'm getting at --
THE CHAIRMAN: Sorry, the answer is contradictory.
MS ANYADIKE-DANES: It seems to be.
THE CHAIRMAN: The answer is contradictory because in the first two lines of your answer, you say:

"If there are issues about general medical condition, she should have been seen by paediatrics."

And then two lines down:

"For general medical issues, sometimes the paediatric team would be contacted."

Which suggests that sometimes -- well, really the surgical team, but sometimes it would be the paediatric team.
MS ANYADIKE-DANES: Do you see that, Mr Zafar? (Pause).
THE CHAIRMAN: Mr Zafar, I can understand your answer up to the last sentence. If your answer had stopped on the fourth line after the words "abdominal pain/distension",

then I could understand it. But you then add:

"For general medical issues, sometimes the paediatric team would be contacted."

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

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

and forgive me for getting into some detail on it, but this involves other people if you're going to set out what you think the system was. It may impact on the questions we ask other witnesses. Are you indicating that depending on the nature of the problem that the child may have, and the first people usually to see that will be the nurses because they're there looking after the child most of the time, that the nurses form a judgment as to whether they should be contacting the surgeons if it's a surgical issue or the paediatricians if it's a medical issue? Is that your understanding of what the nurses did?

A. I think, yes. That is ... It is that because if some problems -- I mean, how they are feeling at that time, how they are thinking the patient -- which direction it's going. It seems to be a medical problem or if wrongly they think it seems to be a medical problem, if they think that they can call a paediatrician as well. It's not a harm to call a paediatrician.

Q. No, I'm not suggesting it is, I'm just trying to understand the system at the moment. So far as you are explaining it, in your view the nurse could exercise a judgment. If she thought the matter of concern to her with that patient was a medical question then she could refer that to a paediatrician and get some medical input

from a paediatrician. If, on the other hand, she formed the view that it was a surgical issue then she would be referring that to a surgeon. Is that what you're saying?

A. I agree in emergency situation she can do that. If she is not anticipating any problem then she can call the team who -- which team that patient belongs at that time, and he can deal.

THE CHAIRMAN: In an emergency?

A. In an emergency situation, if some emergency things are going on and nobody's available, just for example, and then she can ask who is available there in a paediatric ward, if paediatricians are available.

THE CHAIRMAN: I just want to make clear to you, the impression that we have received so far from the nurses who have given evidence from the ward is that they would -- if they wanted to contact a doctor for Raychel's care, they would have tried to contact a surgeon. Their first stop was to go to a surgeon because she was a surgical patient. Does that make sense to you?

A. Yes. If patient belonged to surgeons, they have to call to the surgeons.

THE CHAIRMAN: Okay, thank you. Let's move on.

MS ANYADIKE-DANES: Before we were dealing with that

question, you were recognising that the paediatricians were perhaps more readily available or accessible than the surgeons were, who had theatre commitments, if I can put it that way.

A. Sorry?

Q. You had recognised that the paediatricians may be more readily available because the surgeons had theatre commitments?

A. Yes.

Q. Were you aware of there being any issue, so far as the nurses were concerned, about not readily being able to reach surgeons?

A. I don't think so.

Q. Let me pull up something for you.

THE CHAIRMAN: Let's do it perhaps very concisely this way. A problem was that -- and I think you've already referred to it -- you were not a paediatric surgeon.

A. No.

THE CHAIRMAN: And most of your patients were not children.

A. Yes.

THE CHAIRMAN: So most of your time, you were not on Ward 6?

A. Yes.

THE CHAIRMAN: And the same applied to your surgeon colleagues; isn't that right?

A. Yes.

THE CHAIRMAN: So wouldn't that mean that whereas the paediatricians would regularly be in and around Ward 6, the surgeons were not regularly present?

A. Not present, yes.

THE CHAIRMAN: So that could mean from time to time that the nurses would have difficulty contacting the surgeons because they were elsewhere in the hospital?

A. Well, I don't remember that.

THE CHAIRMAN: You were here this morning when Mrs Millar was giving evidence?

