Monday, 11 March 2013

(10.00 am)

THE CHAIRMAN: Good morning. Mr Wolfe.

MR WOLFE: Good morning, sir. The first witness we have this morning is Dr Mary Butler.

DR MARY BUTLER (called)

Questions from MR WOLFE

MR WOLFE: Good morning, doctor, and thank you for coming. To date, doctor, you've provided the inquiry with two written witness statements --

A. Yes.

Q. -- the first dated 1 July 2005 --

A. Yes.

Q. -- and the second, 14 June 2012.

A. Yes.

Q. And we ask witnesses whether they wish to adopt those witness statements as part of their evidence to the inquiry; do you wish to do so?

A. Yes.

Q. In addition to providing the inquiry with witness statements, you also provided the PSNI with a statement by way of assistance in 2006; isn't that correct?

A. That's right.

Q. In June 2001, the inquiry is aware that you provided some care for Raychel by way of continuing

a prescription for her intravenous fluids; isn't that correct?

A. Yes.

Q. And you did that in your capacity at that time as a senior house officer in paediatrics.

A. Yes.

Q. And your current position is what, doctor?

A. A general practitioner.

Q. In Northern Ireland?

A. Yes.

Q. Could we have your CV up on the screen, please? It might be helpful just to shorten matters. It's at WS026/1 and if we could start at page 7. Just to assist, doctor, we'll move forwards through your CV from its back page, if you like. You qualified in medicine through University College Dublin, isn't that correct, in 1998?

A. Yes, that's right.

Q. And starting in August 1998 then, you had a junior house officer's role in Mid-Ulster Hospital --

A. Yes.

Q. -- before coming to the Altnagelvin in August 1999.

A. Yes.

Q. And if we could move to page 6 of the document, back a page, we see that you go through various rotations and

end up in paediatrics in February 2001.

A. Yes.

Q. That was your introduction to paediatrics.

A. Yes.

Q. You had no previous experience in paediatrics prior to February 2001?

A. No.

Q. In your role in paediatrics, doctor, what were the kinds of tasks that you would have been engaged in from day-to-day?

A. We would attend at the ward rounds and often written in the notes. We'd have looked after the children in Ward 6. And Ward 6 team, which was the day care unit and the infant unit, we'd attend at the labour ward for deliveries and did the post-natal baby checks. And we also would have attended the Special Care Baby Unit and the neonatal unit, carrying out bloods and investigations.

Q. You had a job description, which you've helpfully attached to your witness statement. Perhaps we could have a look at that. It's WS026/2 at page 15, please. We can see the job title, "senior house officer", and paediatric medicine was your first term. This was to be a six-month rotation; is that correct?

A. Yes, that's right.

Q. And the purpose of the role set out there:

"To support the consultants in the provision of care of the patients in Altnagelvin Hospital."

Then it sets out various aspects of that. If we go to the next page, please, page 16. Can I pick up on the bottom of the page, "Study and training":

"Junior doctors are expected to participate in the active teaching programme at the hospital."

At that time, can you remember the extent to which there was an active teaching programme at the hospital for paediatric SHOs?

A. In paediatrics there was supposed to be a perinatal meeting on a Wednesday around lunchtime, I think, and then there were supposed to be separate paediatric training on a Friday afternoon, but quite often you could be called away or maybe it didn't actually happen.

Q. In terms of the nature of the SHO on the paediatric side, in terms of the nature of that role, the inquiry has heard evidence already from Dr Johnston. Do you remember Dr Johnston from your year there?

A. Yes.

THE CHAIRMAN: Did you get a chance to see his evidence from Thursday or hear about his evidence from Thursday?

A. No, I didn't see his evidence from Thursday.

MR WOLFE: In terms of the nature of the SHO role in

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

A. Yes.

Q. Is that familiar to you?

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

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

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Mainly between Ward 6 and the baby unit.

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

A. I don't remember any specifically.

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

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

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

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

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

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

experience of that fluid being supplemented, depending on the child's need?

A. I don't remember specifically Solution No. 18 being supplemented, but sometimes potassium would have been added.

Q. Have you any recollection of other intravenous fluid types being used apart from Solution No. 18?

A. I know that there are other types available. I don't remember at that time any of them being used specifically.

Q. And as you've indicated already, on a paediatric ward such as Ward 6, you would have had some surgical patients.

A. Yes.

Q. Can you help us with this: in terms of the management of those patients, was that seen primarily as a surgical responsibility?

A. I think primarily it would have been seen as sort of a surgical responsibility, yes.

Q. Clearly, in Raychel's case, you were asked to intervene to assist a nurse with a prescription for continuing fluids. Was that a common scenario or regular scenario for you to be asked to intervene and help in this way?

