

1 Monday, 11 March 2013
2 (10.00 am)
3 THE CHAIRMAN: Good morning. Mr Wolfe.
4 MR WOLFE: Good morning, sir. The first witness we have
5 this morning is Dr Mary Butler.
6 DR MARY BUTLER (called)
7 Questions from MR WOLFE
8 MR WOLFE: Good morning, doctor, and thank you for coming.
9 To date, doctor, you've provided the inquiry with two
10 written witness statements --
11 A. Yes.
12 Q. -- the first dated 1 July 2005 --
13 A. Yes.
14 Q. -- and the second, 14 June 2012.
15 A. Yes.
16 Q. And we ask witnesses whether they wish to adopt those
17 witness statements as part of their evidence to the
18 inquiry; do you wish to do so?
19 A. Yes.
20 Q. In addition to providing the inquiry with witness
21 statements, you also provided the PSNI with a statement
22 by way of assistance in 2006; isn't that correct?
23 A. That's right.
24 Q. In June 2001, the inquiry is aware that you provided
25 some care for Raychel by way of continuing

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1 a prescription for her intravenous fluids; isn't that
2 correct?
3 A. Yes.
4 Q. And you did that in your capacity at that time as
5 a senior house officer in paediatrics.
6 A. Yes.
7 Q. And your current position is what, doctor?
8 A. A general practitioner.
9 Q. In Northern Ireland?
10 A. Yes.
11 Q. Could we have your CV up on the screen, please? It
12 might be helpful just to shorten matters. It's at
13 WS026/1 and if we could start at page 7. Just to
14 assist, doctor, we'll move forwards through your CV from
15 its back page, if you like. You qualified in medicine
16 through University College Dublin, isn't that correct,
17 in 1998?
18 A. Yes, that's right.
19 Q. And starting in August 1998 then, you had a junior house
20 officer's role in Mid-Ulster Hospital --
21 A. Yes.
22 Q. -- before coming to the Altnagelvin in August 1999.
23 A. Yes.
24 Q. And if we could move to page 6 of the document, back
25 a page, we see that you go through various rotations and

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1 end up in paediatrics in February 2001.
2 A. Yes.
3 Q. That was your introduction to paediatrics.
4 A. Yes.
5 Q. You had no previous experience in paediatrics prior
6 to February 2001?
7 A. No.
8 Q. In your role in paediatrics, doctor, what were the kinds
9 of tasks that you would have been engaged in from
10 day-to-day?
11 A. We would attend at the ward rounds and often written in
12 the notes. We'd have looked after the children in
13 Ward 6. And Ward 6 team, which was the day care unit
14 and the infant unit, we'd attend at the labour ward for
15 deliveries and did the post-natal baby checks. And we
16 also would have attended the Special Care Baby Unit and
17 the neonatal unit, carrying out bloods and
18 investigations.
19 Q. You had a job description, which you've helpfully
20 attached to your witness statement. Perhaps we could
21 have a look at that. It's WS026/2 at page 15, please.
22 We can see the job title, "senior house officer", and
23 paediatric medicine was your first term. This was to be
24 a six-month rotation; is that correct?
25 A. Yes, that's right.

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1 Q. And the purpose of the role set out there:
2 "To support the consultants in the provision of care
3 of the patients in Altnagelvin Hospital."
4 Then it sets out various aspects of that. If we go
5 to the next page, please, page 16. Can I pick up on the
6 bottom of the page, "Study and training":
7 "Junior doctors are expected to participate in the
8 active teaching programme at the hospital."
9 At that time, can you remember the extent to which
10 there was an active teaching programme at the hospital
11 for paediatric SHOs?
12 A. In paediatrics there was supposed to be a perinatal
13 meeting on a Wednesday around lunchtime, I think, and
14 then there were supposed to be separate paediatric
15 training on a Friday afternoon, but quite often you
16 could be called away or maybe it didn't actually happen.
17 Q. In terms of the nature of the SHO on the paediatric
18 side, in terms of the nature of that role, the inquiry
19 has heard evidence already from Dr Johnston. Do you
20 remember Dr Johnston from your year there?
21 A. Yes.
22 THE CHAIRMAN: Did you get a chance to see his evidence from
23 Thursday or hear about his evidence from Thursday?
24 A. No, I didn't see his evidence from Thursday.
25 MR WOLFE: In terms of the nature of the SHO role in

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1 paediatrics, he highlighted the fact that the SHO role
2 in paediatrics was a little different from other
3 disciplines in the sense that in paediatrics you
4 wouldn't have the experience in the SHO role as other
5 disciplines would have enjoyed.

6 A. Yes.

7 Q. Is that familiar to you?

8 A. I suppose a first-term paediatric SHO's a bit like
9 a junior house officer in paediatrics. That's the first
10 experience that you've had.

11 Q. And in terms of the responsibilities of the SHO during
12 that year, you've outlined some of them. Was this very
13 much a traineeship during that year or were you given
14 solid responsibilities?

15 A. I think it was more like a traineeship. If you had any
16 difficulties you would speak to your registrar or
17 consultant.

18 THE CHAIRMAN: It would be a combination, wouldn't it,
19 because by the time you went on to be an SHO in
20 paediatrics, that was the last six months of your
21 two-year stint as an SHO, wasn't it?

22 A. Yes.

23 THE CHAIRMAN: So you would already have had your JHO year,
24 you had already done a year and a half as an SHO, but in
25 paediatrics you were learning paediatrics --

5

1 A. Yes.

2 THE CHAIRMAN: -- more than you would have done as an SHO in
3 medicine because you would already have been a JHO in
4 medicine?

5 A. Yes.

6 MR WOLFE: Altnagelvin at that time had Ward 6, which was
7 the paediatric ward, and you would have spent most of
8 your time on that ward, presumably apart from when you
9 were dealing with outpatients.

10 A. Mainly between Ward 6 and the baby unit.

11 Q. And Ward 6 was a mixed paediatric medicine ward with
12 some surgical patients.

13 A. Yes.

14 Q. Would it be correct to say that the majority of patients
15 were on the paediatric medicine side and comparatively
16 few patients were on the surgical side?

17 A. From what I remember, that's correct.

18 Q. We asked you in your witness statement about your
19 knowledge of hyponatraemia at that time, fluid
20 management, and electrolyte type issues. You have told
21 us that:

22 "[You were] unable to recall having any advice,
23 training or instruction with regard to hyponatraemia,
24 post-operative fluid management or record keeping
25 regarding fluid management."

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1 Can I just ask you some questions about that? When
2 you answered the question in that way, was that
3 a reference to the teaching or the instruction available
4 to you at Altnagelvin or were you referring more broadly
5 to your entire medical career to that point?

6 A. Well, I don't remember specifically instructions about
7 fluid management or record keeping, but I mean, I know
8 that I did have some. I don't remember any specific
9 instructions about hyponatraemia in that time in 2001.

10 Q. Could I ask you about one specific matter, which arises
11 out of correspondence from Altnagelvin? If we could
12 have up on the screen, please, 316-004e-001. This is
13 correspondence from Altnagelvin to the postgraduate dean
14 from July 2005, doctor. I want to ask you about the
15 section within the letter -- just take your time to
16 familiarise yourself with it -- dealing with whole
17 hospital training. It says:

18 "From 1995 there have been teaching sessions
19 timetabled each year on fluid balance and electrolyte
20 disturbance within the medical division teaching and
21 training programme. This formal training is delivered
22 during the lunchtime teaching programme and aimed at all
23 PRHOs and all other junior medical staff. This is
24 considered a general hospital education opportunity.
25 The lectures on fluid balance were given by an

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1 anaesthetist and the lecture on abnormal biochemical
2 tests, including electrolyte disturbance, by our
3 clinical biochemist. Both these lectures would have
4 been very much aimed at adult care."

5 And then it goes on to talk about what happened in
6 2002. Dr Nesbitt prepared a lecture or a talk
7 specifically in relation to hyponatraemia and
8 electrolyte issues there. Can I ask you, in terms of
9 what was happening when you were there in 2001 and you
10 were on the paediatric medical side, can you remember
11 any teaching in relation to fluid balance and
12 electrolyte disturbance?

13 A. I don't remember any specifically.

14 Q. In terms of what you do remember about that time,
15 obviously, as you've reflected earlier, work commitments
16 tend to have to be prioritised, so if you're dealing
17 with patients you can't go to lectures perhaps. What's
18 your broad recollection of the education available to
19 you during that year?

20 A. Well, as I said, the two meetings I remember was
21 a perinatal meeting on a Wednesday and a paediatric
22 teaching, usually by registrar, on a Friday. Quite
23 often if there wasn't someone available to take it or we
24 could have been called away to deal with a patient.
25 I don't remember it happening very frequently.

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1 Q. And you have no specific memory of attending what's in
2 front of us on the screen?
3 A. I don't have any specific memory of it, no.
4 THE CHAIRMAN: How many paediatric SHOs would there have
5 been between February and August 2001?
6 A. I think there's maybe six or seven, I think it was.
7 THE CHAIRMAN: So you're one of that group?
8 A. Yes.
9 THE CHAIRMAN: Okay.
10 MR WOLFE: Leaving aside the specifics of hyponatraemia,
11 doctor, is it fair to say that by that stage in your
12 career you would have appreciated the whole area of
13 fluid management and electrolytes and the kinds of
14 issues that arose for managing children, for example, to
15 be specific, say if a gastroenteritis patient was in
16 hospital.
17 A. Yes, I think I had an appreciation of that.
18 Q. You have said in your statement that you were aware that
19 urea and electrolytes needed checked daily on paediatric
20 patients --
21 A. Yes.
22 Q. -- who were on ongoing intravenous fluids. And you were
23 aware of the need to record and act on the results, if
24 necessary.
25 A. Yes.

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1 Q. The inquiry's heard some evidence about the approach to
2 electrolyte profiling in paediatric medicine. Can
3 I push you on your memory of this, doctor? If a child
4 was on an intravenous fluid at that time and was being
5 managed on the paediatric medical side of the house,
6 would there have been a formality or a structure about
7 electrolyte profiling?
8 A. I don't remember any specific structure, but I remember
9 that if a child had been on fluids from within 24 hours
10 a U&E would have been carried out on a 24-hour basis.
11 Q. And can you remember the thinking behind that? Why was
12 that, if you like, installed as a regular fixture in the
13 paediatric medical day?
14 A. I don't remember why the reason was.
15 THE CHAIRMAN: I'm sorry?
16 A. I don't remember what the reason was behind it.
17 THE CHAIRMAN: Thinking about it, do you understand the
18 reason for it?
19 A. I understand it would be to check their hydration and
20 check their electrolytes, but I don't know why 24 hours
21 was the time that was picked.
22 THE CHAIRMAN: The reason for this is that a child who has
23 gastroenteritis and has vomiting and diarrhoea is at
24 risk of being dehydrated; right?
25 A. Yes.

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1 THE CHAIRMAN: And you're giving the IV fluid to rehydrate
2 the dehydrated child --
3 A. Yes.
4 THE CHAIRMAN: -- or to prevent dehydration.
5 A. Yes.
6 THE CHAIRMAN: So you know the fluid is going in and that
7 means you have to measure the fluid going out.
8 A. Mm-hm.
9 THE CHAIRMAN: Did you understand any issue about what type
10 of fluid should be going into the child through an IV?
11 A. Generally, we always used Solution No. 18 as maintenance
12 at that time in 2001, but I don't -- didn't know the
13 reasons behind it at that time.
14 THE CHAIRMAN: So you're really focusing just on preventing
15 dehydration; is that what your understanding was, that
16 that's what you were focusing on?
17 A. Yes.
18 THE CHAIRMAN: Making sure the child was not dehydrated?
19 A. Yes. We would have done electrolytes at 24 hours as
20 well just to look at the sodium and potassium.
21 THE CHAIRMAN: Okay. If they were low, what would be done?
22 A. We probably would have taken advice from a registrar.
23 THE CHAIRMAN: Can you remember what sort of advice or what
24 sort of action might be taken for a child -- let's
25 suppose, as I think is almost certainly the case, you

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1 would have treated children with gastroenteritis.
2 They've been on IV fluids for 24 hours, they have tests
3 carried out and they turn out to be low in sodium and/or
4 potassium. So was it your understanding that
5 Solution No. 18 would make up the balance?
6 A. No, I don't think so. At that time if they were low on
7 sodium or potassium, sometimes potassium would be added
8 to the bag of fluids. I don't remember specifically any
9 case where anybody was low on sodium.
10 THE CHAIRMAN: Okay. But the Solution No. 18 would then be
11 topped up with potassium or potassium would be given to
12 a child in some way so that an imbalance would be
13 restored?
14 A. Correct, yes.
15 MR WOLFE: So if I can just dig into that a little bit more,
16 the standard fluid that you seem to be describing is
17 Solution No. 18.
18 A. Yes.
19 Q. But if electrolyte profiling identified an electrolyte
20 imbalance of some sort, then doctors on the paediatric
21 side perhaps more senior to you would look at what
22 needed to be addressed in terms of the fluid that the
23 child was getting?
24 A. Yes.
25 Q. And while Solution No. 18 might continue, you have

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1 experience of that fluid being supplemented, depending
2 on the child's need?
3 A. I don't remember specifically Solution No. 18 being
4 supplemented, but sometimes potassium would have been
5 added.
6 Q. Have you any recollection of other intravenous fluid
7 types being used apart from Solution No. 18?
8 A. I know that there are other types available. I don't
9 remember at that time any of them being used
10 specifically.
11 Q. And as you've indicated already, on a paediatric ward
12 such as Ward 6, you would have had some surgical
13 patients.
14 A. Yes.
15 Q. Can you help us with this: in terms of the management of
16 those patients, was that seen primarily as a surgical
17 responsibility?
18 A. I think primarily it would have been seen as sort of
19 a surgical responsibility, yes.
20 Q. Clearly, in Raychel's case, you were asked to intervene
21 to assist a nurse with a prescription for continuing
22 fluids. Was that a common scenario or regular scenario
23 for you to be asked to intervene and help in this way?
24 A. From what I remember, it was a fairly routine request.
25 Q. Obviously, in this case, Raychel's case, you were being

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1 asked to write up a second bag of IV fluids. But in
2 what other kinds of scenarios would you, as an SHO on
3 the paediatric side, have been asked to intervene and
4 help with a surgical patient?
5 A. Maybe in taking blood samples or inserting IV lines into
6 the patient or sometimes prescribing pain relief.
7 THE CHAIRMAN: Would the request invariably come from the
8 nurses?
9 A. From what I remember, yes.
10 THE CHAIRMAN: Right. And is the scenario then that if
11 there's no junior surgeon around, the nurse might ask
12 you, "This child's bag is empty, would you prescribe
13 a new one?", or, "Would you take a blood test or
14 prescribe a painkiller?", just something along those
15 lines?
16 A. Yes.
17 THE CHAIRMAN: The reason they're doing that is because the
18 paediatricians are generally around the ward, whereas
19 the surgeons typically weren't around the ward; is that
20 it?
21 A. I think that's the reason, yes.
22 MR WOLFE: Can you say, doctor, whether that kind of
23 intervention that we're talking about was something that
24 was generally known, for example, to your supervisors?
25 Would they have known that you would have been asked

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1 from time to time to help out on a surgical patient?
2 A. I don't know if they would have known or not. To me it
3 seemed to be fairly common practice.
4 Q. Dr Johnston, when he gave evidence on Thursday,
5 reflected upon, if you like, the reservations that he
6 would have had in terms of getting involved with
7 a patient who wasn't his, to put it in those terms.
8 Perhaps if we could have up on the screen, please, the
9 transcript of what he said. It's 7 March 2013 at
10 pages 178 and 179. If I could start, doctor, halfway
11 down the left-hand page. The doctor is being asked:
12 "Question: If you were simply being asked to erect
13 another bag of IV solution, would that have concerned
14 you?
15 "Answer: I can't remember being asked to do that,
16 but certainly I would have had reservations about doing
17 that on a patient I didn't have clinical information
18 about.
19 "Question: Why is that?
20 "Answer: Why would I have reservations?"
21 The chairman intervenes:
22 "Because it's not your patient?"
23 "Answer: It's not my patient and I don't know
24 whether the bloods were last checked and what the
25 results were, what the patient presented with."

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1 He goes on at line 12 on the right-hand page,
2 doctor, to say --
3 THE CHAIRMAN: Sorry, Mr Wolfe. Look at lines 1 and 2. He
4 says:
5 "You could be potentially taking on a sort of larger
6 job than it first appears."
7 MR WOLFE: That's right, sir. Do you see that, doctor, the
8 top of the page? If we could highlight that.
9 A. Yes.
10 Q. Then counsel then asks:
11 "So although it seems like a simple enough thing,
12 you would want to know a little bit more about the
13 circumstances of that child before you did something as
14 apparently straightforward as that?"
15 So as apparently straightforward as putting up
16 another bag of fluids and, he says yes. The chairman
17 asks:
18 "I take it would be tempting if a bag of fluid for
19 a surgical child had run out, it'd be -- and the nurses
20 can't get a JHO ..."
21 He says:
22 "I can see how a colleague may get into difficulty.
23 I think you sort of have to weigh up your rapport with
24 the nursing staff. You could be quite unpopular with
25 the nursing staff if there was a point-blank refusal to

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1 help out like that. So I can see why some of my
2 colleagues might have done that because they would have
3 perhaps thought that they were helping."
4 Just pause there, doctor. That's one of your
5 colleagues roughly of the same vintage, same passage
6 through the SHO year, expressing reservations about
7 getting involved with a patient with whom he has no
8 familiarity, even for the apparently straightforward
9 task of prescribing a further bag of fluids. Would you
10 like to comment on that?
11 A. I mean -- I think what he's saying is true, but I don't
12 remember any specific conversation with a nurse, but
13 I mean it wouldn't have just been, "Prescribe some
14 fluids", and me then to write them up. There would have
15 been some sort of discussion around it.
16 THE CHAIRMAN: Sorry, you're talking about Raychel now or
17 are you talking about generally?
18 A. Yes. Well, generally, but Raychel as well.
19 THE CHAIRMAN: Okay. Insofar as you believe you would have
20 had some discussion and would not just have said, "Okay,
21 yes, I'll write up a bag of fluids", what would the gist
22 of that discussion have been?
23 A. I would have wanted to know how long Raychel had been on
24 fluid, what she was in hospital with, what the plan
25 would have been, and if it was 24 hours, if she had had

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1 her urea and electrolytes checked.
2 THE CHAIRMAN: And if you got answers which didn't cause
3 alarm bells to ring, then you might be content to go
4 ahead and prescribe the fluid?
5 A. Yes.
6 MR LAVERY: Mr Chairman, I think it might be important to
7 set an amount of context and have the witness asked
8 about what conversations she had or would have had with
9 the nurses at the time.
10 THE CHAIRMAN: Yes. The doctor will correct me if I'm
11 wrong, but I think she said she can't recall
12 a conversation, but the gist of the conversation she
13 thinks she would have had is the conversation she just
14 summarised. If Dr Butler has any more specific
15 recollection, of course I'd be interested to hear it,
16 but I got the impression that you don't have a specific
17 recollection; is that right?
18 A. I don't, no.
19 THE CHAIRMAN: So what you have been telling me is what you
20 believe you would normally have asked in that type of
21 situation?
22 A. Yes.
23 THE CHAIRMAN: It wouldn't be as simple as a nurse coming to
24 you and say, "Child A has run out of fluid, would you
25 prescribe a bag?", you would make a few enquiries before

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1 you would prescribe the bag?
2 A. Yes.
3 THE CHAIRMAN: Can you remember a situation, doctor, in
4 which you declined to do what the nurse asked because
5 your enquiry about that patient did cause you concern?
6 A. I don't remember specifically, but quite often I would
7 have spoken to my registrar for advice.
8 THE CHAIRMAN: So you'd have spoken to?
9 A. The paediatric registrar if I had any concerns.
10 THE CHAIRMAN: Okay.
11 MR WOLFE: Just to put this in context, a request from
12 a nurse, such as you received from probably Staff Nurse
13 McAuley on that day, to prescribe another bag of fluids
14 would not have been unusual?
15 A. No.
16 Q. And on that day -- and perhaps I can push you on this --
17 you were presumably on the ward dealing with paediatric
18 patients and just happened to be available.
19 A. I assume so, yes.
20 Q. Nurse McAuley, who you may have known at the time as
21 Nurse Rice, tells us, doctor, that she can't recall
22 telling you that Raychel had vomited, but she believes
23 she would have told you that Raychel needed fluids as
24 she was still vomiting. So she doesn't have a firm
25 recollection of it, but it's her belief that in asking