A. When I was there, I don't remember that this practice happened with me or generally, I don't remember.

THE CHAIRMAN: It's not blaming you for it, Mr Zafar, and it's not blaming the other surgeons for it, it's a simple proposition, really, that because you were not dedicated to the paediatric unit and most of your patients were elsewhere, it could be sometimes difficult or slow for you to respond to calls from Ward 6.

A. That may be the case. It is possible, yes. I can't -- I mean, whenever they called, they did call, and I think the surgeons -- they answer [inaudible] the bleep is somewhere.

THE CHAIRMAN: They answer it as best they could, but sometimes they just couldn't.

A. Sometimes they couldn't. At that time the system was

that the on-call person is not only on call, he is also going to the other assignments, theatre, ward.

THE CHAIRMAN: That's the point.

A. That's why it's hard sometimes to reach back immediately to --

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Yes. So the issue was -- or at least the concern was that surgeons were unable to give a commitment to children in Ward 6 unless they are acutely ill, that's the children, and bleeped. That was a specific concern. The reference is 022-097-308. So surgeons are unable to give a commitment to children in Ward 6 unless they, that is the children, are acutely ill and the surgeons are bleeped. That was a concern. Were you aware of that?

A. I don't, because this is not a question to me, this is high level, not me.

Q. You weren't aware of that being a concern?

A. No. I mean, I don't.

Q. Where that goes to is the concern that surgeons are responsive in a way, so they respond to an emergency call, if I can put it that way, rather than perhaps being available to engage perhaps in more proactive care. Were you aware of that sort of concern?

A. You mean the on-call team?

Q. Yes.

A. On-call team is always on call.

THE CHAIRMAN: Sorry, this is isn't just the on-call team. For instance, on Friday 8 June you were on duty.

A. Yes.

THE CHAIRMAN: Not on-call.

A. I was on-call 24 hours.

THE CHAIRMAN: But you were in the hospital on duty. That's why you were doing the ward round.

A. Yes. I was on-call from morning until next morning and in the hospital.

MS ANYADIKE-DANES: But as you've already answered, you wouldn't be necessarily able to commit at any given point in time being able to respond to a child because you had theatre duties and you had your adult patients.

A. That is true because during those days, on-call was made like that, on-call is SHO, registrar and JHO, and the consultant. But the plan, it was really by the person who is responsible for that. On-call, okay, if there's some problem, call bleep, but if at the same time you are doing other assignments you have to do that as well.

Q. Does that mean that you as an SHO who was qualified and presumably did carry out some surgery were dependent really on the pre-reg doctors being available to the nurses to deal with paediatric surgical patients?

A. Yes. JHO was available all the time, JHO's duties included at that time only look after ward patients, not emergency patients, not in Accident & Emergency.

Q. Yes. The system, if I can put it that way, in order for you and the registrars and consultants to carry out your theatre duties and respond to the needs of your adult patients, the system really depended on those JHOs being responsive to the nurses making preliminary decisions and, if necessary, contacting their more senior colleagues?

A. Yes.

Q. That's the system?

A. That is true.

Q. So that system requires them to have, presumably, also easy access to you, because they're only trainees?

A. Yes.

Q. You're a trainee, but they are pre-reg?

A. Yes.

Q. And they need supervision, do they not, as pre-reg?

A. Supervision?

Q. The JHOs would require a degree of supervision too, would they not?

A. Yes.

Q. They are also not specialists in paediatric surgical care, are they?

A. No, they are not.

Q. So how did the system of supervision work for those JHOs in 2001?

A. JHOs were controlled by not SHOs, JHOs were -- I think consultants direct that, they plan their duties and training. I don't know about the other who was responsible for JHOs and how they divided and how they sent them to the wards. I don't know.

Q. I might not have put it in a way that you understood it. I don't mean who is directing their overall training and so forth. Obviously all that system in terms of JHOs, SHOs and registrars are under the consultant.

I understand that. But the first point of call, I think you have just agreed for the nurses, would be the JHO?