A. From what I remember, it was a fairly routine request.

Q. Obviously, in this case, Raychel's case, you were being

asked to write up a second bag of IV fluids. But in what other kinds of scenarios would you, as an SHO on the paediatric side, have been asked to intervene and help with a surgical patient?

A. Maybe in taking blood samples or inserting IV lines into the patient or sometimes prescribing pain relief.

THE CHAIRMAN: Would the request invariably come from the nurses?

A. From what I remember, yes.

THE CHAIRMAN: Right. And is the scenario then that if there's no junior surgeon around, the nurse might ask you, "This child's bag is empty, would you prescribe a new one?", or, "Would you take a blood test or prescribe a painkiller?", just something along those lines?

A. Yes.

THE CHAIRMAN: The reason they're doing that is because the paediatricians are generally around the ward, whereas the surgeons typically weren't around the ward; is that it?

A. I think that's the reason, yes.

MR WOLFE: Can you say, doctor, whether that kind of intervention that we're talking about was something that was generally known, for example, to your supervisors? Would they have known that you would have been asked

from time to time to help out on a surgical patient?

A. I don't know if they would have known or not. To me it seemed to be fairly common practice.

Q. Dr Johnston, when he gave evidence on Thursday, reflected upon, if you like, the reservations that he would have had in terms of getting involved with a patient who wasn't his, to put it in those terms. Perhaps if we could have up on the screen, please, the transcript of what he said. It's 7 March 2013 at pages 178 and 179. If I could start, doctor, halfway down the left-hand page. The doctor is being asked:

"Question: If you were simply being asked to erect another bag of IV solution, would that have concerned you?

"Answer: I can't remember being asked to do that, but certainly I would have had reservations about doing that on a patient I didn't have clinical information about.

"Question: Why is that?

"Answer: Why would I have reservations?"

The chairman intervenes:

"Because it's not your patient?

"Answer: It's not my patient and I don't know whether the bloods were last checked and what the results were, what the patient presented with."

He goes on at line 12 on the right-hand page, doctor, to say --

THE CHAIRMAN: Sorry, Mr Wolfe. Look at lines 1 and 2. He says:

"You could be potentially taking on a sort of larger job than it first appears."

MR WOLFE: That's right, sir. Do you see that, doctor, the top of the page? If we could highlight that.

A. Yes.

Q. Then counsel then asks:

"So although it seems like a simple enough thing, you would want to know a little bit more about the circumstances of that child before you did something as apparently straightforward as that?"

So as apparently straightforward as putting up another bag of fluids and, he says yes. The chairman asks:

"I take it would be tempting if a bag of fluid for a surgical child had run out, it'd be -- and the nurses can't get a JHO ..."

He says:

"I can see how a colleague may get into difficulty. I think you sort of have to weigh up your rapport with the nursing staff. You could be quite unpopular with the nursing staff if there was a point-blank refusal to

help out like that. So I can see why some of my colleagues might have done that because they would have perhaps thought that they were helping."

Just pause there, doctor. That's one of your colleagues roughly of the same vintage, same passage through the SHO year, expressing reservations about getting involved with a patient with whom he has no familiarity, even for the apparently straightforward task of prescribing a further bag of fluids. Would you like to comment on that?

A. I mean -- I think what he's saying is true, but I don't remember any specific conversation with a nurse, but I mean it wouldn't have just been, "Prescribe some fluids", and me then to write them up. There would have been some sort of discussion around it.

THE CHAIRMAN: Sorry, you're talking about Raychel now or are you talking about generally?

A. Yes. Well, generally, but Raychel as well.

THE CHAIRMAN: Okay. Insofar as you believe you would have had some discussion and would not just have said, "Okay, yes, I'll write up a bag of fluids", what would the gist of that discussion have been?

A. I would have wanted to know how long Raychel had been on fluid, what she was in hospital with, what the plan would have been, and if it was 24 hours, if she had had

her urea and electrolytes checked.

THE CHAIRMAN: And if you got answers which didn't cause alarm bells to ring, then you might be content to go ahead and prescribe the fluid?

A. Yes.

MR LAVERY: Mr Chairman, I think it might be important to set an amount of context and have the witness asked about what conversations she had or would have had with the nurses at the time.

THE CHAIRMAN: Yes. The doctor will correct me if I'm wrong, but I think she said she can't recall a conversation, but the gist of the conversation she thinks she would have had is the conversation she just summarised. If Dr Butler has any more specific recollection, of course I'd be interested to hear it, but I got the impression that you don't have a specific recollection; is that right?

A. I don't, no.

THE CHAIRMAN: So what you have been telling me is what you believe you would normally have asked in that type of situation?

A. Yes.

THE CHAIRMAN: It wouldn't be as simple as a nurse coming to you and say, "Child A has run out of fluid, would you prescribe a bag?", you would make a few enquiries before

you would prescribe the bag?

A. Yes.

THE CHAIRMAN: Can you remember a situation, doctor, in which you declined to do what the nurse asked because your enquiry about that patient did cause you concern?