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1 you to prescribe the further bag of fluids, it's the
2 kind of thing she would have told you, that Raychel was
3 vomiting. Can you help us with that?
4 A. I don't remember, but I assume if she said that she did,
5 then I don't think that would have been unexpected for
6 a child in Raychel's case, who was about 12 hours since
7 having her surgery. Because sometimes the drugs or the
8 pain relief or the fact that the tummy has been opened
9 can cause vomiting up to 12 hours afterwards.
10 Q. Yes. We know that you entered your name on the
11 prescription. If we could have that up, please, it's
12 020-019-038. It's the top line, doctor. So it's a
13 1,000 ml bag of Solution No. 18, the rate is 80, the
14 pump type is entered, the serial number of the pump, and
15 then you sign off.
16 A. Yes.
17 Q. And then the details on the right-hand side are the
18 nurses checking off what you've prescribed and then
19 erecting the fluids. I think we clarified with you in
20 your witness statement that the handwritten calculation
21 that appears on the top of the page isn't in your hand;
22 isn't that right?
23 A. That's right.
24 Q. This document is a two-sided document. On the reverse
25 side of it is the fluid balance chart. It can be found

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1 at 020-018-037. Just for the record, doctor, would you
2 remember that the documents that have appeared on screen
3 consecutively are two sides of the one coin?
4 A. I don't really remember, to be honest.
5 Q. Do we have the original in the room so that the
6 doctor ... We have it. (Handed).
7 So whether or not you were specifically told,
8 doctor, that the child had been vomiting, the
9 information plainly would have been in your hand.
10 A. Mm-hm.
11 Q. And by the time of your attendance, can we assume that
12 your attendance would have been at some time close to
13 midday --
14 A. I assume so, yes.
15 Q. -- because the nurses are erecting the new bag of fluid
16 at 12.10, according to their record?
17 A. Yes.
18 Q. So by that time, the recording of vomit would have shown
19 on this sheet, if you'd looked at it, a vomit followed
20 by a large vomit.
21 A. Yes.
22 Q. Would the fact that a child had vomited twice, one of
23 which was large, in the previous two or three hours,
24 have been a factor which at that time you would have
25 taken into account in assessing the need or the

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1 desirability of a further prescription of
2 Solution No. 18?
3 A. Well, I don't think it would have been unusual in
4 a post-operative child, and in Raychel's case, to have
5 vomited within 12 hours of surgery.
6 THE CHAIRMAN: Let me ask you about that, doctor, because it
7 leads on to a different area, which is beyond what
8 we are asking you. When you described a few moments
9 ago -- and I'm afraid you don't have the transcript as
10 it comes up -- but what you said on the top of page 20
11 [draft] -- you were being asked by Mr Wolfe about Staff
12 Nurse McAuley, who you would have known then as Staff
13 Nurse Rice, her recollection is that she would have told
14 you something about the vomiting. Your answer was that
15 that wouldn't have been unexpected for a child like
16 Raychel who was about 12 hours after having surgery.
17 Then you said:
18 "Sometimes the drugs or the pain relief or the fact
19 that the tummy has been opened can cause vomiting up to
20 12 hours afterwards."
21 Okay?
22 A. Yes.
23 THE CHAIRMAN: In Raychel's case, the first recorded vomit
24 wasn't until 8 and then there was another one at about
25 10, according to the record. In terms of post-operative

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1 vomiting, would you expect the first 7 or 8 hours to
2 have no vomits and then vomiting to start after that if
3 it is post-operative vomiting?
4 A. I don't really remember from my recollection, but what
5 I do remember is that up until 12 hours I wouldn't have
6 regarded it as unusual or prolonged at that point.
7 THE CHAIRMAN: Right. But once you get beyond 12 hours, if
8 the vomiting does continue on a fairly regular basis for
9 another six hours or eight or ten hours, at that point
10 it is becoming unusual, is it?
11 A. I'd have thought so, yes.
12 THE CHAIRMAN: So although every child's different and some
13 operations, some removals of appendices are more
14 straightforward than others, if a child is still
15 vomiting 15, 18, 20 hours later, that's a cause of
16 concern?
17 A. Yes.
18 THE CHAIRMAN: You see, I've been told -- and I have to say
19 I find it difficult to accept -- that for Raychel to be
20 vomiting through the afternoon into Friday evening and
21 Friday night wasn't unusual. But from what you're
22 saying, that would be a cause of concern if a child was
23 vomiting that long after an operation?
24 A. Hypothetically speaking, I suppose if I'd been asked at
25 3 or 4 or 5 o'clock or later on when Raychel had vomited

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1 more, I think I would have done something differently as
2 opposed to just prescribing IV fluids.
3 THE CHAIRMAN: And the reason that you would have done
4 something differently was because you'd be worried that
5 you were moving beyond what would not be unexpected
6 post-operative vomiting into an area of unexpected
7 vomiting?
8 A. From my experience, yes.
9 THE CHAIRMAN: Thank you.
10 MR WOLFE: Okay, doctor, so in terms of the tasks that you
11 were performing that morning, assuming that you were
12 either told or saw the fact that Raychel had vomited
13 twice, do I understand you as saying that that would not
14 have inhibited you from prescribing the further fluids?
15 A. That's right.
16 Q. Because vomiting at that time would not have been
17 regarded as unusual?
18 A. From my knowledge, it wouldn't have.
19 Q. In terms of whether you actually attended the child and
20 examined her, I think you've told us in your witness
21 statement that the fact that the notes are silent on
22 that, there is no note to reflect the fact that you had
23 carried out an examination, that the likelihood is that
24 you didn't carry out an examination.
25 A. That's correct.

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1 Q. And in fairness to you, I think that tallies with what
2 Staff Nurse McAuley has told us. She has a recollection
3 of bringing the chart to you, perhaps at the nursing
4 station, and asking you to renew the prescription.
5 A. I think that's probably what happened, yes.
6 Q. In terms of Raychel's condition then at that time,
7 can you help us at all in terms of how she was if you
8 didn't see her?
9 A. I don't know. I don't have a recollection of it.
10 Q. And the recollection that you have, doing your best,
11 is that you were told that she was an appendix patient
12 who had been prescribed IV fluids and that the nurse
13 wanted them continued?
14 A. I assume so, yes.
15 Q. In terms of the fluid that Raychel was
16 receiving Solution No. 18, I think you've told us
17 earlier that that wasn't unusual. In fact, that's what
18 you would have expected.
19 A. Yes.
20 Q. Raychel was receiving a fluid at a rate of 80 ml per
21 hour.
22 MR LAVERY: Mr Chairman, just before we move on to the point
23 about Solution No. 18, I think it might be of some
24 assistance if Dr Butler was asked about what she would
25 have done if any concerns had been expressed by any of

25

1 the nurses about Raychel's vomiting.
2 THE CHAIRMAN: Right. But I think, Mr Lavery, the position
3 is that at that point, if the record was and if the
4 position was that there were two vomits by around the
5 time that Dr Butler was briefly involved, then the
6 nurses ... I think the nurses say they weren't
7 concerned and if that's the information that you were
8 given, which you think you may well have been given,
9 then that would not have concerned you either; is that
10 right?
11 A. Yes.
12 MR LAVERY: The point I'm making, Mr Chairman, is if
13 concerns had been expressed by the nurses, what would
14 she have done?
15 THE CHAIRMAN: So if the nurses are saying to you, "Look,
16 we are getting concerned", or, "We have some concerns
17 about this child's condition, she has vomited twice
18 despite the fact that it was a fairly mildly inflamed
19 appendix and the operation went smoothly", can you
20 speculate on what you might have done at that point?
21 A. Well, I may have asked then to speak to a surgical SHO
22 or I may have examined Raychel myself and spoke to the
23 paediatric registrar for advice about what to do.
24 THE CHAIRMAN: In other words, at that point in your
25 training, if concerns were raised with you, you can't

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1 say inevitably what would have happened, but it's likely
2 that you'd have taken some further steps rather than
3 just prescribe the fluid?
4 A. I think I would have taken further advice from -- yes.
5 THE CHAIRMAN: Thank you.
6 MR WOLFE: The rate at which fluids were being prescribed
7 before you came along, doctor, was 80 ml per hour.
8 A. Yes.
9 Q. And you've told us in your witness statement that:
10 "[You] prescribed the same fluid at the same rate as
11 the original prescription because that was the
12 appropriate response for me at that stage [following
13 surgery]."
14 A. Yes.
15 Q. But you've elsewhere told us in your witness statement
16 that you now recognise that the rate was too high.
17 A. Yes.
18 Q. At that stage in your career, doctor, presumably you
19 were aware of how to calculate fluids at a maintenance
20 regime for a child --
21 A. Yes.
22 Q. -- and you would have followed one of the recognised
23 formulas. The inquiry has heard of something called the
24 Holliday-Segar formula. There are various formulas
25 that, broadly speaking, amount to the same thing.

27

1 A. Yes.
2 Q. In terms of continuing these fluids at the same rate,
3 can you help us, did you calculate the appropriate rate
4 of fluid for the child?
5 A. I don't think so because the calculation would probably
6 have been on the sheet and I didn't calculate because,
7 having been through surgery, I imagined her rate had
8 been used to work out her doses of anaesthetic and also
9 to work out her post-operative fluids. Therefore
10 I didn't change it.
11 THE CHAIRMAN: Who would you have assumed had prescribed
12 that rate?
13 A. I'd have assumed it was either somebody in the surgical
14 team or the anaesthetist.
15 THE CHAIRMAN: Right. If you'd been told she was still
16 receiving the preoperative rate of fluid and that there
17 had been no reassessment of that after the operation,
18 would that have surprised you?
19 A. I think it would have, yes.
20 THE CHAIRMAN: Do you recall what your understanding would
21 have been at that time about who would be responsible
22 for post-operative fluids?
23 A. I think, on the ward, generally it was a surgical team,
24 but quite often we were asked to prescribe as well.
25 THE CHAIRMAN: Right. Did you understand at the time that

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1 there might be a difference between a pre-surgical rate
2 and a post-operative rate?
3 A. I don't think I knew that at the time.
4 THE CHAIRMAN: Or that the difference might be because the
5 concern would be about the SIADH, which can lead you to
6 reduce the amount of fluid given post-operatively; did
7 you know that at the time?
8 A. I don't think so.
9 THE CHAIRMAN: Or did you know that children generally got
10 less fluid post-operatively than they did
11 preoperatively?
12 A. I don't think I knew that at the time.
13 THE CHAIRMAN: Thank you.
14 MR WOLFE: In one of your answers, doctor, just before the
15 chairman intervened just there, you said that you think
16 the calculation for the rate would have appeared
17 somewhere in the documentation that you had access to.
18 A. Yes.
19 Q. I don't think that can be correct, or at least the
20 calculation for this rate that was given to Raychel
21 hasn't been set out in any of the documents that the
22 inquiry has seen. What you have said in your witness
23 statement to us is that:
24 "The fact that Raychel had been through surgery some
25 hours previously, you had assumed her weight was used to

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1 calculate her intravenous fluids rate and anaesthetic
2 doses."
3 A. Yes.
4 Q. Is it perhaps fair to say, doctor, that you assumed that
5 the rate applicable to Raychel's prescription had been
6 properly calculated before you got there and you saw it
7 as your job to simply continue with that rate?
8 A. I think that was my assumption at the time, yes.
9 Q. Put it this way: you didn't see any reason or you
10 weren't given any reason to change the rate?
11 A. Not that I remember, no.
12 THE CHAIRMAN: Doctor, what would it have taken for to you
13 consider changing the rate?
14 A. I think if there had been any concerns about Raychel,
15 they probably would have looked at it a bit more
16 closely.
17 THE CHAIRMAN: Would you have had the knowledge or
18 confidence at that point in your training to change the
19 rate itself or is that something that you would have
20 taken to your registrar or referred to a surgical SHO?
21 A. I think if there had been concerns I would have taken it
22 to the registrar.
23 MR QUINN: Mr Chairman, can I come in with one question?
24 The evidence is coming to a close on this bit. Does
25 that then mean this witness is saying that no one

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1 expressed any concerns to her because if they had, then
2 she would have looked at the rate, that is one of the
3 first things she would look at? It seems to be
4 a logical conclusion, but we haven't asked the question,
5 if you see where I'm coming from.
6 THE CHAIRMAN: Yes.
7 You have said, doctor -- let me see if we can get
8 this -- that the reason why you would have been content
9 to prescribe more fluid on the same basis was that you
10 would have checked with the nurse who asked you to do
11 that and whatever information you received would not
12 have caused you any alarm or made you hesitate; is that
13 fair?
14 A. I think that's fair summary, yes.
15 THE CHAIRMAN: So as counsel for the family has asked, does
16 that mean that no concerns were raised with you about
17 Raychel's condition on that Friday morning?
18 A. I think if there had been any concerns, I would have
19 taken it further rather than just continuing to
20 prescribe the fluids.
21 THE CHAIRMAN: Because if concerns had been expressed, you
22 were an SHO who had been about, what, three or four
23 months into paediatric training --
24 A. Yes.
25 THE CHAIRMAN: -- and she wasn't your patient?

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1 A. Yes.
2 THE CHAIRMAN: So you would have thought it necessary to
3 refer to somebody whose patient she was or somebody more
4 senior on your team, namely the registrar?
5 A. Yes.
6 THE CHAIRMAN: Okay.
7 MR WOLFE: Can I ask you this, doctor: if this had been your
8 patient and you were starting from scratch to address
9 the issue of intravenous fluids, would you have had
10 a different approach to the approach you brought to bear
11 in Raychel's case?
12 A. Well, I suppose if this had been my patient I would have
13 possibly admitted her into a ward and taken a history
14 and examined them as well.
15 THE CHAIRMAN: On your evidence, she would also have been
16 involved in the ward round, wouldn't she, with the
17 registrar and consultant?
18 A. Yes.
19 THE CHAIRMAN: So if you were asked to do something with
20 this child or any other child at about midday, it would
21 be on the back of having been on the ward round a few
22 hours previously?
23 A. Yes.
24 MR WOLFE: You've had the opportunity, doctor, I assume, to
25 read the various expert reports that the inquiry has

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1 obtained.
2 A. Yes.
3 Q. You will have seen a report from a Dr Simon Haynes,
4 who's an expert in paediatric anaesthesia.
5 A. Yes.
6 Q. He has said that:
7 "In [his] opinion, the majority of paediatric
8 trainees [of which you were at the time] would always
9 check the weight of a patient and ensure that the
10 correct rate of fluid administration was ordered."
11 And that, in his opinion, you should have done so in
12 this case. Is he right about that, should you have been
13 starting from scratch and assessing the appropriate rate
14 of fluid to give Raychel by considering her weight,
15 considering the circumstances such as her vomiting,
16 things like that?
17 A. I think if I had been giving the initial fluid
18 prescription, I would have, and of course now with
19 hindsight, even on a follow-up bag of fluids, I suppose
20 I wish I had.
21 Q. Is that you wish you had because you now know that
22 there's a criticism of the rate which Raychel was given?
23 A. I suppose I wish I had if in any way it may have made
24 the outcome different.
25 Q. In fairness to you, doctor, and it's important to

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1 balance these things publicly, Dr Scott-Jupp has written
2 a report as well. Have you considered that?
3 A. Yes.
4 Q. And he has reflected the view that it was entirely
5 reasonable for you to continue the prescription in the
6 same way as had been prescribed previously. In terms
7 of --
8 THE CHAIRMAN: It's also fair to say that Dr Haynes is
9 saying he wouldn't have been so concerned about the rate
10 if it had been a different fluid.
11 MR WOLFE: That's right, he does say that as well.
12 THE CHAIRMAN: Can I take it, Mr Quinn, that although
13 there's a degree of concern about what Dr Butler did or
14 didn't do, that the extent of the family's concern about
15 Dr Butler's intervention is reasonably limited --
16 MR QUINN: It is, yes.
17 THE CHAIRMAN: -- and there are other doctors and nurses
18 about whom they have far greater concerns than
19 Dr Butler?
20 MR QUINN: Yes, particularly later in the day.
21 THE CHAIRMAN: I think, in fairness, Dr Butler should know
22 that.
23 That's why I'm just making the point, doctor.
24 MR WOLFE: I have no other questions at this stage.
25 THE CHAIRMAN: Mr Quinn, Mr Campbell, Mr Lavery?

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1 Okay, doctor, unless there's anything else you want
2 to add to the evidence you've already given and to the
3 statements we have, your evidence to the inquiry is now
4 complete.
5 MR WOLFE: Sorry, sir, could I just ask one question about
6 the aftermath? I apologise for that false start.
7 Doctor, when Raychel died, were you informed of that
8 event?
9 A. No.
10 Q. We know that a number of clinicians and nursing staff
11 were invited to a meeting with a Dr Fulton and it was
12 termed a critical incident meeting. Were you aware that
13 such a meeting had taken place at the time?
14 A. No, I wasn't.
15 Q. Can you say, from your memory, when you became aware
16 that a child called Raychel Ferguson had died and that
17 you'd had some, albeit passing, role in her care?
18 A. It was whenever I was first contacted by the inquiry in
19 2005.
20 Q. Right. So although you were working on Ward 6 day and
21 daily at that time, did you hear about a sudden death
22 that had occurred, arising out of the care and treatment
23 on that ward, thinking back?
24 A. I think I may have, but I didn't realise I was involved
25 in any part of it.

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1 MR WOLFE: Very well.
2 THE CHAIRMAN: Do you remember, doctor, the changes that
3 were introduced into Ward 6 in June 2001, like the
4 replacement of Solution No. 18?
5 A. I don't remember it happening at that time and I left
6 Altnagelvin at the end of July in 2001.
7 THE CHAIRMAN: Okay. Thank you very much. You're now free
8 to leave.
9 (The witness withdrew)
10 THE CHAIRMAN: Let's take a 10-minute break at this point.
11 We'll start at about 11.15.
12 (11.03 am)
13 (A short break)
14 (11.23 am)
15 MRS SANDRA GILCHRIST (called)
16 Questions from MR WOLFE
17 MR WOLFE: Good morning, staff nurse.
18 A. Good morning.
19 Q. Could I ask you to confirm that you've provided two
20 witness statements to the inquiry and that you wish to
21 adopt them as part of your evidence?
22 A. Yes.
23 Q. You qualified as a registered general nurse
24 in February 1987; is that correct?
25 A. That's correct, yes.

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1 Q. And your post-qualification experience was initially in
2 adult nursing; isn't that correct?
3 A. Yes.
4 Q. Just outline, if you would, the history then of coming
5 into paediatric nursing as part of your career.
6 A. I worked on a surgical ward after qualification for
7 about six or seven months, then I moved to a
8 care-of-the-elderly setting for about a year and a half
9 and then I worked in an infectious control paediatric
10 unit for about a year and a half.
11 Q. That was in the Waterside Hospital?
12 A. That was in the Waterside Hospital, yes. Then it closed
13 and the staff were to be cared for then in Altnagelvin
14 Hospital, so the staff that were there in the infectious
15 control unit all moved up to the Altnagelvin site in
16 1990.
17 Q. And that's when you started as a D-grade nurse in
18 Altnagelvin round about May 1990?
19 A. Yes.
20 Q. And of course you've been there ever since.
21 A. Yes.
22 Q. June 2001, were you still a D-grade nurse or had
23 you been --
24 A. D grade.
25 Q. And I understand that you're now a nursing sister on the

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1 paediatric ward.
2 A. That's correct, yes.
3 Q. When did you take up that role?
4 A. It'd be about three years ago, September.
5 Q. Again, after 2001, some time in or about 2004, you
6 obtained a diploma in children's nursing --
7 A. Yes.
8 Q. -- whereas your qualification at the time of nursing
9 Raychel was a general nursing qualification.
10 A. Yes, adult nursing.
11 THE CHAIRMAN: But with more than 10 years' experience of
12 nursing children?
13 A. Yes.
14 MR WOLFE: Have you been at the inquiry to hear any of the
15 evidence to date?
16 A. Last Monday I was here for half a day, yes.
17 Q. We've heard that the Ward 6 in which you nursed in 2001
18 and still nurse today was a mixed paediatric and
19 surgical ward.
20 A. Yes.
21 Q. And you've told us in your witness statement that, in
22 terms of your experience, it would have been that
23 mixture of surgical paediatric and medical paediatric
24 patients.
25 A. Yes.

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1 Q. In terms of surgical experience, you would have had
2 experience of nursing for children who have gone through
3 the common range of childhood operations, such as
4 appendicectomy.
5 A. Yes.
6 Q. Could I have up on the screen, please, your CV as such?
7 If we could look at WS053/1 at page 1, please. You have
8 helpfully set out, staff nurse, an impressive list of
9 training that you've received over the years. Can I ask
10 you some questions about some of those? About seven or
11 eight down, you attended an IV additives course
12 in February 1997.
13 A. Yes.
14 Q. What was covered in that course?
15 A. Giving IV antibiotics only.
16 Q. So this would be a course dealing with the situation
17 where a child needed antibiotics to be delivered by an
18 intravenous mechanism?
19 A. That's correct, yes.
20 Q. That course didn't deal with intravenous fluids per se?
21 A. No.
22 Q. You attended a basic life support training in July 1997.
23 A. Yes.
24 Q. Did that deal with the use of fluids for resuscitation
25 purposes?