A. Yes.

Q. The JHO requires a level of supervision?

A. Yes.

Q. The next person in the chain of seniority, if I can put it that way, is the SHO?

A. Yes.

Q. That would be you?

A. Yes.

Q. So what was the system that enabled the SHOs to provide some sort of supervision over what the JHOs were doing?

A. That is direct supervision, if he is feeling any

problem, that he can inform to the SHO or direct to the registrar or direct to the consultant.

Q. So unless they're actually contacting the SHO or registrar and have managed to contact them, they are actually the person who is dealing face-to-face with the nurse and the paediatric surgical patient?

A. Yes, I think so, yes.

THE CHAIRMAN: And it's up to them to call for assistance if they want assistance?

A. Yes.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: And up to them to know that something is sufficiently serious or significant that they need to contact someone?

A. Yes.

Q. So then if we move on more specifically to SHO duties. I know that you say that you hadn't seen the handbook but I am referring to it because it conveniently sets out what Altnagelvin considered to be the SHO duties. We see it at 316-004g-003. It says under the clinical work that you will be responsible directly to the consultant or consultants to whom you are assigned.

THE CHAIRMAN: Do you agree that you were responsible directly to the consultant to whom you were assigned?

A. I agree that because I have to let him know everything,

what's going on in the ward about his patients.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: I believe I had given you the wrong place. It should be 006.

THE CHAIRMAN: Well, the witness has accepted the point.

MS ANYADIKE-DANES: In fairness, so that he sees what I've put to him --

THE CHAIRMAN: I think he's accepted the point.

MS ANYADIKE-DANES: I think then it goes on to say that even when off duty -- sorry, this is why I wanted to bring it up because I think there's another issue:

"Even when off duty, you have a continuing responsibility for the patient under your care."

Would you have accepted that? It's the final bullet there. And in your witness statement, you said that you regarded yourself as responsible for the day-to-day care of the inpatients and you assisted in major surgical procedures and, under supervision, performed minor surgical procedures and you assisted with appendicectomies. We don't need to pull it up, your second witness statement at page 4. You also took part, 1 in 4 on-call rota. Do you accept all of that?

A. Yes.

Q. When you answered the chairman there that you were responsible directly to the consultant or consultants to

whom you are assigned, that's actually what I was getting at earlier when I was trying to find out who that consultant was. You can see it there, the fourth bullet down:

"So far as your clinical work is concerned, you will be responsible directly to the consultant to whom you are assigned."

You've agreed with the chairman that you accept that that was the case, but who was the consultant to whom you were assigned?

A. I don't remember because there was changing over. I don't remember what was the rota, which rota is going to which consultant and which rota is going to which consultant. I don't remember that. I understand your point, that always assigned with one consultant, but it is not happen -- I don't remember.

Q. Okay. Then it goes on at 004, I hope, to talk about the clearly defined chain of responsibility, of which you were a part, and I think you've accepted that?

A. Yes.

Q. And that part of the responsibility for your actions will ultimately rest on your supervising consultant, and it's important that you liaise closely with him or her. I think it might be 007, sorry.

What I wanted to draw your attention to is that it's

important that you liaise closely with your consultant. Did you understand that that's what you had to do, you had to be in close touch with your consultant?

A. I understand very well. The question is here, we worked with all consultants when we were working here. We have worked with everyone. It was not my ... Of course, always everybody has big desires, but you cannot get all the time. It was not my decision with whom I work, that was the decision by the consultants and how they want to work with us, they did that. It's not mine.

Q. I understand that, you didn't choose the consultant you wanted to work with. It was a different point I was asking you about, which is the point about liaising. What did you think your obligations were about liaising with your consultant, keeping in touch with your consultant?

A. With whom I worked, I was supposed to be informed about the patients and about everything about his patients.

Q. So if we take -- we are going to go to it in detail, but if we take June 8, for example, when you carried out the ward round, you did a post-take ward round involving Raychel and then you went off to do theatre work?