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1 A. Then, no, it did not, no.
2 Q. In 1999, a few lines down, you did paediatric
3 resuscitation in August 1999.
4 A. Yes.
5 Q. Again, did that deal with the use of fluid boluses for
6 the purposes of resuscitation?
7 A. No, it did not, no.
8 Q. You went on to do paediatric resuscitation
9 in February 2004 and May 2005. Again, at that time did
10 the course encompass any learning in relation to fluid
11 management?
12 A. It would have done, yes.
13 Q. And can you help us by comparing and contrasting the
14 course pre-2001 with the course that you did in 2004 in
15 paediatric resuscitation?
16 A. I'd have said there would have been more -- I'm not
17 exactly sure the differences between the two at that
18 time because it was a while ago, so I can't honestly
19 say.
20 Q. Are you telling us that the one in 2004 more involved
21 the use of fluids -- fluid management of children for
22 resuscitation purposes?
23 A. I can't recall if there was a difference between the two
24 at this time.
25 Q. In terms of the number of patients who would have been

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1 on the surgical side in 2001 on Ward 6, the evidence
2 that the inquiry has heard would suggest that the
3 majority were paediatric medical patients.
4 A. That's right, yes.
5 Q. And really, if we look at your statement, you seem to be
6 confirming that:
7 "Three or four patients at any one time would have
8 been surgical."
9 A. That would have been about average, yes.
10 Q. You've said in your witness statement that -- perhaps if
11 we can go to WS053/2 at page 2. At the bottom of the
12 page you're asked to quantify the experience you had
13 gained of working with patients on a paediatric ward
14 by June 2001. You set out the kinds of experience that
15 you had and they're typical medical problems that would
16 be catered for by the paediatricians.
17 A. Yes.
18 Q. You say you also learnt that:
19 "Caring for children is a lot different than caring
20 for adults inasmuch as their bodies' responses to
21 illness and trauma."
22 A. Yes.
23 Q. So what you're doing there is helpfully comparing your
24 experience as an adult nurse with the experience that
25 you had gained as a children's nurse.

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1 A. Yes.
2 Q. And what exactly are you trying to convey, staff nurse,
3 when you say that there's a difference "inasmuch as
4 their bodies' responses to illness and trauma"?
5 A. Children react differently, it's in their make-up.
6 Dealing with trauma or illness would -- there's just
7 a different protocol or different guidelines on how to
8 treat them. You also learn that when you're caring for
9 children as much as the child, you're caring for the
10 whole family.
11 Q. Yes.
12 A. But anatomically, they respond differently, so their
13 treatment would be different.
14 Q. So what you're highlighting there is the fact that
15 children's nursing is a specialism, it involves
16 a particular type of knowledge, a particular type of
17 skill set --
18 A. Yes.
19 Q. -- which is different to the adult setting?
20 A. Yes.
21 Q. In caring for children, do you have to be more watchful,
22 more sensitive to changes than in the adult setting?
23 A. I would say you would do because children tend to cope
24 better with illness for a while before becoming unwell
25 quickly, whereas adults would tend to become unwell

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1 gradually over a period of time.
2 Q. So if you're right, if a child can just drop off and
3 become ill without much in the way of warning --
4 A. Yes.
5 Q. -- does that necessarily suggest that, as a children's
6 nurse, you have to be careful with your observations and
7 your monitoring --
8 A. Yes.
9 Q. -- and you have to look for telltale signs?
10 A. Yes.
11 Q. One of the things, staff nurse, that the inquiry is
12 interested in is to try and log or chart the extent to
13 which nurses -- and indeed clinicians, for that
14 matter -- had a knowledge by 2001 or an experience of
15 managing children's fluid requirements. In general
16 terms, how would you describe your experience or skills
17 at that point in time?
18 A. Sorry, in dealing with what?
19 Q. In dealing with, let's be fairly specific,
20 post-operative fluid requirements for a child.
21 A. Well, generally at that time it would have been usual
22 that a child would be on IV fluids post-operatively
23 until their oral intake dictated that the fluids were to
24 be reduced and then stopped.
25 Q. I don't wish to deal with this with you in any great

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1 detail, but was it your experience that the practice at
2 Altnagelvin at that time was for preoperative fluids to
3 be prescribed post-operatively without any change?
4 A. Yes.
5 Q. Just to flesh that out: a prescription would be written
6 preoperatively by the surgeon, typically --
7 A. Yes.
8 Q. -- the child would have her or his operation --
9 A. Yes.
10 Q. -- and then unless something exceptional happens, the
11 nurses would pick up the prescription again
12 post-operatively and apply the same fluid at the same
13 rate?
14 A. Yes.
15 Q. And that was your experience?
16 A. Yes, it was.
17 Q. And typically, the fluid would be Solution No. 18?
18 A. It would, yes.
19 Q. And in surgical cases, is it fair to say also that your
20 experience was that the person or the team who had
21 responsibility for the post operative fluids was the
22 surgeon, unless the anaesthetist made a specific
23 intervention?
24 A. Yes, it was, yes.
25 Q. In terms of managing a child's fluid balance, you were

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1 aware -- and indeed we'll look at it in terms of the
2 entries you made -- that at that time there was a fluid
3 balance chart that required to be completed --
4 A. Yes.
5 Q. -- every hour?
6 A. Yes.
7 Q. And as part of a child's care plan, if they were in
8 receipt of intravenous fluids post-operatively, it would
9 be typical to record on that fluid balance chart items
10 such as urinary output; yes?
11 A. Yes.
12 Q. Any intake such as oral fluids would be recorded.
13 A. Yes.
14 Q. And output such as vomit would have to be recorded.
15 A. Yes.
16 Q. And the expectation would be, with regard to each of
17 those matters, that a nurse would record them throughout
18 the patient's stay in hospital.
19 A. Yes.
20 Q. You look as if you want to add something to that; no?
21 A. No, it's okay.
22 Q. In terms of your own education in the area of fluid
23 management, can I ask you this: the experts that have
24 looked at this area from the nursing angle for the
25 inquiry have advised us, advised the inquiry, that in

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1 nursing syllabuses, nurses were taught about issues
2 relating to the body's ability to maintain fluid balance
3 and they were told about the disease processes that
4 would cause disturbance of it. Can I ask you whether,
5 in the nursing education that you had before 2001, you
6 would have received that kind of teaching in your
7 training?
8 A. I would say I would have done, but it was 1984 when
9 I started my training, so I can't remember specifically
10 what training I had about fluid balance.
11 Q. I think you've told us that in terms of what was handed
12 down to you in terms of formal training at Altnagelvin
13 changed after 2001 in that you received specific
14 training from Dr Nesbitt; isn't that right?
15 A. Yes.
16 Q. But before 2001, there wasn't anything in terms of
17 formal training or instruction to be had at Altnagelvin
18 in this broad area of fluid management?
19 A. No.
20 Q. Leaving aside what you might have had in your training
21 as a nurse, presumably you learned a lot from working on
22 the ward day-to-day.
23 A. Yes.
24 Q. Have you read the report of Ms Sally Ramsay, which was
25 prepared for the inquiry?

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1 A. Yes.
2 Q. She has said that at a minimum she would expect
3 a registered nurse to be aware that fluid loss from
4 vomiting, if not replaced intravenously, can result in
5 dehydration and electrolyte imbalance.
6 A. Yes, I've read that, yes.
7 Q. Thinking back to 2001, would that accurately summarise
8 your state of knowledge at that time?
9 A. Well, at that time, I believed if a patient was
10 receiving maintenance intravenous fluids then that would
11 make up for any losses that they had either through
12 vomiting or diarrhoea.
13 Q. So breaking that down, what that means is that if
14 a child was receiving Solution No. 18 -- because that
15 was the maintenance fluid of choice at that time, isn't
16 that right?
17 A. Yes. That's correct.
18 Q. You thought that if a child was vomiting, but in receipt
19 of intravenous fluids such as Solution No. 18, they
20 would be okay?
21 A. That's what I believed, yes.
22 Q. Leaving aside this issue of what fluid a child might
23 get, but just dealing with the issue of an electrolyte
24 problem, you would have recognised that at that time
25 that a child vomiting on a prolonged basis would be at

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1 risk of suffering an electrolyte problem?
2 A. At that time I believed that the major issue would have
3 been dehydration rather than electrolyte imbalance. In
4 2001, that's what I believed.
5 Q. In terms of a nursing response to prolonged vomiting,
6 how would you characterise your role if a child was
7 vomiting repeatedly during the day, perhaps having
8 a mixture of small, medium and large vomits? What is
9 the nursing function if that is happening?
10 A. Well, it would be to record the vomits, first of all,
11 and then I would seek medical advice and ask medical
12 doctors to come and assess the child or see a child and
13 go on their instruction.
14 Q. The inquiry has heard some evidence that in terms of
15 carrying out electrolyte profiles on children who might
16 have diarrhoea or might have vomiting, that wasn't
17 something that was part of the surgical arrangements
18 that, to put it bluntly, the surgical team were less
19 regular in terms of arranging electrolyte profiling for
20 their children.
21 A. Well, in 2001, the electrolyte profiles would be done on
22 medical patients at least 12-hourly. The surgical
23 patients, they would not have been done -- every
24 24 hours. So ... Sorry, 24-hourly, I meant to say, for
25 medical patients.

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1 THE CHAIRMAN: And that was automatic, they would be done at
2 least every 24 hours and if there was any particular
3 cause they might be done more often? On the medical
4 side the minimum was 24 hours.
5 A. Yes.
6 THE CHAIRMAN: And on the surgical side, there just wasn't
7 a practice?
8 A. No.
9 THE CHAIRMAN: Okay. When Mr Wolfe asked you about
10 prolonged vomiting there and you said you would seek
11 advice from doctors, can I get from you, sister, what
12 you regard as prolonged vomiting? You heard Dr Butler
13 this morning.
14 A. Yes.
15 THE CHAIRMAN: Dr Butler was saying that if post-operative
16 vomiting goes on for more than 12 hours, she regards
17 that as causing concern and that's the point at which
18 she would think about what else might be done. But
19 I have been told that -- and I have to say, it does seem
20 to me to be remarkable -- the fact that Raychel was
21 vomiting through the day, through the afternoon and into
22 the evening didn't cause some of your nursing colleagues
23 to be concerned because they regarded that as normal or,
24 if not normal, not unusual.
25 A. It did happen that post-operative patients did vomit,

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1 but when I noted her vomits at 9 and then afterwards,
2 I did contact a doctor to come and see her.
3 THE CHAIRMAN: Is that because you recognised that vomiting
4 was going on for too long?
5 A. Looking back at her fluid balance chart, I could see
6 that she had been vomiting during the day, but it was
7 the coffee-ground vomit and then the three small ones
8 that I witnessed and recorded. She was obviously in
9 discomfort, so that's why I contacted the doctor to
10 assess her.
11 THE CHAIRMAN: Thank you.
12 MR WOLFE: You've expressed the view that in the presence of
13 vomit or diarrhoea, the use of an intravenous fluid --
14 and at that time it was Solution No. 18 -- would have
15 given you comfort that the child wouldn't come to any
16 great harm: is that a reasonable summary?
17 A. Then, yes.
18 Q. Again, if I could just put to you what Ms Ramsay has
19 said about this. She has said that this assumption,
20 which is reflected in your evidence, that when an
21 infusion of intravenous fluids is in place, that the
22 child is therefore getting adequate hydration,
23 regardless of their output and regardless of any other
24 intake, that that assumption that it was all safe, if
25 you like, is surprising in her view. In other words, at

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1 that time in 2001, should you not have appreciated that
2 by giving a child a low-sodium fluid, such as
3 Solution No. 18, was not likely to be sufficient to
4 replace the losses that a child would be suffering from
5 vomiting?
6 A. Well, in 2001, I would have believed that they were
7 using the best solution or intravenous solution because
8 all the surgical consultants and medical consultants and
9 everyone in the hospital who worked with kids knew that
10 that was the solution that we used and there had never
11 been any issues raised before or that I was aware of.
12 Q. Had you any experience of working with patients who
13 might have been on Solution No. 18, but when electrolyte
14 profiling came back to show some kind of imbalance, the
15 fluid was then changed or supplemented with potassium or
16 sodium?
17 A. If the potassium had been low, I know we would have
18 changed to Solution No. 18 with added potassium already
19 made up. I can't remember nursing a child who had low
20 sodium. I may have done before that, before 2001, but
21 I just can't recall caring for anybody who had a low
22 sodium.
23 THE CHAIRMAN: Can you give me an example of circumstances
24 in which a child might be low in potassium? Was that
25 from gastroenteritis?

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1 A. It could be, but also children who were asthmatics and
2 who were on salbutamol had the potential too to drop
3 their sodium [sic].
4 THE CHAIRMAN: Thank you.
5 MR WOLFE: And since 2001, sister, as reflected in your
6 witness statement, you now have a better understanding
7 of the appropriate approach to fluid management.
8 A. Yes, definitely.
9 Q. And you've said that you now know that it's not enough
10 just to replace fluids but that appropriate --
11 Mr Campbell?
12 MR CAMPBELL: Mr Chairman, I'm told by one of the personnel
13 from the board that perhaps at line 17 [draft], the
14 answer should have read "potassium".
15 THE CHAIRMAN: You are quite right because I think this
16 witness has -- yes, she was giving examples of when the
17 potassium level might drop, not the sodium.
18 MR CAMPBELL: I think she may have said "sodium", but I
19 think she meant potassium.
20 A. I meant potassium. Sorry about that.
21 THE CHAIRMAN: That's okay. That's the last word in the
22 answer at line 17 [draft]. Thank you.
23 Just while we're on that, had you seen a child's
24 bloods come back low in sodium before that you can
25 remember?

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1 A. Not that I can recall.
2 THE CHAIRMAN: Okay, thank you.
3 MR WOLFE: Just recapping on what your understanding
4 improved to in the post-2001 period. You did attend
5 at the talk series that Dr Nesbitt prepared; isn't that
6 right?
7 A. Yes.
8 Q. And you learned that it was not enough just to replace
9 fluids, but appropriate IV fluids must be used,
10 depending upon the electrolyte condition of a patient?
11 A. That's correct, yes.
12 Q. And you also learned that the efficacy of the fluid must
13 be monitored with regular blood electrolytes.
14 A. That's correct, yes.
15 Q. To what extent in the pre-2001 period were nurses
16 dependent upon doctors, whether on the surgical or
17 medical side, for changing a child's fluid make-up?
18 A. Sorry, could you repeat that again?
19 Q. Before 2001, would you agree with me that the nursing
20 role was largely to monitor and observe a child and to
21 report any changes to doctors and any concerns to
22 doctors?
23 A. Yes.
24 Q. Would it ever have been part of your role as a nurse to
25 suggest to a doctor that they might consider electrolyte

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1 profiling of a patient?
2 A. In 2001 or before 2001, I would have seen it as the
3 doctor's role to realise when an electrolyte profile
4 would needed to have been taken.
5 THE CHAIRMAN: I've heard of every now and again that
6 a nurse might be concerned about what's happening with
7 a child and there might be a sort of young-ish or junior
8 doctor in and the nurse might give a steer to that
9 doctor or direct him or her towards one way forward
10 rather than another way forward.
11 A. That could be [inaudible: no microphone].
12 THE CHAIRMAN: So the doctor still has to be the one who
13 takes the bloods --
14 A. That's correct.
15 THE CHAIRMAN: -- and orders the testing, but the nurse can
16 steer the doctor in a way she thinks is appropriate;
17 is that right?
18 A. Yes, that could be correct, yes.
19 THE CHAIRMAN: Particularly with the junior doctors in
20 surgical who really were quite junior?
21 A. Believing that they were doctors, I would assume that
22 they would have better knowledge of when to do bloods or
23 when to change fluids.
24 THE CHAIRMAN: Okay, thank you.
25 MR WOLFE: In 2001, before June 2001, would you have had the

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1 knowledge to understand when an electrolyte profile
2 might usefully be done?
3 A. It's very difficult to say now, but I would assume that
4 I'd have some knowledge then when it would have to be
5 done, but as I say, you're reliant on doctors to have
6 the knowledge and the expertise to know when they would
7 have to be done.
8 Q. Taking it out of the technicalities of when an
9 electrolyte profile might usefully be done or when
10 concerns are such that it perhaps should be done, can
11 I ask you this more general question: as the inquiry
12 understands it, the first response generally to a nurse
13 looking for assistance for a surgical patient tended to
14 come from a junior house officer.
15 A. That's correct, yes.
16 Q. Is that your experience too? And junior house officers
17 on the surgical side, by the standards of the time,
18 would be on a six-month rotation in that field or in
19 that discipline; isn't that right?
20 A. That's correct, yes.
21 Q. And in the nature of things would be typically
22 inexperienced in terms of dealing with paediatric
23 surgical patients.
24 A. Yes.
25 Q. And therefore, would you agree with the synopsis of some

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1 of the experts who have looked at this, who say that
2 junior doctors are often beholden to the greater
3 experience of paediatric nurses to enable them to
4 understand when a child is ill to the extent that the
5 patient might need a medical review?
6 A. Well, if I'd contacted the surgical JHO, if they had
7 concerns, I'd expect them to escalate them up to their
8 SHO or their registrar.
9 Q. But in terms of looking at it from the nursing side, is
10 it not the nurse's responsibility to provide all of the
11 relevant information and then, if you like, a prompt to
12 the effect that this child needs looked at by somebody
13 more senior than a JHO?
14 A. It would depend on the child's condition.
15 Q. So it may be difficult to analyse this in this general
16 way. We'll look at the specifics in Raychel's case in
17 a moment. But as a general proposition, you would agree
18 that the nursing role is to communicate effectively with
19 the doctors and to reflect any concerns that they might
20 have about a child?
21 A. That's correct, yes.
22 Q. Could I bring you to the events of 8 June 2001? On that
23 night, you came on duty to work a night shift on Ward 6
24 at or about 7.45 in the evening.
25 A. Yes.

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1 Q. And the inquiry has heard that you were part of
2 a three-nurse team, comprising Staff Nurse Bryce and
3 Staff Nurse Noble. There was also a nursing auxiliary
4 on duty called Ms Lynch.
5 A. That's correct, yes.
6 Q. And there was another nurse called Staff
7 Nurse Patterson, but she was primarily working in the
8 infant unit on that evening.
9 A. Yes.
10 Q. Does all of that accord with your memory?
11 A. Yes.
12 Q. The nurse in charge that night was Staff Nurse Noble.
13 A. Yes.
14 Q. In terms of the allocation of work that night, sister,
15 can you recall how the work was to be carried out?
16 There were three nurses on Ward 6. How were you
17 expected to do your duties by each particular patient?
18 A. Well, we weren't allocated areas to work or specific
19 patients to work. The nurse in charge would have done
20 the medicine round and myself and the other nurse,
21 Nurse Bryce, would have done the observations on the
22 children for the night or for that evening.
23 Q. And so just looking at this a little bit further, the
24 nurse in charge, Nurse Noble, is doing the medicine
25 round --

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1 A. Yes.
2 Q. -- and the time taken to do that can presumably vary,
3 but typically it would take a couple of hours to do that
4 up and down the ward?
5 A. It could have done, yes.
6 Q. Of course, it can be a slow process and notes have to be
7 made and that kind of thing. In terms, then, of the
8 observations, that leaves the two of you -- that's
9 Staff Nurse Bryce and yourself -- to focus on
10 observations.
11 A. Yes.
12 Q. And does Staff Nurse Noble come into that area of work
13 after she's finished with the medications?
14 A. After that?
15 Q. Yes.
16 A. She could have been involved in any observations that
17 were done after that, after she'd finished the
18 medicines. Her role just didn't stop at doing
19 medications.
20 Q. Yes. We know, and we'll look at this in a moment, that
21 you carried out observations on Raychel as part of her
22 four-hourly care plan --
23 A. That's correct, yes.
24 Q. -- at 9.15 or thereabouts. And then she would next be
25 seen just after 1 o'clock on the care plan. But aside

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1 from those formal observations that are carried out
2 four-hourly, what is are responsibilities, aside from
3 that, during the night?
4 A. Well, because Raychel was on intravenous fluids and all,
5 we would have been in with her every hour -- one of us
6 would have anyway -- to check the fluid balance --
7 sorry, check the IV cannula site and the drip was set to
8 alarm every hour, to alert us to go and do that and put
9 on her fluids for another hour.
10 Q. In terms of how you communicated as a team, it would
11 obviously be important for you to be telling your nurse
12 colleagues about any developments with patients, any
13 issues of concern.
14 A. Yes. Well, that went on all the time because you worked
15 as part of a team.
16 Q. And of course, there are written records as well that
17 could be consulted.
18 A. Yes.
19 Q. In terms of the surgical or medical resources that were
20 available to you on that night, as you've indicated that
21 typical first port of call for a surgical patient, if
22 you needed assistance, was a JHO; is that right?
23 A. Yes.
24 Q. Just to be clear, if you thought that a child had
25 a particular difficulty or was causing you a particular

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1 concern, did you have to go straight to the JHO or
2 could you escalate it yourself?
3 A. We could escalate it ourselves, but it would have
4 depended on the condition of the child or the urgency.
5 Q. So if it was an urgent matter of concern, you could have
6 made a decision to call in an SHO?
7 A. Yes.
8 Q. And typically, surgeons wouldn't be a constant presence
9 on the paediatric ward at night. You would have to, if
10 you like, call them in using the bleep or another
11 communication system, such as the telephone.
12 A. Yes.
13 Q. Whereas, is it fair to say, that there would always be
14 a paediatrician on the ward --
15 A. Always? No.
16 Q. -- at night? No?
17 A. No.
18 Q. Where would a paediatrician typically be at night?
19 A. They could be on the ward or in the infant unit, which
20 would be the floor below, or they could be in the neonatal
21 unit. There are various places they could have been.
22 Q. You attended a nursing handover that night; is that
23 right?
24 A. That's correct, yes.
25 Q. Is that typically quite a formal affair in that you

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1 would report to sister's office or some room somewhere
2 and sit down and listen to the various reports?
3 A. Yes. It would be in an office -- it's usually opposite
4 room I -- and we sit down and we hear of all the
5 patients on the ward.
6 Q. Can you recall who delivered it that night?
7 A. No, I can't recall.
8 Q. In terms of your previous exposure to Raychel as
9 a patient, you hadn't worked the previous night; isn't
10 that right?
11 A. That's correct, yes.
12 Q. So you were coming to Raychel's case fresh for the first
13 time on the evening of 8 June?
14 A. Yes.
15 Q. And could I have up on the screen, please, the record of
16 the handover, which was apparently delivered on that
17 night, at 063-032-076?
18 The information that we've received so far, sister,
19 is that broadly speaking, the nurse who is delivering
20 the handover will have received a series of printouts
21 relating to each patient on the ward. And while the
22 individual nurse delivering the handover may not have
23 particular knowledge of a patient, this document here --
24 or a document of this type -- contains a summary of
25 a patient's condition and helps that nurse to deliver

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1 relevant information at the handover.
2 A. Yes.
3 Q. And this document, if we could highlight the bottom
4 third or so -- it seems -- and you may not have
5 a specific memory of this, but help us if you can --
6 that at the handover you and your colleagues would have
7 been told that, in Raychel's case, her observations
8 appeared satisfactory, she continued on the antibiotic
9 PR Flagyl, that she'd vomited three times that morning,
10 but had been tolerating small amounts of water in the
11 evening. But then there is a development. She was
12 vomiting that afternoon and IV Zofran was given with
13 fair effect. And of course, this is all wrapped around
14 the fact that Raychel was an appendicectomy patient who
15 had had her operation some 20 hours or so earlier.
16 Broadly speaking, can you remember that this kind of
17 information would have been given at handover?
18 A. The nurse who was giving the handover would have used
19 this document to deliver the handover. I can't recall
20 exactly what words were said at the handover.
21 Q. Is it fair to say that although you can't remember
22 specifics of the handover, that you were not given any
23 information that caused you any concern about Raychel at
24 that stage?
25 A. Not that I can recall, no.

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1 THE CHAIRMAN: Sorry, just let me pause you there. If the
2 information that you received was what is set out on
3 that document in front of you, that would tell you that
4 she vomited three times this morning, she was sipping
5 some water, then she was vomiting again in the afternoon
6 and she had received an anti-emetic.
7 A. Mm-hm.
8 THE CHAIRMAN: So what does that suggest to you, that she
9 has been unwell, but the anti-emetic has brought things
10 back under control again?
11 A. That's what I would have believed, yes.
12 THE CHAIRMAN: Right. I don't want to overanalyse it,
13 sister, but when it says, "IV Zofran given with fair
14 effect", what does "fair effect" mean to you?
15 A. I'm not sure what the person meant when they wrote that,
16 but I thought it would have been ... I don't know what
17 "fair" would indicate. I don't know what the person
18 would indicate by that. I would thought it would be
19 effective.
20 THE CHAIRMAN: Would you interpret that, if this is what you
21 were told or read, to mean that the anti-emetic had
22 worked?
23 A. I would have done, yes, because I would expect somebody
24 to add something to the end of it if she'd vomited
25 afterwards.

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1 MR WOLFE: In terms of the sources of information available
2 to nursing staff such as you, commencing their night
3 shift and not having previously dealt with a patient,
4 would it be typical to read up on the other notes that
5 are available, such as what's on the chart, for example?
6 A. Well, if it was the first time you were going to
7 a patient and taking and recording their observations or
8 anybody's observations, you would have been looking at
9 previous observations and anything else that was
10 available at the bottom of the bed.
11 Q. So you have the handover, you get the information that's
12 conveyed at that stage, and it's when you then go to the
13 patient's bedside, so for example you're doing to do the
14 observations or you're going to check on the intravenous
15 drip --
16 A. Yes.
17 Q. -- that would be the point in time at which you would
18 then dip into or read the chart?
19 A. Yes.
20 Q. You have recalled in your witness statement for the
21 inquiry that your first dealings with Raychel were
22 triggered by her father contacting you.
23 A. Yes.
24 Q. And he contacted you to change the bed linen on
25 Raychel's bed because she had vomited on it?

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1 A. Yes.
2 Q. You sought the assistance of Nursing Auxiliary Lynch to
3 help you with that.
4 A. Yes. As far as I can remember, yes.
5 Q. I ask you about that small detail because you'll recall
6 that when you initially provided a witness statement on
7 10 June 2001 -- a very short period after the events you
8 were involved in -- you had remembered that it was
9 Staff Nurse Bryce who had assisted you with that task.
10 A. Yes.
11 Q. But in your subsequent statements you have changed that
12 and you've indicated that it was Ms Lynch who was
13 involved.
14 A. I can't fully recollect which of them it was. I think
15 it was one of them, but I just can't recollect exactly
16 which of them it was.
17 Q. I think Ms Lynch would say it was her and Ms Bryce would
18 say that it wasn't her, if you follow.
19 A. Yes.
20 Q. In any event, you did attend to Raychel's bedside and
21 you changed the bed linen; is that correct?
22 A. That's correct, yes.
23 Q. Can you recall who was there at the time?
24 A. As far as I can remember, it was Mr Ferguson with
25 Raychel.

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1 Q. Was it your impression that Raychel had recently
2 vomited?
3 A. And that's why I was changing the bed, is that what you
4 mean?
5 Q. Yes.
6 A. Yes.
7 Q. That makes sense, doesn't it, because if there had been
8 vomit on the bed, the parents wouldn't want it present
9 in that state for any particular length of time?
10 A. No.
11 Q. This event of being summoned to Raychel's room to change
12 the bed linen happened shortly after the handover, the
13 nursing handover.
14 A. Yes.
15 Q. And the handover took place at or about 8 o'clock.
16 A. Approximately, yes.
17 Q. Does it typically start at about 7.45 and finish at
18 about 8?
19 A. It could take any time up until 8.30. It depended on
20 how many children were on the ward and who was giving
21 the handover.
22 Q. Yes. And the vomit that had made its way on to the bed
23 linen, that wasn't recorded in any note that you made.
24 A. No.
25 Q. It should have been recorded in a note, should it?

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1 A. Yes.
2 Q. Raychel, as we know, had had an anti-emetic at or about
3 6 o'clock, and it was now sometime between 8 and 8.30;
4 isn't that right?
5 A. I can't be sure of exactly the time, but it sounds
6 reasonable, yes.
7 Q. So she was vomiting, on this account, within two,
8 two-and-a-half hours of receiving the anti-emetic.
9 A. Yes.
10 Q. We know, as time moves on, you come and formally do the
11 observations at or about 9.15. What was Raychel's
12 condition, can you recall, at the time you were changing
13 the bed linen?
14 A. The time I was changing the bed linen?
15 Q. Yes.
16 A. She got out of the bed to sit beside the bed on the
17 chair, from what I can recall, and that her dad was
18 there at the time. Once we had changed the bed, it
19 wasn't long afterwards that she had vomited again and it
20 was into a vomit bowl.
21 Q. Could I ask you this: Mr Ferguson's recollection is that
22 shortly after vomiting on the bed, the bed linen was
23 changed, as you describe, but she vomited again on to
24 the bed linen, and it was changed again; is that your
25 recollection?

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1 A. I only recall changing the bed the once.
2 Q. And it's his recollection that during the time that it
3 took to change the bed linen, Raychel was made to stand
4 or was standing, yet she could hardly stand, and this
5 made Mr Ferguson very concerned and indeed upset to the
6 extent that he phoned his wife and complained that the
7 nurses weren't listening to him and weren't apparently
8 taking Raychel's condition seriously.
9 You can't remember changing the bed a second time;
10 is that right?
11 A. No.
12 Q. And in terms of the condition of the child at the time
13 that you did change the bed, is it fair to say that she
14 didn't look very well?
15 A. She looked pale. I can't remember anything more
16 specific than that. I remember -- I just recall her
17 sitting in a chair at the side of the bed. I don't
18 remember getting her to stand. I might have asked her
19 to stand, maybe she sat on the chair at the side -- I'm
20 not 100 per cent sure.
21 Q. In terms of any discussion that you might have had with
22 her, can you recall anything?
23 A. I don't recall what I said to her, no.
24 Q. So here we are at or about 8.30, you've just had the
25 handover, you're aware that Raychel has vomited in

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1 a setting where she's, in recent times, just had an
2 anti-emetic. Were you aware at that time that the
3 vomiting that had started at 8 am that morning had
4 preceded an initial phase after her surgery where she
5 appeared to be recovering quite well? In other words,
6 after her operation finished at midnight the night
7 before or 1 o'clock the night before, she didn't vomit
8 and had appeared to be coping very well. Were you aware
9 of that at that time?
10 A. Well, post-operative vomiting wouldn't have been that
11 unusual. It did happen. Not in every case, obviously,
12 but her prolonged vomiting or periods of vomiting,
13 whenever I was with her that evening, prompted me to
14 phone the doctor to assess her.
15 Q. Yes. We'll come to that in stages. But just pausing at
16 or about 8.30 in a usual case or in a case which might
17 be thought typical of a mild appendicitis, would you
18 have thought or envisaged that she should have been
19 mobile at that point, not vomiting, consuming maybe some
20 light food and generally being up and about?
21 A. I wouldn't have thought she would be eating. I thought
22 at that time a post-operative child might have been
23 tolerating sips, but every one of them are completely
24 different, so I couldn't really say that most children
25 would have been, no.

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1 THE CHAIRMAN: Okay.
2 MR WOLFE: You say that Raychel vomited shortly after the
3 incident where she'd vomited on the bed linen. That's
4 the first vomit that you record then on the fluid
5 balance chart, is it?
6 A. Yes.
7 Q. And could we have that up on the screen, please? It's
8 to be found at 020-018-037. You make an entry:
9 "Vomiting coffee grounds plus plus."
10 Is that right?
11 A. Yes.
12 Q. So this is the first time that you pick up this document
13 and you make that entry. So in terms of what you knew
14 at that time, you've had the nursing handover and then
15 you're getting, if you like, a more detailed picture
16 from this document: is that fair?
17 A. Yes.
18 Q. And in terms of what had gone before, you would have
19 seen a vomit at 8 o'clock, a large vomit at 10 o'clock
20 or thereabouts, and the fact that she passed urine at
21 that point. And then later in the day at 1 o'clock,
22 "vomited plus plus", followed by the same description at
23 or about 3 o'clock.
24 A. Yes.
25 Q. What would the "vomited plus plus" have meant to you as

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1 you read it that night?
2 A. That would have meant a medium vomit to me and I would
3 have estimated that at about 150/180 ml, approximately.
4 Very approximate.
5 Q. A doctor then came at 6 o'clock to give the anti-emetic.
6 Were you aware of the time at which he came from what
7 you knew at that time?
8 A. I can't recall if I was aware of the time, no.
9 Q. And it would appear that you wouldn't have been aware
10 that Raychel was vomiting at that time because it was
11 nowhere recorded.
12 A. No.
13 Q. And then you identified a vomit at or between 8.00 and
14 8.30. If you'd been writing that vomit into the notes,
15 the vomit that appeared on the bed linen, how would you
16 have described it?
17 A. I would have had to go on my estimation of what
18 I thought it had been, if it had been a mouthful or
19 appeared to be a mouthful. But I ... I can't recall
20 exactly.
21 Q. Well, in the nature of things you'd have had to make an
22 estimate --
23 A. An estimate.
24 Q. -- because the vomit didn't appear in a receptacle.
25 A. That's correct, yes.

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1 Q. And you'd have had to make a judgment based on,
2 I suppose, how widespread it was on the bed linen. Was
3 that a coffee-ground vomit?
4 A. Not that I recall, no.
5 Q. But the vomit that you then detected at 9 o'clock was
6 a coffee-ground vomit?
7 A. It was, yes.
8 Q. And it was medium in terms of its volume?
9 A. Yes.
10 Q. Was that produced into a receptacle?
11 A. Yes, it was.
12 Q. And by medium, I think you've described something in the
13 region of about 150 ml: is that fair?
14 A. Approximately, yes.
15 THE CHAIRMAN: 150 to 180.
16 MR WOLFE: On the chart in front of us, there's a further
17 entry in your hand:
18 "Vomited small amount X 3."
19 A. Yes.
20 Q. In terms of the time between those two entries or
21 between those two vomits, was that a short period of
22 time? It was certainly within the hour, was it, based
23 on this record?
24 A. Yes. But I couldn't say if it was like 55 minutes or
25 half an hour because it's just written on the hour.

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1 Q. Yes. But had it happened before the attendance of
2 Dr Curran?
3 A. Yes.
4 THE CHAIRMAN: Just so that I understand it, sister, when
5 you first encountered Raychel, you were called by her
6 father and you changed the bed. That vomit isn't on the
7 page in front of us.
8 A. No.
9 THE CHAIRMAN: But within the next hour or so, there's
10 a "vomit plus plus", which you describe as medium, and
11 then three small vomits.
12 A. Yes.
13 THE CHAIRMAN: And that's roughly over an hour or so, is it?
14 A. Yes, but as I say, I can't quantify the length of time
15 in between.
16 THE CHAIRMAN: One's an entry at nine and one's an entry at
17 ten.
18 A. Yes, but because there's only spaces for on the actual
19 hours, there's no time documented.
20 THE CHAIRMAN: Yes, thank you.
21 MR WOLFE: There's a further entry in the slot along the
22 line from 2300, sister. Do you see that?
23 A. Yes, I do.
24 Q. We understand that to be in the hand of Staff
25 Nurse Patterson.

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1 A. That's correct.
2 Q. It appears that you have made three entries or you've
3 signed off on three entries, isn't that right, in the
4 signature column?
5 A. Yes.
6 Q. Is the later one at 0200 yours as well?
7 A. It is, yes.
8 Q. That's a total of four. And those signatures reflect
9 the fact that you've checked the intravenous fluids;
10 is that right?
11 A. That's correct, yes.
12 Q. In terms of the coffee-ground vomit that you detected at
13 or about 9 o'clock, you discussed that with Staff Nurse
14 Noble; is that correct?
15 A. Yes.
16 Q. In terms of the discussion that you had with her, why
17 were you having it, first of all?
18 A. Well, at around that time I had carried out Raychel's
19 observations as well and she had been complaining of
20 a headache. So as Nurse Noble was near room I or just
21 outside room I doing the medicines, she said she would
22 give her PR paracetamol for her headache. That's why
23 I discussed it with her.
24 Q. Was the fact that the vomiting was now coffee grounds of
25 significance?

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1 A. Well, I thought maybe she had a wee tear when she was
2 vomiting. That's why it was all blood in it, there was
3 blood in it.
4 Q. Yes, but the fact that there was blood in it, was that
5 a significant development for you?
6 A. I ... I just thought that maybe it was a more forceful
7 one and that she had torn a wee vessel or something
8 somewhere.
9 Q. Taking all of the vomiting together, by that point and
10 the fact that you'd now had blood in the vomit, were you
11 regarding that in combination or the fact that there was
12 now coffee-ground vomits as being significant? Was it
13 the combination of vomiting?
14 A. It was the coffee-ground vomit because the three small
15 vomits afterwards were not long. There was the one at
16 9 o'clock or around 9 o'clock, coffee-ground vomit. The
17 three small ones after that were not particularly long
18 after that.
19 Q. Were they coffee ground also?
20 A. I think if they had been, I would have written --
21 I would have charted it as coffee grounds.
22 Q. So you have this conversation with Staff Nurse Noble and
23 the conversation reached a conclusion that medical
24 intervention should be sought?
25 A. I don't recall exactly what we conversed about. I know

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1 that I had told her that Raychel had complained of
2 a headache. But the three small vomits -- I did tell
3 her or speak to Nurse Noble and say that I was going to
4 contact the surgical doctor because of her vomiting.
5 Q. Yes. And could you help us with this, sister: by this
6 stage in the day, you had been on duty for a little over
7 an hour, an hour and a half by this point when you're
8 having this conversation with Staff Nurse Noble --
9 A. Yes.
10 Q. -- and there had been four recorded vomits during the
11 day; isn't that right?
12 A. Yes.
13 Q. And in the course of the hour and a half that you had
14 been on duty, there had been the vomit that wasn't
15 recorded, the coffee-ground vomit, and then three
16 further small vomits?
17 A. Yes.
18 Q. And were you now regarding this vomit as being something
19 that was worrying or of concern?
20 A. Well, I wasn't overly concerned. Her temperature, pulse
21 and respirations were within reasonable limits and, as
22 I say, that's what prompted me to seek advice from the
23 surgical doctors.
24 Q. Taking all of the vomits -- that's the four earlier
25 in the day, the several incidents since you have come on

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1 duty, and also bearing in mind the fact that she's had
2 an anti-emetic and bearing in mind the fact that she now
3 has a headache and is pale -- that wasn't a normal
4 situation for a child who has just come through
5 a straightforward appendix operation.
6 A. Well, as I say, it wouldn't have been unusual for
7 children to vomit for up to 24 hours after an
8 appendicectomy. So the fact that she was pale was
9 because she'd just had several vomits.
10 Q. Are you saying that all of those things that I've put
11 into the mix -- the vomiting, the headache, the fact
12 that an anti-emetic hasn't worked, and there's also the
13 fact that she hasn't passed urine, at least according to
14 this record -- are you saying none of that was terribly
15 unusual?
16 A. I'd say it's unusual, but it was not unheard of. And
17 all those reasons, that's why I contacted the surgical
18 doctor.
19 Q. We'll just maybe bring up on the screen, before we move
20 on, the observations that you carried out. We can find
21 those at 020-015-029. At the bottom of the page you
22 make an entry at 9.15.
23 A. Yes.
24 Q. And you have recorded -- is that "colour flushed to
25 pale"?