A. Yes.

Q. And be on call for the rest of the remaining 24 hours, and in fact you ultimately came back, responding to

a call in the early hours of the morning of 9 June. So what I would ask you, though, is, in the scheme of that, what did you consider it necessary or how did you liaise with your consultant over that day?

A. Mr Gilliland was on call, I remember.

Q. Yes.

A. And I also wish, what you are asking me, that I have enough time and sit down and talk to him and about his patient and told him everything, which is not happened. When you are going to go through all the 20, 30 patients, and after that you have to go to theatre at 9 o'clock or 9.30, it's very difficult to inform about all patients to the consultants. But if there's a potential risky patient, risk is there or some other patient which is requiring consultation by the senior colleagues, I am supposed to be.

Q. Yes.

A. At that time, that practice was going on in the surgical wards, which we have done.

Q. So how you interpreted "liaise" to mean is that if you had a concern about a patient, you would contact the consultant about that?

A. Definitely I have to inform him that something is going wrong with the patients and I need a further help or I am going to theatre or going to other assignments and

a senior colleague has to come and see that patient.

THE CHAIRMAN: Whereas if a patient is progressing as expected and normally, you don't need to trouble the consultant with information about that patient?

A. If the patient is doing well, no problem. Not necessary to let him know that. The next day he will ...

THE CHAIRMAN: Okay, thank you.

MS ANYADIKE-DANES: You've already accepted that you weren't experienced in dealing with paediatric cases. Were you aware of guidance, this is the good surgical practice guidance, were you aware of guidance that indicated that surgeons should only treat children if they have the appropriate training and ongoing experience in the clinical care of children and their specialty, unless of course there's an emergency. Were you aware of anything like that?

A. This is normal ethics. If someone is trained with some specialty, he has to deal with that specialty.

Q. Did you regard yourself as having a specialty in relation to children?

A. No, I do regard that. I regard that. If I'm not a specialist in paediatrics, I'm not going to operate that.

Q. And how did you gain that specialism in children?

A. How I did?

Q. Yes. You said you thought you did have that specialism in children, in paediatrics, so I'm asking you how you gained it.

THE CHAIRMAN: I think he said he's not a specialist in paediatrics.

MS ANYADIKE-DANES: "If I'm not a specialist in paediatrics, I'm not going to operate that."

I took from that because he was involved in Raychel by himself, at the ward round, that he was regarding himself as being sufficiently specialist to conduct that ward round by himself.

A. Well, in here I was a surgical team -- one of the surgical team members. This was a simple round, it was not operation. In Altnagelvin, there was no specialist, general surgeon for paediatrics; right? That's why all surgeons, they have taken part in the paediatrics -- their patients. In that regard, I also did that. This is part of my SHO training here that I have to look after surgical -- if there's any surgical patients in paediatric wards, that you have to go and see those patients. Whatever outcome will come from me, that is the consultant assessment that I'm doing right or wrong.

Q. Yes. So you regarded yourself as being sufficiently trained, I don't mean that in a pejorative sense --

A. Yes.

Q. -- to carry out a ward round involving a paediatric patient?

A. No, I mean, if ... Let's put it that way. Specialist need required for that children, from a surgical input, definitely the senior -- I mean, the surgeon or surgeons can go and see that patient. But it was a simple post-appendicectomy and I mean, I was allowed to go and see and do the round.

Q. Well, did you know at the time you started that ward round that it was going to be a simple post-appendicectomy?

A. Well, I was just -- I know that appendicectomy was done overnight. And she -- I don't know how she is feeling when I went there. I mean, appendicectomy, what I know, it was normal, there was no problem.

Q. Sorry, I didn't mean it quite in that way. Presumably there were other patients -- were there other patients that you saw during that ward round or was it just Raychel?