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1 A. Yes.
2 Q. "Flushed to pale"?
3 A. Yes.
4 Q. And is that conveying an observation that her colour's
5 changing from red to white --
6 A. Yes.
7 Q. -- and is varying? Is it going red to white and back
8 again?
9 A. No, no.
10 Q. Is that that she had been flushed and was now pale?
11 A. Well, it would have been over a short period of time --
12 I would say about seconds, I'm not too sure -- but
13 I thought the paleness would be due to the vomiting. As
14 I've recorded there, she was vomiting plus plus, so
15 I was writing down exactly what I observed.
16 THE CHAIRMAN: Sister, does the vomiting plus plus at 9.15
17 mean she was vomiting at that point or that she had
18 vomited earlier? Do I take it this is a 9.15
19 observation?
20 A. Yes.
21 THE CHAIRMAN: So she's got a headache, she's vomiting and
22 she's going from flushed to pale?
23 A. Yes.
24 THE CHAIRMAN: Right.
25 MR WOLFE: So at this stage you're face-to-face with the

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1 child for the purposes of doing these observations?
2 A. Yes.
3 Q. And you have recorded temperature, pulse and respiratory
4 rate.
5 A. Yes.
6 Q. You didn't record blood pressure?
7 A. No.
8 Q. Blood pressure, it seems, hasn't been recorded since 7
9 am the previous morning or early that morning. Are you
10 aware of Ms Ramsay's observation that blood pressure
11 in the presence of ongoing vomit would have been
12 a sensible thing to be recording?
13 A. I have read her report, yes.
14 Q. Is she right on that? Should you have been recording
15 blood pressure?
16 A. Yes.
17 THE CHAIRMAN: Because the nurses who started these
18 observations did record blood pressure and then it looks
19 after that as if you're the third one in a row not to
20 take it. Was there a reason for that? It looks a bit
21 curious about why you would start taking blood pressure
22 and then stop. In fairness to you, Staff Nurse Roulston
23 hadn't taken it, nor had Staff Nurse McAuley or
24 Nurse Rice as she was at that time. Why would that be?
25 A. I don't know why they would have stopped doing it and

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1 I don't know why I didn't do it.
2 THE CHAIRMAN: Okay. Thank you.
3 MR WOLFE: Are you telling the inquiry that it should have
4 been done?
5 A. Sorry?
6 Q. Are you telling the inquiry that you think now that it
7 should have been done?
8 A. Looking back now, yes, it should have been done.
9 Q. The observations that you did carry out were within the
10 normal range; isn't that right?
11 A. Yes.
12 Q. But while the observations were normal, you had a child
13 in front of you who was looking sick; isn't that right?
14 A. Yes, she'd been vomiting and, as I say, that's why
15 I contacted medical help.
16 Q. Yes. Did you think about the headache and what it might
17 signify?
18 A. I didn't, no.
19 THE CHAIRMAN: Is that because, if any of us are sick and
20 vomiting, having a headache wouldn't be unusual to go
21 with it?
22 A. That's what I thought at the time, yes.
23 THE CHAIRMAN: So you didn't think of that as a sign of
24 something separate or extra, it was just part of being
25 sick?

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1 A. Yes.
2 THE CHAIRMAN: Okay.
3 MR WOLFE: You passed that issue of her headache on to Staff
4 Nurse Noble to deal with in terms of medication and she
5 administered paracetamol; isn't that correct?
6 A. That's correct, yes.
7 Q. In terms of the level of concern for Raychel at that
8 point, can I reflect to you the perspective of
9 Mr Ferguson, who tells the inquiry that at or about
10 9.30, which is shortly after you'd been with Raychel,
11 he was extremely concerned for her well-being because he
12 tells the inquiry he contacted his wife and he contacted
13 her because he says Raychel was bright red in the face,
14 had complained that her head was "wild sore" -- that's
15 what the child said to him -- and then vomited blood in
16 the bed. The nurses then came in, he says, and made
17 Raychel stand, she could hardly stand, and then within
18 minutes she had vomited on the bed again. And all of
19 that prompted him, at 9.30 or so, to contact his wife to
20 say the nurses weren't listening to him.
21 The evidence that he has put in a witness statement
22 is intended to convey his concern that (a) Raychel was
23 very ill in his eyes and (b) his belief that nurses
24 weren't taking her condition very seriously. Was that
25 the position, that nurses weren't taking her condition

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1 seriously?
2 A. I don't agree that we weren't taking her condition
3 seriously. I mean, when he approached me that she had
4 been sick and asked to change the bed, I did that, and
5 after her periods of vomiting I told him what I was
6 going to do, that I was going to contact the surgical
7 doctor to come and assess her. So I was taking his
8 concerns on board.
9 Q. Can you remember having any form of discussion with
10 Mr Ferguson about his child's condition?
11 A. The only thing that I can recall -- I mean, I could have
12 had a general conversation, I can't recall exactly. But
13 I did tell him that I was -- I know I did tell him that
14 I was going to contact a doctor to come and see her.
15 But if there was another conversation around that,
16 I have no recollection of exactly what it was or if
17 there was any or very much.
18 Q. Can I ask you a point of detail in relation to a point
19 of detail he raises? He says that he recalls you
20 checking Raychel's records and then you stated to him
21 that you thought a doctor had been up and given Raychel
22 something, but that he hadn't signed for it, and you
23 then told him you'd get another doctor to give Raychel
24 more stuff to stop her from being sick. So I know you
25 tell us you have a clear memory of telling him that you

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1 would get a doctor --
2 A. Yes.
3 Q. -- but it's the first bit. Do you have a memory of
4 telling him that you thought a doctor had come up and
5 given her something but hadn't signed for it?
6 A. Well, it was on the medication prescription sheet,
7 a doctor had written the time, but he hadn't actually
8 signed for it, that he'd given it.
9 Q. Right. Maybe we'll check the record over lunchtime and
10 see if we can work out what that might mean.
11 Moving to the arrangements that went into getting
12 a junior house officer to attend --
13 MR QUINN: Mr Chairman, if my friend's going on to another
14 subject, I just want to pin this down while we're on
15 this one. Could we ask the nurse: did she ever tell
16 Mr Ferguson that the child had burst a blood vessel if
17 that's what she means by "bursting a wee vessel".
18 That's point 1. And does she think that it is relevant
19 that she has been vomiting so violently that she has
20 burst a blood vessel, if in fact that is what she means,
21 which I assume is the case?
22 THE CHAIRMAN: Okay. Let's take it in parts. Does that
23 ring a bell, that you might have told Mr Ferguson
24 something about Raychel having burst a blood vessel?
25 A. I don't recall having said that, no.

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1 THE CHAIRMAN: Can that happen sometimes if a child or
2 a person is vomiting?
3 A. If they'd had a forceful vomit.
4 THE CHAIRMAN: Could that account then for blood in the
5 vomit that a blood vessel's burst?
6 A. I mean we're talking about a small blood vessel. It
7 could do, yes.
8 THE CHAIRMAN: Would that give an indication of how severe
9 the vomiting is?
10 A. If it was a forceful one, yes.
11 THE CHAIRMAN: So that would add to the concern that this is
12 repeat vomiting and, if that's what's said, if
13 Mr Ferguson's memory about this is right that --
14 MR QUINN: Sorry, sir, he's not actually saying he was ever
15 told that. That's the point he's making. He is saying
16 that none of that was told to him. He is saying if
17 he had been told that, he would have been very, very
18 concerned. What we have now -- and I've checked the
19 statement -- this witness has never said in her
20 statement before that there was any suggestion that
21 there was a blood vessel that was burst. And this is
22 a very concerning point for the parents because they
23 obviously -- anyone who isn't medically trained -- and
24 perhaps even those with training -- would see that as
25 a very important issue. Because what we have now is

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1 we have repeat vomiting, significant vomiting,
2 a significant volume of vomiting, and vomiting as
3 attested by this witness that was so severe that it
4 burst a blood vessel.
5 That leads on to the next question. Number one --
6 THE CHAIRMAN: Sorry, at what point did the witness say
7 that?
8 MR QUINN: Page 74, line 16 [draft transcript] --
9 THE CHAIRMAN: Just give me one second.
10 MR QUINN: -- where she says "torn a wee vessel" or
11 something similar. So the first question is that she
12 agrees that it is a blood vessel she's referring to.
13 The second question I have to ask is: did she ever
14 tell the parents about that because that would be
15 something that would concern them. They say no, so it
16 seems that she is also confirming that that is the case
17 that never told the parents. But the third and more
18 alarming feature is that she had never told the doctor.
19 THE CHAIRMAN: If that's what you thought at the time and
20 that does indicate forceful vomiting, is that not
21 something that you would pass on?
22 A. Well, that's what the coffee ground -- coffee grounds
23 indicates that there's blood.
24 THE CHAIRMAN: So are you saying that the reference to the
25 possibility of a burst blood vessel is the same as

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1 coffee grounds?
2 A. I'm talking about a minute blood vessel. I'm not
3 talking about a huge vessel --
4 THE CHAIRMAN: Because otherwise there would be blood
5 flowing freely --
6 A. -- and it'd be fresh blood as well.
7 THE CHAIRMAN: -- so I understand that.
8 So do you say that the small burst blood vessel is
9 in effect the same as coffee grounds, that that leads to
10 the coffee-ground vomit?
11 A. Yes.
12 THE CHAIRMAN: And you then say your note, the note you
13 made, shows that coffee-ground vomit was recorded?
14 A. Yes.
15 THE CHAIRMAN: Okay.
16 MR WOLFE: I'm going, sir, to move into the area that
17 focuses particularly on the reasons for getting the
18 doctor in and what was said to the doctor. Would it be
19 an appropriate time now to break?
20 THE CHAIRMAN: Yes. We'll come back at 2 o'clock.
21 Sister, your evidence will be finished this
22 afternoon. Okay? So we'll hear you for as long as
23 necessary -- I don't think it will be necessary to sit
24 terribly late to finish your evidence.
25 There should be some developments this afternoon,

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1 Mr Lavery, about documents and privilege.
2 MR LAVERY: We should be in a position to outline any
3 developments when Mr Stitt arrives.
4 THE CHAIRMAN: We might do it after -- if he is here at
5 about 1.45, could he have a word with Ms Anyadike-Danes
6 and Mr Wolfe? I don't want to start a debate at
7 2 o'clock which prevents this witness finishing, so we
8 might do it the other way round -- finish the witness
9 and then do the privilege argument -- but I'm not going
10 to keep Sister Gilchrist in the witness box overnight
11 because we're arguing about documents. If I have to sit
12 late today, it will be sitting late to do the documents
13 issue, not to finish the witness.
14 (12.57 pm)
15 (The Short Adjournment)
16 (2.00 pm)
17 MR WOLFE: Good afternoon, sister. I want to bring you
18 straight to the decision to contact Dr Curran and bring
19 him to see Raychel. In terms of why you thought it was
20 necessary to contact a junior house officer, could you
21 explain the factors that you took into account when
22 deciding to make that contact?
23 A. The fact that Raychel had suffered the large vomit --
24 sorry, the medium vomit, I beg your pardon -- and then
25 the three small vomits as well and the fact that it was

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1 causing her distress prompted me to contact him.
2 Q. Would you have made that contact, do you think,
3 regardless of whether the vomiting was coffee-ground in
4 nature?
5 A. No, I don't believe I would. Because of the vomiting,
6 the four vomits, the medium vomit and the three, I would
7 have contacted him anyway.
8 Q. Right. So the fact that there was coffee-ground vomit
9 wasn't a factor in your decision; it was the fact that
10 there were four vomits in quick succession?
11 A. Yes.
12 THE CHAIRMAN: And that this would be causing Raychel
13 distress?
14 A. Yes.
15 MR WOLFE: In terms of what you wanted the doctor to do, did
16 you give that any consideration?
17 A. Well, I wanted him to come and see her and examine her
18 and see if maybe another anti-emetic would be
19 appropriate at that time.
20 Q. In your witness statement to the inquiry you have told
21 us that you spoke to Ann Noble about the continuing
22 vomiting being experienced by Raychel --
23 A. Yes.
24 Q. -- and you discussed contacting the doctor so that he
25 could administer an anti-emetic to see if it could give

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1 Raychel some relief.
2 A. Yes.
3 Q. In Staff Nurse Noble's recollection for the inquiry, she
4 indicated that it was concluded that Raychel needed to
5 be seen by a doctor because the first anti-emetic hadn't
6 worked and she might benefit from another one.
7 A. Okay.
8 Q. Does that ring a bell? Does that sound sensible?
9 A. I can't remember the exact words, but I did tell her
10 that I was going to contact the doctor to see if it
11 would be suitable for her to have another anti-emetic,
12 yes.
13 Q. In addition to wanting a doctor there to give an
14 anti-emetic, you also seem to be saying that you wanted
15 the doctor to examine her.
16 A. Well, I thought it would be part of his role to look at
17 the observation charts and examine Raychel as well.
18 I mean, the observation sheets and the fluid balance
19 sheet and everything was there at the bottom of her bed
20 for him to make an assessment of her.
21 Q. Just before we leave the coffee grounds altogether and
22 look at what you may or may not have said to the doctor,
23 coffee grounds are an indicator of severe vomiting and
24 retching; is that your understanding?
25 A. I know retching could cause it, that's what I said

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1 before lunch, that something forceful -- if it was
2 forceful ... That's what I would consider causing
3 coffee grounds.
4 Q. Your colleague, Staff Nurse Noble, indicated to the
5 inquiry that she had considered that the coffee-ground
6 vomits were indicative of a Mallory-Weiss tear. She
7 didn't share that information with you?
8 A. That's words that I wouldn't have been familiar with at
9 that time.
10 Q. But it does seem, on your account, that the fact of
11 coffee-ground vomit wasn't the trigger for getting the
12 doctor, it was the distress to the child in the presence
13 of a number of vomits that had happened in quite a short
14 period of time?
15 A. No, I'm saying that despite the fact that there was
16 coffee grounds, the times that she had vomited, I still
17 would have contacted a doctor.
18 Q. Yes. In deciding to contact a doctor, we looked earlier
19 at whether you could in any particular circumstances
20 have made contact with a more senior doctor.
21 A. Yes.
22 Q. And you indicated to me that, well, whether I went for
23 a JHO or an SHO, maybe somebody more senior than that,
24 would depend upon the particular facts of the case;
25 isn't that right?

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1 A. Yes.
2 Q. So if you were very concerned about a child's condition,
3 you may not go for a JHO, you might go for somebody more
4 senior?
5 A. Yes.
6 Q. Why didn't you ask for a more senior doctor to attend
7 Raychel?
8 A. Because when I contacted the JHO, it was to come and see
9 her initially and for him to make an assessment if he
10 could contact the SHO or not.
11 THE CHAIRMAN: So in terms of maybe a hierarchy, you would
12 call in the JHO and if he thought that the concerns were
13 maybe greater than you thought or if he thought he
14 needed more senior assistance, he could then ask for it?
15 A. An SHO, yes.
16 THE CHAIRMAN: Right. In other words, he could refer it up
17 the line, you didn't have to?
18 A. That's what I believed then, yes.
19 THE CHAIRMAN: Has that relaxed at all since 2001, since
20 Raychel's death?
21 A. Yes, it has indeed, yes.
22 THE CHAIRMAN: So are you now freer to go past an SHO to
23 a registrar or even to a consultant?
24 A. Yes. I would have no problems going as high as I could
25 if I felt it was necessary.

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1 THE CHAIRMAN: Is that because of Raychel's death or because
2 of a change in nursing more generally?
3 A. I believe it's a change in nursing more generally. We
4 do not have surgical JHOs on the ward any more either as
5 well, as you know. But I think people are more -- what
6 would be the word -- feel able to contact higher up the
7 ladder on their own volition rather than depending on
8 going through a doctor.
9 THE CHAIRMAN: Okay.
10 A. A more junior doctor.
11 THE CHAIRMAN: Thank you.
12 MR WOLFE: As I understand your evidence, sister, at that
13 time if you had weighed all the evidence up and if you
14 had reached the conclusion that this was a serious
15 matter or a matter causing some concern, you could, in
16 2001, have made the call to get an SHO?
17 A. I could have done, yes.
18 THE CHAIRMAN: But would you have been less inclined to do
19 that in 2001 than you would be now?
20 A. Yes, definitely.
21 MR WOLFE: But again, as I understand your evidence today,
22 not only did you wish this doctor who was going to come
23 to consider administering an anti-emetic, you wanted
24 this doctor to assess Raychel?
25 A. Well, I wouldn't have thought he would just have come

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1 and given an anti-emetic on my say so, no; I presumed
2 that in his role that he would have examined her and
3 assessed her as well as that.
4 Q. But when you talk about wanting that doctor who would
5 come to assess Raychel, was that to assess whether an
6 anti-emetic was necessary or whether she was suitable
7 for an anti-emetic or was it more generally than that?
8 A. Well, at the end of the day it would have been his call
9 what he would do.
10 Q. Yes.
11 A. And as a staff nurse, we weren't able to administer
12 anti-emetics. So even if it was written up "as
13 required", we wouldn't have been able to do that.
14 Q. Yes.
15 A. So it would have been on his call to do that. And if
16 he was assessing her, I would think that he would take
17 into consideration her observations, her output, and a
18 physical examination.
19 Q. Of course. But I want to focus on this issue about
20 assessment. Did you think she required assessment?
21 A. I don't expect a doctor just to come and give an
22 anti-emetic or a drug and just leave again.
23 Q. Yes. But if I have understood your evidence so far,
24 you're saying to the inquiry you weren't particularly
25 concerned about her, you simply wanted her to be

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1 considered for the administration of an anti-emetic
2 because here we had a number of vomits quickly and this
3 is causing the child some distress.
4 A. Yes, but I wanted him to come and see her.
5 Q. Yes.
6 A. Not just to administer an anti-emetic, but to come and
7 see her.
8 Q. So can I interpret what you are saying as follows: you
9 felt that she probably needed an anti-emetic, but that
10 was for a doctor to decide upon?
11 A. Yes.
12 Q. And secondly, you felt she would benefit from a general
13 assessment in relation to her well-being?
14 A. I think the assessment would come first.
15 Q. Yes. How did you make contact with the doctor?
16 A. I would have rung the switchboard in the hospital and
17 asked them to bleep the surgical JHO on call for Ward 6.
18 Q. And a doctor, Michael Curran, picked up on this
19 communication?
20 A. Yes.
21 Q. Did you speak to him?
22 A. Yes, on the phone, yes.
23 Q. Did you speak to him at any other point apart from on
24 the phone?
25 A. No.

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1 Q. And you're quite sure about that?
2 A. As sure as I can be, yes.
3 Q. So the only communication you had with him was on the
4 phone, you didn't speak to him on the ward at all?
5 A. No.
6 Q. Either before or after he saw Raychel?
7 A. No.
8 THE CHAIRMAN: Sister, when you spoke to him on the phone,
9 that was to give some detail about why you wanted him on
10 the ward; isn't that right?
11 A. That's correct, yes.
12 THE CHAIRMAN: Would that conversation be on the basis that
13 you would expect to talk to him when he comes to the
14 ward?
15 A. I would have been available, but at that time of the
16 evening when we were doing observations on other than
17 children, there's 23 children on the ward, so from the
18 time I spoke to him on the ward until the time he came,
19 you know, it could be half an hour, it could be
20 10 minutes, so I was going on doing observations on the
21 other children, waiting for him to come.
22 THE CHAIRMAN: Would you keep an eye out for him coming so
23 that, assuming he's going to spend five or ten minutes
24 with Raychel, if you saw him coming in and you were
25 doing observations on another child, there's a good

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1 chance that you'd be able to finish that and still get
2 to speak to him before he leaves?
3 A. If I had seen him, yes, I would have done.
4 THE CHAIRMAN: Or if you can't see him before he treats
5 Raychel, you'd want to speak to him after he's treated
6 her to know what his take on it is.
7 A. As I say, if I'd have seen him afterwards, I would have
8 asked him, yes.
9 THE CHAIRMAN: Was it common for doctors to be bleeped to
10 Ward 6 to come in and see a patient and not speak to
11 a nurse before they saw the patient or during their
12 assessment of the patient or before they left?
13 A. Well, they would have some contact with somebody, but it
14 wouldn't necessarily have to be me because there was
15 only the three of us there -- and that's myself,
16 Nurse Noble and Nurse Bryce -- knew that I'd contacted
17 the doctor, so he could have spoken to either one of us.
18 THE CHAIRMAN: Okay.
19 MR WOLFE: It's right to say that, when the doctor arrives,
20 he will require some direction in terms of where the
21 patient is.
22 A. Yes.
23 THE CHAIRMAN: He has to get into the ward?
24 A. Yes.
25 THE CHAIRMAN: The starting point is it's almost certainly

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1 a nurse who will let him into the ward.
2 A. Yes, it'd be a member of staff, yes.
3 THE CHAIRMAN: Right. Then he has to be told where Raychel
4 is.
5 A. Yes.
6 THE CHAIRMAN: And if he's going to give her drugs, he has
7 to know where the drugs are.
8 A. Yes.
9 MR WOLFE: In the witness statement that you wrote in 2001,
10 you said you explained to Dr Curran Raychel's nausea and
11 vomiting and he said he would come to see her. He
12 arrived on the ward and administered cyclizine, and this
13 was at approximately 10 o'clock.
14 A. Yes.
15 Q. So when you said in that statement that you explained to
16 him about Raychel's nausea and vomiting, can you help us
17 with any more detail than that?
18 A. That would have been on the phone.
19 Q. Yes.
20 A. Well, I would always have said who she was and what
21 she'd had done, her operation, and that she was still
22 vomiting. I would ask him to come and see her.
23 Q. Yes. So you'd have told him that she was an
24 appendicectomy patient?
25 A. Yes.

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1 Q. And that she was still vomiting?
2 A. Yes.
3 Q. You wouldn't have thought it relevant to tell him the
4 period of time over which she had been vomiting?
5 A. I don't recall exactly, I just remember telling that she
6 had been vomiting. I don't recall giving a specific
7 period of time to him on the phone, no.
8 Q. You wouldn't have thought it relevant to tell him about
9 the volume of vomit?
10 A. Well, if he was coming to see her he could have looked
11 at her observation sheet, her fluid balance sheet and it
12 was all documented there, the types of vomiting and the
13 amounts. So I assume that he would look at the fluid
14 balance sheet and see that.
15 Q. That was certainly available to him at the bed?
16 A. Yes.
17 Q. And again, in terms of whether you specifically told him
18 on the telephone that the vomiting had now become coffee
19 grounds, would you have thought that relevant to tell
20 him?
21 A. I could have told him on the phone. I can't remember
22 specifically if I said it was coffee-ground vomit or
23 not.
24 Q. The inquiry has heard from Dr Curran. He believes that
25 he spoke to a nurse upon his attendance at the ward

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1 in relation to Raychel specifically. That wasn't you?
2 A. No.
3 Q. He has also said that he would draw a distinction
4 between being asked by a nurse to come and administer an
5 anti-emetic and, alternatively, come to see a patient to
6 review her. Do you see that distinction?
7 A. Yes.
8 Q. On the one part, a nurse might say to a doctor, "Would
9 you come and give a patient an anti-emetic? She has
10 been vomiting uncontrollably for a period of time". But
11 if you were particularly concerned about a child, you
12 might, in addition, ask the doctor to review her
13 overall.
14 A. I asked him to come and see her --
15 Q. Yes.
16 A. -- and if he thought it appropriate to give an
17 anti-emetic ... But when I meant "see her", I meant
18 examine her, at least come and, you know, look at her
19 chart. At the end of the day he'll make his own
20 assessment of her.
21 Q. He says that he came and examined her abdomen.
22 A. Yes.
23 Q. Obviously that was part of the context for her being in
24 hospital, but his evidence to the inquiry was that the
25 nursing staff who he spoke to didn't suggest any urgency

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1 or any concern which would have merited a review of
2 Raychel's condition. Can I just focus on that? You
3 were coming at this from the perspective that Raychel
4 was suffering vomiting, but it was something that you
5 regarded as common.
6 A. I said it wasn't unusual.
7 Q. And so far as you were concerned, while you wanted
8 a doctor there to relieve the distress of the vomiting,
9 you hadn't reached the view that it was something
10 potentially serious that required a review?
11 A. In his role as a doctor, it would be to assess the
12 child, which would be a physical examination, looking at
13 her charts, and then making his decision from there.
14 Q. If you'd thought about it and thinking about it now,
15 Raychel's condition at that time was something that
16 merited quite a close look, wasn't it?
17 A. Yes.
18 Q. And it merited quite a close look because she'd been
19 vomiting throughout the day on and off; isn't that
20 right?
21 A. Yes.
22 Q. And now the vomiting was being, if you like, turned up
23 a notch because you've got a series of vomits in close
24 succession; isn't that right?
25 A. Yes.

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1 Q. And there's now blood in the vomit. Dr Curran has said
2 that he wasn't told about the blood in the vomit and, if
3 he had been told that it was coffee grounds, this would
4 have raised a red flag for him, and by that he meant
5 that he would have summoned a more senior colleague to
6 look at Raychel; do you follow that?
7 A. Yes.
8 Q. You can't help us in terms of whether you told him about
9 the coffee grounds?
10 A. No, but I mean I have it documented on Raychel's fluid
11 balance sheet -- "Intake and output chart" as we called
12 it then -- that it was coffee-ground vomit. So ... So
13 I thought then when he would come and see her, he could
14 see the amount of vomiting and the vomit was coffee
15 ground at that time around 9 o'clock.
16 Q. So what you're saying, sister, from a nursing
17 perspective in terms of communications with a doctor,
18 you should only be expected to go so far. The full
19 detail is on the note, he has the notes in his hand or
20 he can readily access them and, from a medical doctor's
21 perspective or from a doctor's perspective, that was all
22 the information he needed?
23 A. No. I mean, he had a phone call from me, he had the
24 medical notes and he also had three staff nurses then to
25 communicate with if he felt he should get more

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1 information.
2 Q. Do you think, when you think about it now, that you
3 should have been focusing his attention towards the fact
4 that this wasn't a normal or straightforward situation,
5 that this was a matter that required a more senior
6 input?
7 A. Well, obviously, from looking at it from now, yes.
8 Q. You will have looked at the various experts who have
9 commented on this area in reports.
10 A. Yes.
11 Q. And you will appreciate from those reports that the
12 nursing role is described in broadly the following
13 terms, that a nurse's duty is to observe and monitor and
14 to describe for a doctor any departure from normality,
15 any departure from the normal recovery pathway. Would
16 you agree that that is the role of the nurse?
17 A. Yes.
18 Q. When you think about it now, do you think that you
19 adequately conveyed to Dr Curran that this was
20 a situation that required a closer look?
21 A. Well, obviously from looking at it from now, it wasn't
22 adequate, no.
23 Q. The inquiry has heard that, upon Dr Curran's attendance,
24 the anti-emetic drug was left out for him. Somebody had
25 gone to the drug cupboard, presumably, and left the

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1 cyclizine available for him in advance of his
2 attendance; did you do that?
3 A. No.
4 Q. The implication of leaving the drug out available for
5 him might be that the doctor is being handed a fait
6 accompli, that he was being told what to do; is that
7 a reasonable inference to draw from that?
8 A. If it had been left out for him, it would have been left
9 in the treatment room and he would have no reason to go
10 into the treatment room before going to see Raychel.
11 Q. I don't follow. What does that mean?
12 A. I asked him to come and see Raychel, so his -- you'd
13 have thought his first port of call would have been her
14 medical notes and then going to see Raychel, or seeing
15 Raychel first and made his assessment. Then, to get the
16 anti-emetic, he would have had to have gone to the
17 treatment room, which is down the corridor, if he
18 thought that was appropriate. It wasn't left by her
19 bedside.
20 Q. This is a more general question than just Raychel's
21 case. If you'd reached the view as a nurse that an
22 anti-emetic might be helpful and you've got a doctor
23 along or you're getting a doctor along, is it the habit
24 to go to the drug cabinet and get the drug out in
25 advance of the doctor coming?

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1 A. Now you're talking about?
2 Q. No, back in 2001.
3 A. It happened occasionally, yes.
4 Q. And is that, if you like, to speed up the process or for
5 convenience?
6 A. Well, because of the busyness of the ward at the time,
7 we thought if it was there he could administer it, yes.
8 Q. But are you saying that ultimately, rather than just
9 pick up the drug and run with it, if you like, it's for
10 the doctor to make his assessment before actually then
11 using the drug?
12 A. Yes.
13 Q. Given that you were the person who informed the doctor
14 of Raychel's problem in order to get him there in the
15 first place, when you think about it now, should
16 you have made it your business to meet and greet him and
17 then be in a position to receive his findings after his
18 assessment?
19 A. You say looking at it now?
20 Q. Yes.
21 A. Yes.
22 Q. In terms of how this --
23 THE CHAIRMAN: I think to be fair, sister, looking at it
24 now, everything's different, isn't it?
25 A. It is, yes.

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1 THE CHAIRMAN: What I'm interested in is for the standard
2 at the time because frankly, looking back, there's
3 a whole lot of people who would do things different than
4 they did in June --
5 A. That's correct, yes.
6 THE CHAIRMAN: What does strike me as a bit unexpected, as
7 an outsider, is that when the doctor's called to the
8 ward, there doesn't really appear to be any clear
9 evidence that he talks to anybody very much. He goes to
10 see Raychel and he leaves and there's not much by way of
11 a conversation. Is that typical of what happened at
12 that time if a doctor was called to the ward?
13 A. At night-time, it could have been because there was less
14 staff on, obviously, and at that time -- and in the
15 evening too -- when we were doing observations, we were
16 going from room to room and child to child, so --
17 THE CHAIRMAN: So you might miss him?
18 A. You might miss him, but I --
19 THE CHAIRMAN: So you might miss him when he comes in, but
20 you might still argue that he should have been looking
21 for you on the way out?
22 A. Me or one of my colleagues, but preferably me because it
23 was me who contacted him.
24 THE CHAIRMAN: Thank you.
25 MR WOLFE: But having contacted him, you were obviously

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1 expecting him to attend.
2 A. Yes.
3 Q. And at some point at or about 10 o'clock or shortly
4 thereafter, you must have been wondering, "Where has
5 that doctor got to? Has he not attended?"; did that
6 occur to you?
7 A. Well, I mean, I was obviously doing observations on
8 other children, and I was told later on that he had been
9 and that he had given the cyclizine, so ... Because
10 I didn't speak to him I presumed if he had been there he
11 had spoken to somebody else. We didn't just stand and
12 wait for the doctor to come to the ward, you know.
13 There was --
14 Q. But given that it was coffee grounds that was now
15 emerging into the picture, is that not the kind of thing
16 that really ought to dictate that a nurse should speak
17 to the doctor?
18 A. As I say, there was another two staff nurses there, so
19 I thought if he didn't speak to me, he could speak to
20 either of the other two nurses.
21 Q. In terms of the recording of a doctor's visit, in this
22 case there was no contemporaneous note that the doctor
23 had attended, other than his signature in the kardex;
24 isn't that right?
25 A. That's correct, yes.

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1 Q. The decision to call a doctor, the reasons for calling
2 a doctor, his assessment and the plan going forward are
3 all matters that should be recorded in the notes; isn't
4 that right?
5 A. In the medical notes?
6 Q. In nursing notes.
7 A. Well, because there was a computerised DM Nurse that we
8 used in those days, the updating wouldn't have been done
9 until later on in the shift. So you didn't necessarily
10 leave the patient, go in -- go into the computer and
11 update at that time. It would have been done later on.
12 Q. So are you saying that the culture or the practicality
13 at that time was not to make a note, not to make
14 a contemporaneous note?
15 A. Sorry, I don't know what you mean.
16 Q. Well, we know that, come 6 o'clock in the morning, the
17 episodic care plan was updated, isn't that right --
18 A. Yes.
19 Q. -- towards the end of the shift? And the inquiry has
20 heard how that's done and in many respects that note
21 assists the new shift coming on early in the morning;
22 isn't that right?
23 A. That's correct, yes.
24 Q. But that process suffers from the disadvantage of the
25 note is only being made eight hours after the event and

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1 nothing is being put down on paper at the time of the
2 event; do you follow?
3 A. Yes.
4 Q. What I'm anxious to learn from you is: was it the case
5 at that time that you simply didn't make a note of
6 a significant development like the attendance of the
7 doctor at the time it was happening?
8 A. Well, when we attended handover you usually had
9 a notebook which you carried in your pocket and any
10 relevant notes you would have written down about
11 particular patients, so you could have written it
12 in that. The DM Nurse was not an ideal system to have
13 at all because it was not mobile, if you like.
14 Q. You have said in your witness statement that Raychel
15 settled to sleep shortly after the doctor attended.
16 A. Yes.
17 Q. Your next involvement with Raychel was to do the
18 2300 hours IV observations; isn't that right?
19 A. Yes.
20 Q. Was she asleep at that point?
21 A. As far as I can remember, yes. I'm not 100 per cent
22 sure now.
23 Q. What was your understanding of what should have happened
24 with regard to monitoring and observing Raychel after
25 the doctor's attendance?

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1 A. In regards to?
2 Q. Monitoring and observing her condition.
3 A. Well, every time that somebody was in doing her IV
4 infusion and checking her cannula, you would be
5 observing at that time, you mightn't necessarily be
6 writing observations, but you were in the room.
7 Q. So that's every hour?
8 A. Yes.
9 Q. You were aware that Raychel had had an anti-emetic
10 earlier in the day.
11 A. Yes.
12 Q. And then you were aware of the fact that it didn't
13 resolve the problem and she had the series of vomits
14 that you had to deal with by getting Dr Curran to
15 attend.
16 A. Yes.
17 Q. Was there no plan in place to keep a close look at
18 Raychel, given all of this history, after the second
19 anti-emetic was administered? In other words, you have
20 reflected the position where you would attend every
21 hour, which is the normality --
22 A. Yes.
23 Q. -- the normal arrangement, but was there not a special
24 arrangement put in place to take account of her
25 particular situation?

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1 A. It was the fact that she hadn't any more vomiting at
2 that time at 11 o'clock when I was in and I'm not sure
3 if she had -- she'd slept before 11, but I'm not sure if
4 she was sleeping at 11 o'clock. But it would be
5 a general observation of Raychel herself.
6 Q. You were aware -- and perhaps it'd be convenient to put
7 it up on the screen again -- the further vomit recorded
8 by Staff Nurse Patterson. You're aware that that
9 appears in the records now?
10 A. Yes.
11 Q. We'll just put that up on the screen again. It's the
12 fluid balance chart at 020-018-037?
13 THE CHAIRMAN: You said a few moments ago, sister, that
14 there was no record kept at the time of Dr Curran's
15 visit, but on the DM Nurse system the record would be
16 updated at the end of the shift.
17 A. Yes.
18 THE CHAIRMAN: Who would update it?
19 A. It could be either of the three of us.
20 THE CHAIRMAN: But if nobody had been with Dr Curran and
21 knew what his observations were or his assessment was,
22 how would you update it?
23 A. I don't know. I'd assume that he would have spoken to
24 somebody.
25 THE CHAIRMAN: You see, I'm not sure if that's right, which

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1 means that if somebody had gone to update the record --
2 this is the problem about the DM system, that if nobody
3 does speak to the doctor at the time of his visit and
4 get a report from him and if he doesn't write it up
5 himself, then no meaningful record will be made.
6 A. No.
7 THE CHAIRMAN: You might be able to record at the end of
8 a shift that you called a doctor, but what exactly he
9 found, what exactly he did, will be very hard to record
10 because nobody's spoken to him.
11 A. It'd be hard to record, yes, but normally they wrote in
12 the medical notes as well.
13 THE CHAIRMAN: Yes, but, to put it bluntly, your position
14 is that the doctor should have made an entry in the
15 medical notes --
16 A. Yes.
17 THE CHAIRMAN: -- when he came out to see a child?
18 A. Yes.
19 MR WOLFE: We'll maybe go to that episodic care plan just
20 after this document. In terms of the coffee-ground
21 vomit recorded by Staff Nurse Patterson in that
22 2300 hours slot, as I understand it from your witness
23 statement you weren't aware of that further vomit at the
24 time you made the entry with regard to the fluids at
25 23.00.

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1 A. Yes -- sorry. I wasn't aware, no.
2 Q. That's right. You might have picked it up when you made
3 the observations at 2 o'clock in the morning, isn't that
4 right, because it was on the sheet by that time?
5 A. It was, yes.
6 Q. There was another vomit described by you as a "mouthful"
7 at 0035 hours --
8 A. Yes.
9 Q. -- in which you assisted Staff Nurse Bryce. We'll come
10 to that in detail in a moment, but it's not recorded on
11 this chart.
12 A. No, it was like a dried vomit, so we thought it was from
13 one of the earlier vomits.
14 Q. So you didn't think it was necessary to record it
15 because you couldn't determine whether it was a fresh
16 vomit?
17 A. It was dried at that time, so I didn't make a note of
18 it, no.
19 Q. Had you noticed that vomit at 11 o'clock, that vomit on
20 the pyjamas?
21 A. When?
22 Q. When you were carrying out your observations as recorded
23 here at 23.00. Presumably you hadn't noticed a mouthful
24 of vomit on her pyjamas at that point?
25 A. Not at that point, but she was under the sheets.

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1 I mightn't necessarily have seen it.
2 Q. Just in terms of the record that was entered on to the
3 episodic care plan at 0600 hours with regard to the
4 doctor's visit, sir, it's at 020-027-064. You can see
5 at the bottom half of the page:
6 "Carry care forward, 06.00."
7 Of course, the irony of this record, sister, is that
8 it is being made after Raychel's collapse; isn't that
9 right? And you're reflecting back to a period of time
10 pre-midnight when the doctor had come; isn't that right?
11 A. I didn't update this, so ...
12 Q. No, it has been updated by your colleague, Mrs Noble.
13 And you've recorded here that the --
14 THE CHAIRMAN: So this really is retrospective --
15 MR WOLFE: Yes.
16 THE CHAIRMAN: -- by a number of hours?
17 MR WOLFE: And it has been recorded that:
18 "The doctor was contacted and IV Valoid given with
19 effect."
20 It's fair to say that in that there was at least one
21 other vomit picked up by Staff Nurse Patterson and
22 recorded, that the Valoid eventually had effect but
23 there was at least one other vomit; isn't that fair?
24 A. Yes.
25 THE CHAIRMAN: What's our best estimate of the time that

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1 Dr Curran came out at?
2 MR WOLFE: 10.15. He puts that time into the kardex.
3 THE CHAIRMAN: So the entry of his visit is made almost
4 eight hours later?
5 MR WOLFE: That's right.
6 So again, sister, in terms of where you and your
7 nursing colleagues were at with Raychel, the doctor
8 came, administered the anti-emetic. Neither you nor
9 your colleagues appear to remember speaking to him,
10 apart from your telephone conversation, and is it fair
11 to say that collectively you didn't sit down and examine
12 or assess where Raychel was in terms of her condition
13 and a plan for going forward?
14 A. After she had her IV cyclizine, yes, she did have
15 another vomit, but then she settled and went to sleep.
16 Myself and Staff Nurse Bryce were with her just after
17 half 12 and her vomit had still subsided at that stage.
18 So I thought that the IV cyclizine was doing its job and
19 that she seemed to have settled. Her observations were
20 fine and her responses when we spoke to her were fine as
21 well and appropriate.
22 Q. Do you think that the 11 o'clock vomit picked up by
23 Staff Nurse Patterson should have been reported back to
24 the doctor?
25 A. In hindsight, yes.

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1 Q. You, as you've indicated, attended with
2 Staff Nurse Bryce when Raychel was found to have this
3 vomit on her pyjamas at just after midnight and
4 a decision was made to take her pyjama top off and
5 change her.
6 A. Yes.
7 Q. Would that have involved necessarily dismantling the
8 intravenous fluid and then reconnecting it?
9 A. Sometimes you would have taken the bag out of the
10 machine and put it through the arm of the pyjamas and
11 then put it back in again. But it was just ... I didn't
12 like to see a child lying with pyjamas with a mouthful
13 of vomit on it. So I wouldn't have actually
14 disconnected the fluids, no.
15 Q. It would be something of an inconvenience to do that?
16 A. Not an inconvenience, no.
17 Q. Well, if this was merely a small amount of dried vomit,
18 why would you go to that degree of bother?
19 A. Because if it was my child, I wouldn't want her lying
20 there in pyjamas with a mouthful of vomit on it either.
21 Q. You say in your witness statement that you had no
22 concerns at that time.
23 A. No.
24 Q. Is it fair to say that you had concerns earlier in the
25 evening, that's why you got the doctor?

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1 A. About her vomiting, yes.
2 Q. And you're saying you have no concerns at that time, in
3 other words by half 12 --
4 A. No.
5 Q. -- because Raychel had settled to sleep as far as you
6 were concerned --
7 A. Yes.
8 Q. -- and the anti-emetic had done the trick, stopped the
9 vomit?
10 A. Yes.
11 Q. You'd talked to Raychel at 12.30; is that right?
12 A. Yes.
13 Q. And you asked her if she was okay?
14 A. Yes.
15 Q. And she replied "yes"; is that right?
16 A. She said she just wanted to lie down and sleep.
17 Q. So at that point you had lowered her down on the bed and
18 placed her pyjama top over her?
19 A. Mm-hm.
20 Q. You saw Raychel for observations at 2 o'clock; is that
21 right?
22 A. Yes.
23 Q. Could I have up on the screen, please, your witness
24 statement, which you initially provided to the Trust on
25 10 June 2001. It's to be found at 012-004-094.

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1 You have made this statement on 10 June, sister.
2 A. Yes.
3 Q. Why did you make a statement on 10 June?
4 A. Because when we heard that Raychel had passed away, my
5 senior nurse, sister on the ward, advised me to make
6 a statement.
7 Q. Invited you or advised you?
8 A. Advised me.
9 Q. Which sister is that?
10 A. McKenna.
11 Q. Were you the only nurse advised to make a statement at
12 that time?
13 A. As far as I know, Staff Nurse Noble and
14 Staff Nurse Bryce and Nursing Auxiliary Lynch. And I'm
15 not sure of how many other people were asked at that
16 time.
17 Q. Were you given any understanding why it was necessary to
18 make a statement?
19 A. Because of Raychel's sudden passing. She just advised
20 us that while it was fresh in our memories because it
21 was deemed like a critical incident ...
22 Q. Yes. Was she giving you this advice in an informal
23 capacity, nurse to nurse, or was she directing you to do
24 it as an employee of the Trust?
25 A. No, she was just a -- nurse to nurse.