A. No, only Raychel.

Q. Oh, so you just came to see Raychel?

A. Raychel.

Q. And how did you know to come and take that ward round?

A. Because I was told that there's one patient post-appendicectomy in Ward 6 you have to go and see.

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

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

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

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

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

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

Altnagelvin?
A. Yes.
Q. And in fact, a trainee was supposed to attend a consultant ward round unless there was some very good reason?
A. Yes.
Q. What determined whether a consultant was going to have a consultant ward round so far as you were aware?
A. If the team is led by consultant on the round, that will mean that it's a consultant round.
Q. It's automatically a consultant round?
A. It is automatically a consultant round.
Q. And how do you know whether any particular ward round is going to be a consultant ward round?
A. It depends on the consultant.
Q. How do you know ahead of time?
A. I don't think he can immediately come and start the round, it's a consultant round. It's not -- it depends on why, that I know -- not necessarily that he has to inform me that he is going to come and do his round. Sometimes he can, sometimes ... Because he's a team leader.
Q. So in practice, you really had to be there for every ward round unless there was some very good reason why you couldn't be there?

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

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

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

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

rounds, not paediatric ones necessarily?
A. I think that was the reason that maybe they asked me to go and see that patient post-op and they have gone to other patients. Maybe, I don't remember that.
Q. So Raychel may have been the only paediatric --
A. Yes.
Q. -- post-surgical patient?
A. Yes. Only one patient.
THE CHAIRMAN: I think that's what you said before the break, that you saw Raychel, that was the only child you saw on Ward 6.
A. Yes.
MS ANYADIKE-DANES: I mean as a post-take. Were there any other surgical patients in Ward 6?
A. In paediatric wards, no.
Q. Sorry?
A. Not in paediatric wards.
Q. Sorry? I may not have put it --
THE CHAIRMAN: Raychel was the only child he saw on Ward 6 that morning.
MS ANYADIKE-DANES: I know she was the only child. What I was asking was slightly different, whether she was the only surgical child on Ward 6.
A. Only surgical. I remember that I haven't seen any other surgical patient in Ward 6.

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

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

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

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

a patient to the paediatricians and the paediatricians came and see that patient, I am available there, I don't remember that.

Q. Thank you. When you had previously, before I put to you some of the potential significance of the ward round -- when you answered yourself for what you took the purpose of it was, you said to make sure -- the post-take ward round -- the patient was recovering well, their vital signs were okay and their wounds were fine. When you come to do a ward round, what is it that you're doing when you do it yourself so you are not following the registrar or the consultant? What are you doing to try and satisfy yourself as to that objective? What do you actually do with the patient?

A. Well, when you come to the patient, you will see the patient, how he is feeling, he or she is feeling, general observation. "General" means how looks like, she is happy, not happy, face is happy or not happy, dry or not dry. Make judgments from that points. And after that, just speak with her in a happy mood and ask her how she is feeling after surgery, politely, and take the history from her. She will say if she is not feeling well.

Q. And what do you mean by "take the history from her"?

A. How you are, do you feel any pain, do you have a good

sleep or not, have you eaten or not. All that questions you have to ask.

Q. Do you want to know whether they've gone to the toilet yet?

A. Naturally, she has opened her bowel or did she pass her [inaudible] or not. This is important in a general surgery.

Q. So those are questions that you would typically ask a patient?

A. I do like to ask typically, but you asked me what I do.

Q. Yes, exactly. That's what I'm saying.

A. If you are asking typically for this patient, you have to put a different question. You are asking me generally?

Q. Generally, yes.

A. Generally I have told you that I'm doing that way and I look around the patients, what she is doing. As soon as I'll see her -- and after that I will examine her as well if needed. If she is stable, no problem, no need to go and examine her, and ask the sister how she is feeling with her. Sister means nurse, attending nurse.

Q. Yes.

A. And how she is feeling. She will also give you some history how she was overnight, day, hour before, two hours before, and take from there. That observation

helps you.

Q. And if it's a paediatric patient you might also ask the parents, I presume?

A. If the parents are available, you have to ask, definitely. Parents are more important.

Q. Would you want to speak to a parent if --

A. I like to, yes.

Q. So if a parent's not there, you might ask where they are, are they likely to be available and so on?

A. Yes.

Q. And apart from your observation and the discussion with the nurse and maybe a conversation that you might have with a parent, what then are you doing about the notes and the charts and so forth? Is that another source of information that you would use?