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1 Q. And making the statement two days after the events
2 within which you were involved, the events were clearly
3 fresher in your memory --
4 A. Yes.
5 Q. -- than they are now.
6 A. Yes.
7 Q. And with regard to your visit with Raychel at 02.00, you
8 say:
9 "I again took and recorded Raychel's temperature,
10 pulse and respiratory rate. They again were
11 unremarkable. She was asleep, but rousable. I checked
12 her intravenous infusion and cannula site and recorded
13 this on her fluid balance chart. I did not see Raychel
14 after this until 03.40."
15 So at that time Raychel was asleep but rousable?
16 A. Yes.
17 Q. Could I ask you to look at WS053/1, page 3? The
18 penultimate paragraph:
19 "At approximately 02.00, I again took and recorded
20 Raychel's temperature ..."
21 Just as you had it in your previous statement. They
22 were unremarkable. You then say:
23 "She was asleep, but woke when I placed the aural
24 thermometer in her ear."
25 This is a departure from your earlier statement.

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1 I am going to ask you some questions about that:
2 "I asked her if she was okay. She replied 'yeah' or
3 'yes', I cannot be sure which."
4 So in your previous statement, Raychel was asleep --
5 A. Yes.
6 Q. -- but rousable.
7 A. Yes.
8 Q. In this statement you've had some short words or word
9 with her.
10 A. Yes.
11 Q. This is your statement for the inquiry in 2005, when
12 presumably the events of four years previously weren't
13 as fresh in your mind: is that right?
14 A. When I said that she was rousable, if she hadn't have --
15 if I hadn't been able to rouse her, I would have done
16 something about it.
17 Q. Right. So what --
18 THE CHAIRMAN: Sorry. At 2 o'clock you wouldn't want to
19 waken her?
20 A. No --
21 THE CHAIRMAN: When you're doing observations this, is
22 a girl who's been sick all day, you had some concerns,
23 but they're limited; isn't that right?
24 A. Yes.
25 THE CHAIRMAN: So if she's getting a good night's sleep,

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1 you'd want her to get a good night's sleep?
2 A. But I'd also want to know that she was rousable. If
3 I found that she wasn't rousable I would have put my
4 hand on her shoulder or ... So that was my ...
5 THE CHAIRMAN: Would that be a standard thing to do with
6 a child who you are doing observations on during the
7 night?
8 A. Yes.
9 THE CHAIRMAN: You don't wake them, but you see if they can
10 be woken?
11 A. I would always try and elicit some kind of response from
12 them, yes.
13 THE CHAIRMAN: Right.
14 MR WOLFE: So in Raychel's case, you wanted to rouse her in
15 order to establish some communication?
16 A. But it's the same with every child that I'd done
17 observations on, yes. I know 2 o'clock is not the
18 nicest time to be woken at, but it is part of your
19 observation.
20 Q. So whether or not you had any particular concern about
21 a child, you would want to rouse them into a state by
22 which they can communicate with you?
23 A. Usually, yes.
24 Q. Why didn't you, in your first statement to your
25 employer, indicate that you had established such contact

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1 with her?
2 A. I said that she was rousable, so in my mind that meant
3 that she answered me when I asked her if she was okay.
4 If I said I couldn't rouse her, I wouldn't expect her to
5 say anything.
6 Q. What you should have said in your first statement is,
7 "She was rousable and I roused her so that she was in
8 a position to communicate with me"? Is that what you
9 meant to say?
10 A. Sorry? Would you repeat that again?
11 Q. You have merely in the first statement said that she was
12 rousable --
13 A. Yes.
14 Q. -- not that you had roused her. In the second
15 statement, not to put too fine a point on it, you have
16 managed to rouse her so as to establish some form of
17 communication.
18 A. I put the thermometer in her ear, it's sometimes enough
19 to rouse somebody.
20 Q. The point that I'm making to you is that while these
21 events were fresh in your memory in 2001, you didn't
22 refer to this communication from Raychel to you. And
23 I'm asking you why you saw fit to include it in your
24 2005 statement.
25 A. Because when I said she was rousable --

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1 Q. Are you saying that's what you meant by the word
2 "rousable"?
3 A. Yes.
4 Q. At 0200, as we saw earlier -- we needn't put it up on
5 the screen -- you checked Raychel's fluids.
6 A. Yes.
7 Q. By that time, I estimate that Raychel's intravenous
8 fluid bag would have been running down, it having been
9 erected at 12.10 the previous afternoon. If she's on
10 80 ml an hour, it should be complete, running down, by
11 the early hours of the morning.
12 A. Okay.
13 Q. Isn't that right, that it would take some 12 to 13 hours
14 for it to run down?
15 A. Yes, but you also had the 150 ml in the burette to take
16 into consideration as well -- and when the bag had been
17 changed before, there might have been another 150 then.
18 But I didn't change bag fluids at that time, no.
19 Q. So the way this burette works is that it retains
20 a quantity?
21 A. The burette is connected to the bag of fluids. We keep
22 it -- every time we check it on the hour, we would fill
23 it up from the bag to 150. Then when it alarmed, you
24 came back and if it was running at, say, 50 ml an hour,
25 you would have checked that only 50 ml had gone out of

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1 it. It's like a safety measure if you like. So you'd
2 have still had that 150 ml there as well and there could
3 have been 150 ml in it whenever the bag was erected at
4 12.10 also.
5 Q. Your next dealings with Raychel were after her seizure.
6 A. Yes.
7 Q. And you came back off a break to be told by Staff Nurse
8 Noble that Raychel had had this difficulty.
9 A. Yes.
10 Q. Can you recall all of your involvement for the next hour
11 or so at that time?
12 A. When I came back, I knew that a paediatric SHO was there
13 and that a surgical JHO was there, and I assisted the
14 surgical JHO when he took bloods from Raychel. She had
15 oxygen on at that time, her saturations were being
16 monitored. I was just concerned as to get more senior
17 help at this stage and when I went out to see
18 Dr Johnston --
19 Q. He was the paediatric --
20 A. -- he was the paediatric SHO -- to see if he would come
21 and see her. But when I went out to get him, he had
22 left the ward, so I said to the surgical JHO to bleep
23 the paediatric registrar who I knew was two floors away
24 and convenient.
25 Q. We know that to be Dr Trainor.

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1 A. Yes, Dr Trainor, sorry. Because at that stage I thought
2 we need more senior input than what we had at the time.
3 Q. Right.
4 A. And he was just about to lift the phone and Dr Trainor
5 came up the corridor with Dr Johnston.
6 Q. Could I just pause there. Staff Nurse Noble's
7 recollection is that you bleeped Dr Trainor, that was
8 her recollection in her statement. But that's not the
9 case?
10 A. That I bleeped her?
11 Q. Yes.
12 A. No.
13 Q. You instructed Dr --
14 A. I was with Raychel so I asked Dr Curran to bleep
15 Dr Trainor, the paediatric registrar, to come to the
16 ward immediately.
17 Q. Yes.
18 A. But before I had time to lift the phone, Dr Trainor came
19 up the corridor with Dr Johnston.
20 Q. So at that stage, you realised matters were sufficiently
21 serious as to call for more senior input?
22 A. Yes.
23 Q. And you were concerned that that senior input wasn't
24 there at that time for whatever reason?
25 A. Yes.

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1 Q. And you thought the most appropriate step at that time
2 was to get a registrar on the paediatric side there?
3 A. Yes.
4 Q. And that's the action that you took?
5 A. Yes.
6 Q. When Dr Trainor arrived, that was at approximately 4.20
7 by your recollection.
8 A. Yes.
9 Q. Sorry to push you on that, but are you able to help us
10 in terms of why you have identified that as the time or
11 why you identified it as the time at the time?
12 A. I don't know why I've put in that time. I can't recall
13 now.
14 Q. You have said in your witness statement that:
15 "At the time of Dr Trainor's arrival, Raychel's
16 pupils were sluggish, but reacting to light."
17 A. Yes.
18 Q. As opposed to her pupils becoming fixed and dilated?
19 A. Yes.
20 Q. So there was some, if you like, still some life in her
21 eyes?
22 A. Yes.
23 Q. Could I just ask you to consider the note that
24 Dr Trainor wrote at 020-015-023? Just the bottom half
25 of the page is all I need to refer to. She recalls in

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1 a note that was made later that morning, retrospective
2 in that sense:
3 "Called to see a patient 4.15. On examination,
4 looking very unwell, unresponsive. Pupils dilated and
5 unresponsive."
6 I'm just interested if you can help us at all. You
7 are seeing Raychel's eyes as having some life, albeit
8 they were sluggish, at the time of Dr Trainor's arrival?
9 A. It was me who was doing Raychel's observations at that
10 time and they became dilated very, very quickly after
11 that.
12 Q. Right. So --
13 A. So I don't know the time span. It could have been
14 minutes.
15 Q. You made your observation from a position of being quite
16 close to Raychel?
17 A. Yes.
18 Q. Before Dr Trainor arrived?
19 A. Yes.
20 Q. Dr Trainor's actions were quite quickly to come in to
21 Raychel's room, is that right --
22 A. Yes.
23 Q. -- and to commence a process of examination?
24 A. Yes.
25 Q. And are you saying, just to be clear, that within that

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1 short period of time Raychel's pupils had become fixed
2 and dilated?
3 A. Yes.
4 Q. The inquiry understands from the evidence that is
5 available that, quite quickly, an emphasis was placed on
6 obtaining bloods for Raychel. Indeed, Dr Curran had
7 taken bloods for biochemistry prior to your arrival;
8 is that your understanding?
9 A. I was with Dr Trainor, so -- yes, that's correct, yes.
10 Q. Just help us on this. Did you assist Dr Curran with the
11 bloods?
12 A. Yes.
13 Q. The first set of bloods?
14 A. Yes.
15 Q. And the results of those were available for Dr Trainor
16 shortly after or about the time she arrived?
17 A. As far as I can recall. I don't remember exactly what
18 time they were available because I was with Raychel at
19 that time.
20 Q. Were you aware of any discussion about the results of
21 the electrolyte tests that had been performed?
22 A. I can't recall. It could have been said, but I can't
23 recall results. I just don't have a recollection of
24 hearing results.
25 Q. It was the known from the first set of results that

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1 Raychel's serum sodium was low; does that help you?
2 A. No.
3 Q. Do you remember that contact was made with Dr McCord by
4 Dr Trainor?
5 A. Yes, I remember her making contact with him, yes. But
6 I don't know what time that was or approximate time.
7 Q. Did you witness any part of the telephone conversation
8 between them?
9 A. No, because she would have had to have gone out to the
10 telephone. I was still with Raychel.
11 Q. Shortly after that conversation, the inquiry understands
12 that Raychel suffered desaturations and respiratory
13 arrest, requiring the input of an anaesthetist.
14 A. Yes.
15 Q. Were you present at that time?
16 A. No.
17 Q. What was your last involvement with the care of Raychel?
18 A. Staff Nurse Noble carried her down to the treatment room
19 and it was around then that her saturations started to
20 dip down and she was being bagged, but at that time
21 I left the treatment room. Staff Nurse Noble was in
22 there, Dr McCord and Dr Trainor; I can't remember who
23 else was present at that time.
24 Q. Obviously, sister, it would have been appreciated at
25 that time that Raychel was gravely ill.

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1 A. Yes.
2 Q. And ultimately, in the course of that morning, Raychel
3 was brought to the Royal Belfast Hospital for Sick
4 Children by transfer.
5 A. Yes.
6 Q. When she died on 10 June, who informed you of her
7 passing?
8 A. It was when I came into work because I was on night duty
9 the Saturday and Sunday night as well, so when I came in
10 on night duty on 10 June that I was told.
11 Q. Can you remember who told you?
12 A. I think it was Sister McKenna.
13 Q. And were you given any understanding of what had caused
14 her death at that point?
15 A. I really can't recollect the conversation at that time.
16 Q. Is that because it was so long ago or because you were
17 upset?
18 A. It was just so devastating, I just ... Disbelief and
19 just ...
20 THE CHAIRMAN: And it must have been roughly at the same
21 time that the sister asked you to make your statement,
22 which we were looking at earlier on.
23 A. Yes.
24 MR WOLFE: In the days that followed, a critical incident
25 meeting or review was established.

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1 A. Yes.
2 Q. And do you remember attending that?
3 A. Yes.
4 Q. It was convened by Dr Fulton.
5 A. That's correct, yes.
6 Q. And at that meeting you have told us in your witness
7 statement that you were asked to account for the care
8 that you had provided to Raychel over the course of
9 8 June, early morning of 9 June.
10 A. That's correct, yes.
11 Q. How do you recall that meeting? How would you describe
12 it?
13 A. Sorry, what do you mean?
14 Q. Sorry, I ran two questions into one there. Do you have
15 a reasonable recollection of that meeting?
16 A. Not a great recollection, no. I remember some things
17 about it.
18 Q. Okay. Let me ask you a broad question: what was the
19 atmosphere like at the meeting?
20 A. I think it was just nobody could believe what had
21 happened. We all went through the events of those two
22 days and then when Dr Nesbitt had talked about the
23 Solution No. 18 and it was considered inappropriate, but
24 that nobody -- we weren't aware of how inappropriate it
25 was at that time. And there were steps taken to -- from

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1 the nursing point of view, anyway -- to make sure that
2 all output was recorded, that electrolyte profiles were
3 done at least daily on surgical patients. But other
4 than that, my recollection of anything else is very,
5 very slim. It was just -- I think everybody had
6 such ... Couldn't believe that it had happened,
7 just ... When it's somebody you're looking after, it's
8 just devastating for everybody.
9 Q. Thank you. Can I see if I can push your memory on
10 a number of specific points? We know that Dr Nesbitt
11 attended the meeting; do you remember him?
12 A. Yes.
13 Q. Was he known to you before the meeting? He was
14 a consultant anaesthetist.
15 A. I'd maybe seen him about the hospital, but not on
16 a to-speak-to basis.
17 Q. He's recorded in a number of places -- notably his
18 police witness statement from 2005 -- that at that
19 meeting on 12 June 2001 there was discussion that
20 Raychel had really got too much of this fluid, too high
21 a rate; can you remember that being discussed?
22 A. I can't recall it being discussed. I'm not saying it
23 wasn't discussed, I'm just saying I have no
24 recollection.
25 Q. One thing you have touched upon is an acceptance at that

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1 meeting that Raychel had received what you called the
2 wrong fluid and that wasn't something that you knew
3 at the time.
4 A. No.
5 Q. There has been evidence that some information about that
6 had come via a nurse in the Royal to a nurse
7 in Altnagelvin. In other words, a nurse in the Royal
8 had told a nurse in Altnagelvin that Raychel had
9 received the wrong fluid. Is that something you know
10 anything about?
11 A. No.
12 Q. Can you say whether that was discussed at the meeting?
13 A. I don't recall.
14 Q. In his witness statement to the police, Dr Fulton
15 indicated that at that meeting, just as I think you've
16 said, there was discussion about the need for more
17 regular blood tests, to profile electrolytes.
18 A. Yes.
19 Q. Is that something that was discussed at the meeting?
20 A. As far as I can recall, yes.
21 Q. And can you say whether it was recognised at the meeting
22 that Raychel's electrolyte profile ought to have been
23 tested at some point during 8 June?
24 A. It could have been discussed, but, as I say, some of the
25 points I remember and others ... I can't remember the

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1 full -- everything that was discussed in the meeting.
2 THE CHAIRMAN: But one of the points to come out of the
3 meeting was about doing more regular electrolytes on
4 surgical patients?
5 A. Yes.
6 THE CHAIRMAN: Right.
7 MR WOLFE: Does it follow, sister, that because it was now
8 going to be a situation where electrolytes were going to
9 be done more regularly that this was triggered by the
10 events of Raychel's care?
11 A. Undoubtedly, yes.
12 Q. That it was recognised that there was some kind of
13 shortfall there?
14 A. Yes.
15 Q. One of the things that developed thereafter was that
16 junior house officers on the surgical side no longer
17 attended at patients in the way that Dr Devlin and
18 Dr Curran attended with Raychel.
19 A. That's correct, yes.
20 Q. Is it your understanding that that arose out of the
21 events of Raychel's death?
22 A. I think so, but I'm not 100 per cent sure.
23 Q. Was there any discussion at the meeting on 12 June, so
24 far as you can recall, about the nature and extent of
25 Raychel's vomiting?

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1 A. I'm sorry, I can't remember everything that was
2 discussed. It was ... I just don't have a recollection
3 of everything that was discussed. Some of the things
4 stick in my head and others -- I'm saying they may have
5 been discussed, but I don't remember.
6 Q. Do you accept that Raychel's vomiting was severe and
7 prolonged?
8 A. Yes.
9 MR WOLFE: Sir, I have no further questions from this side
10 of the room. I'll look round.
11 MR QUINN: I have two short issues. If I work backwards
12 perhaps.
13 The parents are a little bit concerned that there
14 was an assertion by the witness that Raychel was awake
15 at about 2 o'clock in the morning and that she said
16 "yeah" or "yes" in answer to some questions that were
17 posed. The parents want to make the point through me
18 that they want to challenge that however it can be
19 challenged because they say that when they left, they
20 described Raychel as zombie-like. They want to make
21 that point. It's perhaps not a point for a question,
22 but they want to bring it to the fore on the transcript
23 that when the experts give evidence, it's something we
24 should look at.
25 THE CHAIRMAN: This is the difference between

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1 Sister Gilchrist's two statements about rousable and
2 actually having been roused?
3 MR QUINN: Yes. The other point I should make by way of
4 passing, the statement that is reference 012-004-094 is
5 a statement over which the DLS claim privilege, number
6 218. So it seems as though that privilege has now been
7 waived. If we look at "218" on the list, "Statement
8 from S/N Gilchrist dated 10 June 2001". There can be no
9 other statement that I can find in any of my bundles,
10 but --
11 THE CHAIRMAN: Provided there's no other version of it.
12 MR QUINN: That's what I'm frightened of. I wanted to
13 highlight that now while I was on my feet.
14 THE CHAIRMAN: Just wait one second.
15 MR QUINN: The statement is now on the screen and you'll see
16 that, at page 8 of the letter of discovery, third
17 item --
18 THE CHAIRMAN: Just give me one second. (Pause). What's
19 the item number, Mr Quinn?
20 MR QUINN: Item 218, page 8, "Statement from S/M ...", which
21 I assume is a typo. That should be "... S/N Gilchrist,
22 dated 10 June 2001". It's on the discovery letter list,
23 "Revised schedule DLS inquest file".
24 THE CHAIRMAN: They've just revised that list and left it
25 out.

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1 MR WOLFE: The other point, of course, is that that point
2 that we're looking at about how the 02.00 entry is
3 described, about being rousable, is exactly how it was
4 presented to the coroner at the inquest.
5 MR QUINN: Yes. That's why I was aware of that. That's why
6 I wanted to make the point, that that's exactly how it
7 was presented. I'm sorry, sir, I only have the "Revised
8 schedule, DLS inquest file".
9 THE CHAIRMAN: Well, at lunchtime we were given a reduced
10 list and, after we finish with the witness, we're going
11 to break for a few minutes and let you have a look at
12 that.
13 MR QUINN: I'll leave that point then until the proper time.
14 THE CHAIRMAN: Just while you're on that. Sister, the point
15 that's on here, where you said in your statement on
16 10 June that Raychel was asleep and rousable, that
17 appears to be the same evidence that you gave to the
18 coroner.
19 A. Yes.
20 THE CHAIRMAN: You put the same statement to the coroner.
21 But then that changed when you came to give your
22 evidence to the inquiry. I presume that before you gave
23 evidence to the inquiry, you met with the Trust lawyers.
24 A. The inquiry here?
25 THE CHAIRMAN: Sorry, before you gave your evidence to the

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1 inquest, to the coroner, you met with the Trust lawyers?
2 A. Yes.
3 THE CHAIRMAN: I'm not going to ask you what was discussed
4 with them, but that statement was not added to in your
5 evidence to the inquest; isn't that right? But it was
6 added to when you came to give your statement to the
7 inquiry?
8 A. Yes.
9 THE CHAIRMAN: Do I understand your point to be that
10 rousable, "she was asleep but rousable", means to you
11 that that's what you would do to any child, not just
12 Raychel, and when you describe how she did say something
13 to you, that only confirms that she was rousable?
14 A. To me, rousable would be someone answering me back.
15 THE CHAIRMAN: Okay, thank you. You had a second point,
16 Mr Quinn?
17 MR QUINN: Yes. The general point again in relation to what
18 notes were kept at the bed and what notes were kept by
19 the nurses' station. I make this point because of the
20 very substantial difference between Dr Curran's evidence
21 about the red flag coffee grounds and what was on the
22 note and where the notes were kept. There's going to be
23 an issue in this case in relation to what responsibility
24 do the nurses have to tell the doctors about various
25 issues and what should the doctors check for themselves.