A. That is documentary note. You can get information from the observational chart, what's happening, if it's immediate post-op. Sometimes longer, then there's no chart available, only generally you have to go on clinical evidences, clinical history, biochemical or clinical history. That will give you the results about how she's feeling.

Q. But typically, you would want to look at the charts?

A. I would like to.

Q. And I think you said that you wouldn't necessarily

examine a patient unless you had some concern?

A. In surgical patients, immediate post-op, if there is something going on or you are not happy with that, if your concerns are there, of course I will examine. If patient is stable, nothing had happened after operation, sitting on the chair or a bed, happy, talking, then there's no point to ask him that, "Okay, I want to listen to this, I want to listen to that". You just have to observe them.

Q. Yes. Then if we move to another element of a ward round. When Mr Zawislak was giving his evidence, he talked about it's possible to have a simultaneous ward round and handover. He said that in his transcript of 5 February at page 97, starting at line 5. He said that he would expect the post-take ward round to be led by a consultant, who would be informed by either the SHO from the previous night, and it would be, he thought, typically a simultaneous ward round. So the SHO from the previous night would be providing that continuity, if I can put it that way, the handover would be happening all as part of the ward round.

A. Yes.

Q. When I asked you about handovers, you acknowledged that they were important for quality of care?

A. Yes.

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

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

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

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

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

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

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

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

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

A. No, that was --

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

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

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

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

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

MR STITT: No.

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

MR STITT: I understand that.

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

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

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

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

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

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

MR STITT: I understand that point.

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

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

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

THE CHAIRMAN: Absolutely.

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

THE CHAIRMAN: Yes.

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

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

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

given his answer.

Then you could have looked, because it was available for you to do, at Mr Makar's clinical note. In fact, I think you said you did look at his clinical note?

A. Yes.

Q. Because it was from his clinical note that you took what had happened and didn't feel the need to discuss matters with him; would that be right?

A. Yes.

Q. Because effectively he had written it down?

A. The reason was that, she was feeling well and she was not showing me any unhappiness where I had to speak with him and let him know.

Q. And if you'd looked at that -- in fact, you said you looked at it. It's at 020-007-011. Apart from describing what had happened, it tells you or would have told you that her sodium level was 137, which is normal, and that she had been put on IV fluids. And that's what you would have learnt from looking at that immediate note. In fact, you see that at 012.

THE CHAIRMAN: That's right.

MS ANYADIKE-DANES: Thank you.

Then you could also have looked at the prescription sheet. Once you'd seen that she had been put on IV fluids, you could have looked at the prescription sheet

to see what she had been put on, because that would have told you something -- it would have told you her fluid regime. And if you had gone to her prescription sheet, which is at 020-021-040, that would have told you that she had been put on Solution No. 18, which is a solution that you say you hadn't particularly been familiar with before you came to Altnagelvin. You'd have seen that the rate was 80 ml an hour and you'd have seen that it was erected at 10.15 on the evening of 7 June. If you had seen that rate at 80 ml an hour, would you have thought that that was a little high, maybe, a little excessive?

A. What was my decision at that time, I just started sips and I asked to reduce the fluid.

Q. Sorry, it's a different question. If you had seen --

THE CHAIRMAN: The witness is allowed to answer it in this way and we can go back to the point. But the witness is quite entitled to answer this point in the way that he was answering it.

Your position is that having seen Raychel, you decided that she should start sipping fluids and that, as the day went on, the intravenous fluids should be reduced?

A. Yes.

THE CHAIRMAN: And then discontinued?

A. Yes.

THE CHAIRMAN: Right. Having said that, I understand that's your position, but you were being asked perhaps a slightly different but related question. Did you notice or did you observe the rate at which she was obtaining fluid? That's the first point. Did you? This sheet in front of you, did you see that?

A. No. Well, I understand that, but at that time I have taken a decision to reduce the fluid. That is why I haven't gone too much attention towards that side, how much is going on, when I have decided, I told that, and my decision was, okay, start sips as soon as she was tolerating, just stop -- I mean reduce the fluid and stop it.

THE CHAIRMAN: So can I take it in this way? From looking at the records, you understood that she had had a straightforward appendicectomy, which had gone well?

A. Yes.

THE CHAIRMAN: When you came along to see her on the Friday morning, you spoke to her and observed her and she seemed well. And Sister Millar, who was with you, seemed to have the same view, that she was well. There's a separate point about that, about a vomit, but in general Sister Millar was not overly concerned about Raychel's condition.

A. Yes.

THE CHAIRMAN: Is that why you say that you thought things appeared to me to be quite normal and, since they seemed to be normal, I thought she should start sipping fluids as the day went on and that the intravenous fluids should be reduced and then stopped, and you say that that advice was given because you were satisfied about her condition?

A. Condition, yes.

THE CHAIRMAN: Okay. So the rate at which she was receiving fluid did not seem to you to be an issue of any importance?

A. The reason was only that, at that time my attention is gone that she is going to stop the fluid, IV, and there will be no more fluid and she will be okay.

THE CHAIRMAN: Does that mean that the rate at which she was receiving fluid did not seem at that point to you to be anything significant?

A. No, I understand she is getting more fluid. I understand that.

MS ANYADIKE-DANES: Sorry, did you --

A. At that time, her general condition was not that -- I mean ...

THE CHAIRMAN: When you say that you knew she was getting more fluid, do you mean that on that morning, on that

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

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

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

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

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

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

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

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

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

THE CHAIRMAN: As he found her.

MR STITT: Yes.

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

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

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

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

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

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

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

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

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

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

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

MS ANYADIKE-DANES: But I'm going to ask him whether he would be surprised at that because Mr Makar has given his evidence about that, about what --

THE CHAIRMAN: Yes. Well, let's see if we can get these points resolved before we break for the day.

MS ANYADIKE-DANES: That area, Mr Chairman, I would rather not deal with in a very short way because what the practice was, who knew what, requires me to not only ask this witness those sorts of questions, but also put to him what the others have said. Some of those others are his colleagues in the surgical discipline, which is Mr Zawislak, Mr Makar and Mr Gilliland, as well as others who are from different specialties that also had the care of Raychel. That is a very important point and I would rather not deal with that point too summarily, if I can put it that way.

THE CHAIRMAN: The point will wait until Mr Zafar's evidence resumes, but I don't think it is necessary to go through what each other person says in order to explore the issue. We don't need to put to this witness or to any other witness what every other witness says in the area, and that will not happen.

MS ANYADIKE-DANES: No, Mr Chairman, with respect, I don't intend to do that. But I have provided a schedule of how I hope to go through this witness with his evidence.

There is a logic to it and I will try and deal with it as succinctly as possible, but there are reasons why one puts the questions.

THE CHAIRMAN: Thank you.

Mr Zafar, I'm afraid we're not going to finish your evidence this afternoon. If necessary, we can ask you to resume your evidence on a date to be arranged by video link. But that becomes difficult because on the video link we don't have the facility to put up in front of you the various documents to which we're referring, the documents which come up on the screen. It's much easier for you to give your evidence if you can see the documents in the same way as you've seen the documents this afternoon. I think it's correct that you're not available next Monday or Tuesday. What I would like to be explored after I rise now is whether there is some half day next week, Mr Stitt, when Mr Zafar could come back on either Wednesday or Thursday. If you could explore the various options about dates and liaise with Ms Anyadike-Danes about that.

MR STITT: Yes, we'll work through that, obviously the sooner the better.

THE CHAIRMAN: That's certainly right. The other issue is that, if at all possible, I would prefer him to be here because I think it is easier to be here rather than

doing it down the line by video link.

MR STITT: I agree with that.

THE CHAIRMAN: I'll rise and we'll resume on Monday morning at 10 o'clock. We have two nurses on Monday, Nurse Bryce and Nurse Patterson. Thank you very much.

(5.05 pm)

(The hearing adjourned until 10.00 on Monday 4 March 2013)

I N D E X