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1 So it's going to be important as to where --
2 THE CHAIRMAN: I think sister has made it clear a couple of
3 times that the least -- at the very least, the fluid
4 balance chart was at the bedside, which seems to be
5 a pretty consistent point.
6 MR QUINN: It does.
7 THE CHAIRMAN: The fluid balance chart, the observations
8 chart and the kardex.
9 MR QUINN: Yes.
10 THE CHAIRMAN: Okay.
11 MR QUINN: I'm with you on that, sir. I just wanted to make
12 sure that we were on all fours with our recollection of
13 it.
14 The last point -- and it's again a point that the
15 parents want me to ask -- is a point in relation to the
16 alarm going off in relation to the observations on the
17 fluid management side of things. I would like to ask
18 the witness as to what were the settings on the system
19 and whether or not that system can be pushed around the
20 ward because that is Mr Ferguson's recollection: he took
21 Raychel down the ward corridor and his recollection
22 is that there was no alarm on the system when she was
23 pushing her own drip and they would like some further
24 information in relation to that issue.
25 THE CHAIRMAN: You mean if, for instance, he took her to the

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1 toilet, the drip went with her, but the alarm didn't?
2 MR QUINN: He says he didn't take her to the toilet at that
3 visit, but he will say he definitely did take her down
4 the corridor. We assume that there can be some sort of
5 meeting of minds on that because one can assume the
6 nurse might have thought he was taking her to the
7 toilet. So there may be some meeting on that point.
8 But what he doesn't meet with is that he will say he has
9 absolutely no recollection of the alarm going off during
10 the daytime when he was there. And though it may be put
11 on again after the 8 o'clock shift started off, I would
12 like this witness to say whether or not she recalls what
13 system was used and how it had become recorded so
14 accurately, which the nurse expert queries.
15 THE CHAIRMAN: Have you worked day shifts over the years as
16 well as nights?
17 A. Yes, at the time I was doing both. Every few weeks
18 you'd be on nights.
19 THE CHAIRMAN: The reason this is being raised is that
20 Mr Ferguson doesn't remember the alarm going off at all
21 during the day, but does remember the alarm going off at
22 night. In your experience, was there some way of
23 quietening the alarms or turning them off during the
24 day?
25 A. No. There was no way it was turned off. There's no way

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1 it could have been turned off.
2 THE CHAIRMAN: Then do I take it that part of what you say
3 is that it'd be counterproductive to take it off because
4 the reason for the alarm is to make sure the child
5 continues to receive the fluid? So if you turn off the
6 alarm, the fluid might run out, nobody might be with her
7 or a parent or a visitor might not notice, in which case
8 the child stops getting fluid until somebody notices it.
9 A. Yes.
10 THE CHAIRMAN: Well, if a child goes down the corridor with
11 a parent or a friend or something, how does the alarm go
12 with the child?
13 A. It's all built into the pump. The pump also has
14 a battery on it, so when you disconnect it from the
15 wall, it still runs, and the alarm will still go off --
16 THE CHAIRMAN: Right.
17 A. -- if it was on the hour or for any other reason that
18 it would alarm.
19 THE CHAIRMAN: Does it go off if it malfunctions?
20 A. Yes. If the battery's low in the machine, it will alarm
21 as well.
22 THE CHAIRMAN: Okay. I understand.
23 Mr Lavery, have you anything? Mr Campbell? Nothing
24 further?
25 Okay. Sister, that brings to an end your evidence

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1 to the inquiry, so unless there's anything you want to
2 add before you leave the witness box you are now free to
3 leave.
4 A. Thank you.
5 THE CHAIRMAN: Thank you very much indeed.
6 MR CAMPBELL: Sir, just before you rise, I think that now
7 concludes the evidence from my seven nurse clients.
8 First of all, can Sister Gilchrist withdraw from the
9 witness box?
10 (The witness withdrew)
11 THE CHAIRMAN: Of course.
12 MR CAMPBELL: My clients have asked me to say a few words on
13 their behalf, Mr Chairman, and just for the record --
14 THE CHAIRMAN: Let me hear what line you're going down,
15 Mr Campbell.
16 MR CAMPBELL: It's merely by way of an expression of regret
17 and sympathy.
18 THE CHAIRMAN: Of course. Go on ahead.
19 MR CAMPBELL: For the record, my clients are staff nurses
20 Noble, Patterson, Bryce, McAuley, Roulston and sisters
21 Gilchrist and Millar. The giving of evidence by these
22 ladies, you will have observed, Mr Chairman, has been at
23 times emotional and difficult for them and although you
24 did give each of them the opportunity to say something
25 towards the end of their evidence, none of them felt

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1 able or in a position to do so. That is quite simply
2 because they were devastated and remain devastated by
3 the very tragic outcome of Raychel's case. Each and
4 every one of them is a mother and, from that point of
5 view, can well understand the depth of loss that the
6 Ferguson family have been suffering for the 12 years
7 since her tragic and untimely death. The nurses wish me
8 to express their deepest sympathies to the Ferguson
9 family.
10 THE CHAIRMAN: Thank you very much, Mr Campbell.
11 Mr Quinn, over lunch a revised, reduced list arrived
12 from DLS in which they've cut back on the documents for
13 which they're claiming privilege. And they've confirmed
14 that it's advice privilege, not litigation privilege
15 they're claiming. I'm going to break for 15 minutes and
16 let you look at the list. I want to look at it for
17 a few minutes. I think Ms Conlon now has it to
18 distribute. I'll come out again in 15 or 20 minutes
19 after you've had a chance to look at it.
20 (3.35 pm)
21 (A short break)
22 (4.30 pm)
23 Discussion on privilege
24 THE CHAIRMAN: Have we made progress?
25 MR STITT: Yes, Mr Chairman, we have.

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1 THE CHAIRMAN: Let's do it in order. There was the old
2 Altnagelvin file 1 and 2, or our files 21 and 22.
3 I think Ms Dillon has agreed a note on this with
4 Mr Johnson and that's been circulated.
5 Mr Doherty, Mr Quinn if there are any queries about
6 that, could those be picked up tomorrow morning when
7 Ms Dillon is back. I hope there aren't any queries, but
8 if there are, she can deal with those tomorrow morning
9 in conjunction with Mr Johnson. So let's leave that for
10 now.
11 Mr Stitt, we have a truncated claim for privilege on
12 the Altnagelvin inquest file, also known as the DLS
13 inquest file; isn't that right?
14 MR STITT: That's correct.
15 THE CHAIRMAN: And I think Ms Anyadike-Danes was going to
16 speak to you about --
17 MR STITT: They've all been dealt with.
18 THE CHAIRMAN: What more do I need to do on that? You
19 wanted a bit of clarification?
20 MS ANYADIKE-DANES: I did and there were -- for example,
21 there were some file notes where we didn't know who was
22 involved in it. Mr Stitt has looked at the original
23 file and he's provided me with that further information
24 and I have shared that with Mr Quinn and his instructing
25 solicitor. What I suggest happens is that gets

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1 incorporated into this index to make sure we don't go
2 too far adrift and people understand it. I am prepared
3 to do it myself and e-mail that to Mr Stitt so that he
4 can satisfy himself that I've got what he was telling me
5 correctly and then we should have a final version of
6 that. The only queries I raised related to the ones
7 where they are still seeking to claim privilege.
8 I haven't sought to raise those sorts of queries about
9 other documents because every other document we're going
10 to receive and people will see for themselves what the
11 document contains.
12 MR STITT: In relation to that latter point, sir, the
13 relevant persons are here this afternoon, as per your
14 request.
15 THE CHAIRMAN: Thank you very much.
16 MR STITT: So the actual mechanics of replicating the
17 original file will be done early tomorrow morning when
18 all the relevant pages -- all the pages -- will be
19 photocopied and numbered in the same manner as the final
20 index. Then the pages for which no privilege is claimed
21 will be handed and distributed and it will then be
22 obvious as to which is the bundle for which privilege is
23 claimed and which is not.
24 THE CHAIRMAN: Could I raise one issue? There's a side
25 point and it might save some trouble tomorrow. On the

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1 revised list I've been given, there's things like item
2 11, "Folder of Altnagelvin payments, letters and
3 receipts". Is that relevant to anything? That's
4 21 pages of photocopying which will then be done many
5 times over so that every interested party gets it.
6 MR STITT: I appreciate that, but by the same token, as I
7 think I've alluded to before, it's a particularly
8 complex file and there will be some unnecessary copying.
9 We do feel, for the sake of completeness and to ensure
10 that everyone can follow, every page should be
11 photocopied so there's no room for ambiguity.
12 THE CHAIRMAN: If we receive a full copy of the documents
13 which are not privileged, then a view can be taken about
14 how many of those need to be copied and distributed.
15 MR STITT: Yes.
16 THE CHAIRMAN: I mean, there's one on the following page at
17 item 21, a recorded delivery receipt to Ms Brown.
18 Unless there's something dramatically interesting --
19 MR STITT: No it's not, it's spectacularly uninteresting.
20 That having been said, if I may take you up on this,
21 Mr Chairman, if we take item number 10, I'll take
22 direction on this from any other interested party,
23 "Inquest hearing notes", 62 pages.
24 THE CHAIRMAN: These are notes which were made at the
25 two-day inquest; is that right? Are they 62 pages or

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1 six?
2 MR STITT: 62.
3 THE CHAIRMAN: They are 62, are they? Right. Those are
4 notes that were made as the inquest went along?
5 MR STITT: Yes, there's no added value to those notes.
6 They're a note of the inquest.
7 THE CHAIRMAN: I suppose the safest way is, notwithstanding
8 my concern since this issue has now reached this stage,
9 if you can give us a full copy of the documents in
10 respect of which there is no claim for privilege and
11 we can have a discussion about how many of those
12 documents can then be culled from the list which is
13 photocopied and distributed.
14 MR STITT: I think if we start with everything, that's
15 probably the better place.
16 THE CHAIRMAN: Okay. That then leaves the claim for
17 privilege, which on the face of it looks to be advice
18 privilege and on the face of it looks to be
19 well-founded, unless Mr Quinn, do you have any initial
20 reaction to the claim for advice privilege?
21 MR QUINN: No, I wouldn't have, and that is the category
22 that I would have addressed your good self on today.
23 I can see no argument that I could put up at this stage
24 against that.
25 THE CHAIRMAN: Just to confirm that, there was a submission

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1 made to us about the reports by doctors Warde and
2 Jenkins and it came before you represented the
3 Fergusons, Mr Quinn. It came through Mr Coyle and
4 Mr Doherty on 30 October 2009. At page 51 they said:
5 "We reiterate we do not wish to see the documents
6 setting out any advice on foot of these reports as that
7 is clearly covered by advisory privilege.
8 MR QUINN: That's the advice that I discussed with Mr Coyle
9 at lunchtime and that's the line we are taking.
10 THE CHAIRMAN: That seems to be bringing this issue to an
11 end and we can confirm that, with a bit more tidying up,
12 between tonight and tomorrow morning.
13 MR STITT: Yes.
14 THE CHAIRMAN: Okay, great.
15 MS ANYADIKE-DANES: Mr Chairman, if I may just interject.
16 It relates to something Mr Coyle communicated to me over
17 the evening when he was obviously not seeing the reduced
18 claim, but nonetheless thinking about what his position
19 is. As I understand it, he is the person, on behalf of
20 the family, who would be making any submissions. The
21 issue that he had was to do with the possibility that
22 there has been some sort of waiver or collateral waiver.
23 There was an awful lot of documentation already out
24 there. There's quite a bit of documentation that
25 relates to particularly the experts, Dr Jenkins and

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1 Dr Warde, and I think the slight concern, in fairness to
2 him -- because I see he's not here -- is whether there
3 might have been some waiver there and that might be
4 something to be explored.
5 THE CHAIRMAN: That's on the basis that if the Trust has not
6 claimed privilege for the reports by Dr Warde and
7 Jenkins, can it then claim privilege for discussions or
8 exchanges about those reports?
9 MS ANYADIKE-DANES: Yes, that's one, and I think he was also
10 conscious of the fact that Staff Nurse Noble, as she was
11 then, and Sister Millar have given evidence and have
12 indicated certain things of what they believe the
13 clinicians and Trust may have understood following on
14 from the critical incident review meeting. For example,
15 about the incidents of severe and prolonged vomiting,
16 which was a point on which the Trust sought expert
17 advice. So if that information has already been
18 conveyed to us from the witness box in terms of what
19 they think the clinicians and Trust knew on that
20 question, then there may be an issue and I put it no
21 higher because it's his point really for him to
22 consider. I'm conscious that there may be something
23 there that he may wish to address you on.
24 THE CHAIRMAN: If there is to be any issue about that,
25 Mr Quinn, could we know about it quickly?

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1 MR QUINN: We will know by first thing tomorrow morning.
2 THE CHAIRMAN: Thank you.
3 MR STITT: Can I come back on this point about reports, the
4 Warde report and the Jenkins report. Of course,
5 I wasn't involved, but I have obviously sought
6 instructions in relation to what happened. Perhaps you,
7 sir, could correct me if I've got this wrong. What
8 originally happened is Altnagelvin Trust, when asked by
9 the inquiry to provide their documentation, turned over
10 their entire file in an attempt to assist. You have
11 been kind enough to describe the Trust as a beacon in
12 certain respects and that's the way they were operating.
13 That's the Trust.
14 Then the legal team were in contact with the DLS and
15 we have given legal advices and you've handed over stuff
16 which is obviously privileged, and in fact you, sir,
17 even pointed out to the Trust that they had handed over
18 prima facie privileged documents. So they made a claim
19 through you for a privilege, notwithstanding the fact
20 that the documents had already been handed over,
21 in relation to those two reports. And I understand that
22 you held a hearing at which Mr Stevenson QC was involved
23 and you made a ruling that they were privileged and
24 privilege had not been waived. That ruling was
25 subsequently challenged by the family, effectively --

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1 THE CHAIRMAN: Yes.
2 MR STITT: -- and you reversed yourself.
3 THE CHAIRMAN: Well, no, what happened, it's not quite true
4 that I reversed myself. Mr Coyle and Mr Doherty put in
5 a submission and, after their submission had been
6 received, it was then Mr Simpson QC was going to make
7 a submission on behalf of the Trust. Instead of
8 receiving a submission, we then got a letter from -- I'm
9 just looking for now. It's a letter date
10 27 November 2009 from Ms Beggs on behalf of the Trust.
11 The inquiry had sent her the skeleton argument submitted
12 by Mr Doherty on behalf of the Fergusons. That skeleton
13 argument was limited to whether the reports from
14 Dr Jenkins and Dr Warde were privileged and Ms Beggs
15 said:
16 "I would confirm on the advice of senior counsel the
17 Western Trust does not intend to claim legal
18 professional privilege in respect of these reports. In
19 view of this, it is not our intention to submit
20 a skeleton argument on behalf of the Trust."
21 Effectively, the Trust abandoned its claim for
22 privilege.
23 MR STITT: I think that's right and I stand corrected.
24 I thought that you had actually altered your own
25 opinion, but obviously that letter speaks for itself.

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1 Well, I will wait with interest to see what Mr Quinn has
2 to say, if anything.
3 THE CHAIRMAN: Okay, that's that, which might be heading
4 towards resolution.
5 The Brangam Bagnall file for the Belfast Trust on
6 the inquest, we have an index for that, but
7 I understand, Mr Stitt, that you're seeking more time
8 before advising what the Trust's position is on claiming
9 privilege for any of the documents that we have the
10 index of; is that right?
11 MR STITT: Yes. The file is relatively straightforward, as
12 I indicated to you last week. I can't see anything
13 controversial and I'd hoped to be able to give you the
14 final list today. Unfortunately, it requires a meeting
15 with a senior member of the Trust and that cannot take
16 place before Wednesday. I'm hoping that as soon as that
17 person is advised as to the nature of what's happening,
18 that should be hopefully a speedy decision. It's not
19 directly within my control. I have urged all involved
20 to expedite this as soon as possible. I will go on
21 record as saying I don't see it as controversial, but
22 that's just my view, obviously, and I may be wrong about
23 that.
24 THE CHAIRMAN: I'd like to know at some point on Thursday
25 what the position is about that.

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1 MR STITT: I will make sure that the relevant person in the
2 Trust is advised of that today --
3 THE CHAIRMAN: Thank you.
4 MR STITT: -- so that they will know in advance of the
5 meeting on Wednesday that a decision is expected by you,
6 sir, on Thursday.
7 THE CHAIRMAN: There are then litigation files of which
8 I think there might, as it turns out, be three. There
9 might be a DLS litigation file, a Brangam Bagnall
10 litigation file and an MSC Daly litigation file. There
11 is a query --
12 MR STITT: A query. We haven't found an MSC Daly one, but
13 I'm not in a position to say there isn't one and our
14 searches are continuing in relation to that. I had
15 indicated that I had felt the one that I've seen is
16 the DLS file and it seemed to be what it said on the
17 outside: it was a litigation file, a litigation which is
18 still extant.
19 THE CHAIRMAN: Yes.
20 MR STITT: I would be -- there are some documents which are
21 peripheral, but it's still obviously all in the same
22 file.
23 THE CHAIRMAN: Our understanding from Adam's case was that
24 when Brangam Bagnall folded, MSC Daly then took over its
25 files, but dead files went to storage in Mallusk. And

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1 then when all the work went into DLS, the MSC Daly files
2 were forwarded to DLS. If that understanding is
3 correct, any MSC Daly file should have gone to DLS and
4 would be maybe subsumed into the DLS file or be
5 ancillary to it.
6 MR STITT: I will make sure today that a further search is
7 put in train in the DLS to see if there's an MSC Daly
8 litigation file in relation to Raychel. I did read the
9 transcript when Mr Simpson was addressing you
10 in relation to the searches and the number of days it
11 took at Mallusk. I think that's probably dead ground by
12 now.
13 THE CHAIRMAN: The query was:
14 "Is there a Brangam Bagnall file from that era as
15 well? Where you have a Brangam Bagnall inquest file
16 query, is there a Brangam Bagnall litigation file for
17 what would have been the old Royal Trust?"
18 MR STITT: I'm not aware of one. I doubt if I could put the
19 Mallusk matter any further than Mr Simpson did last year
20 when he addressed you on it.
21 THE CHAIRMAN: Okay. Let's keep on top of this. First of
22 all, I'm grateful to everyone who's put a lot of work
23 into this over the last week or week and a bit. I think
24 it's a reminder to everybody that it's far better if you
25 sort these issues out in advance rather than on the hoof

1 as we go through the hearings. The way this developed
2 is unfortunate. It now seems to be on the way to
3 becoming less controversial than it appeared to be last
4 week. And as always with these things, the sooner we
5 get them done the better, because it minimises the risk
6 of any confusion or uncertainty. It also minimises the
7 rather more serious risk of anybody who has given
8 evidence having to be recalled to give evidence because
9 there is new documentation which needs to be raised with
10 them.
11 MR STITT: Nobody wants that.
12 THE CHAIRMAN: Okay, let me leave it like that until
13 tomorrow. I am grateful as I understand that the
14 chief executive of the Western Trust has come and I'm
15 grateful to her for her attendance. I know there is --
16 MR STITT: Ms Way is at the back. She has come down and
17 left her duties for the day, but she does believe that
18 this inquiry is particularly important and she's
19 intending, I think, to come back tomorrow again, such is
20 her concern for the issues in question.
21 THE CHAIRMAN: I'm grateful to her because I'm sure there's
22 other ongoing important things in the Western Trust to
23 handle and I'm grateful to Ms Way for taking the time to
24 be here and to everyone else who's put themselves out to
25 catch up on something which we should all have taken

1 care of before now.
2 I will adjourn now until tomorrow morning. I think
3 the timetable is changing a bit this week. We'll still
4 be sitting Tuesday, Wednesday and Thursday. Tomorrow
5 morning we have Dr Trainor first and then Mr Zafar.
6 Mr Zafar is flying in tomorrow morning, so we'll start
7 with Dr Trainor and go on to Mr Zafar. You'll recall
8 he's a recalled witness because we didn't finish him
9 before. I can't let that happen again with him because
10 I have had significant difficulties in getting him back.
11 We will have to get through Mr Zafar and Dr Trainor
12 tomorrow.
13 On Wednesday it's Mr Makar and Dr McCord. On
14 Thursday morning, it's Mr Bhalla and Mr Gilliland.
15 Mr Bhalla is giving evidence by video link. We have
16 that video link from 9.30 until 12.30, so I'd like
17 everyone here on Thursday morning by 9.20. We have
18 a three-hour time slot with him. That should be enough.
19 And then we want to get into Mr Gilliland and try and
20 get through his evidence so he isn't left hanging over
21 the long weekend ahead.
22 So until tomorrow morning. Thank you very much.
23 (4.49 pm)
24 (The hearing adjourned until 10.00 am the following day)
25

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