A. I don't remember specifically, but quite often I would have spoken to my registrar for advice.

THE CHAIRMAN: So you'd have spoken to?

A. The paediatric registrar if I had any concerns.

THE CHAIRMAN: Okay.

MR WOLFE: Just to put this in context, a request from a nurse, such as you received from probably Staff Nurse McAuley on that day, to prescribe another bag of fluids would not have been unusual?

A. No.

Q. And on that day -- and perhaps I can push you on this -- you were presumably on the ward dealing with paediatric patients and just happened to be available.

A. I assume so, yes.

Q. Nurse McAuley, who you may have known at the time as Nurse Rice, tells us, doctor, that she can't recall telling you that Raychel had vomited, but she believes she would have told you that Raychel needed fluids as she was still vomiting. So she doesn't have a firm recollection of it, but it's her belief that in asking

you to prescribe the further bag of fluids, it's the kind of thing she would have told you, that Raychel was vomiting. Can you help us with that?

A. I don't remember, but I assume if she said that she did, then I don't think that would have been unexpected for a child in Raychel's case, who was about 12 hours since having her surgery. Because sometimes the drugs or the pain relief or the fact that the tummy has been opened can cause vomiting up to 12 hours afterwards.

Q. Yes. We know that you entered your name on the prescription. If we could have that up, please, it's 020-019-038. It's the top line, doctor. So it's a 1,000 ml bag of Solution No. 18, the rate is 80, the pump type is entered, the serial number of the pump, and then you sign off.

A. Yes.

Q. And then the details on the right-hand side are the nurses checking off what you've prescribed and then erecting the fluids. I think we clarified with you in your witness statement that the handwritten calculation that appears on the top of the page isn't in your hand; isn't that right?

A. That's right.

Q. This document is a two-sided document. On the reverse side of it is the fluid balance chart. It can be found

at 020-018-037. Just for the record, doctor, would you remember that the documents that have appeared on screen consecutively are two sides of the one coin?

A. I don't really remember, to be honest.

Q. Do we have the original in the room so that the doctor ... We have it. (Handed).

So whether or not you were specifically told, doctor, that the child had been vomiting, the information plainly would have been in your hand.

A. Mm-hm.

Q. And by the time of your attendance, can we assume that your attendance would have been at some time close to midday --

A. I assume so, yes.

Q. -- because the nurses are erecting the new bag of fluid at 12.10, according to their record?

A. Yes.

Q. So by that time, the recording of vomit would have shown on this sheet, if you'd looked at it, a vomit followed by a large vomit.

A. Yes.

Q. Would the fact that a child had vomited twice, one of which was large, in the previous two or three hours, have been a factor which at that time you would have taken into account in assessing the need or the

desirability of a further prescription of Solution No. 18?

A. Well, I don't think it would have been unusual in a post-operative child, and in Raychel's case, to have vomited within 12 hours of surgery.

THE CHAIRMAN: Let me ask you about that, doctor, because it leads on to a different area, which is beyond what we are asking you. When you described a few moments ago -- and I'm afraid you don't have the transcript as it comes up -- but what you said on the top of page 20 [draft] -- you were being asked by Mr Wolfe about Staff Nurse McAuley, who you would have known then as Staff Nurse Rice, her recollection is that she would have told you something about the vomiting. Your answer was that that wouldn't have been unexpected for a child like Raychel who was about 12 hours after having surgery. Then you said:

"Sometimes the drugs or the pain relief or the fact that the tummy has been opened can cause vomiting up to 12 hours afterwards."

Okay?

A. Yes.

THE CHAIRMAN: In Raychel's case, the first recorded vomit wasn't until 8 and then there was another one at about 10, according to the record. In terms of post-operative

vomiting, would you expect the first 7 or 8 hours to have no vomits and then vomiting to start after that if it is post-operative vomiting?

A. I don't really remember from my recollection, but what I do remember is that up until 12 hours I wouldn't have regarded it as unusual or prolonged at that point.

THE CHAIRMAN: Right. But once you get beyond 12 hours, if the vomiting does continue on a fairly regular basis for another six hours or eight or ten hours, at that point it is becoming unusual, is it?

A. I'd have thought so, yes.

THE CHAIRMAN: So although every child's different and some operations, some removals of appendices are more straightforward than others, if a child is still vomiting 15, 18, 20 hours later, that's a cause of concern?

A. Yes.

THE CHAIRMAN: You see, I've been told -- and I have to say I find it difficult to accept -- that for Raychel to be vomiting through the afternoon into Friday evening and Friday night wasn't unusual. But from what you're saying, that would be a cause of concern if a child was vomiting that long after an operation?

A. Hypothetically speaking, I suppose if I'd been asked at 3 or 4 or 5 o'clock or later on when Raychel had vomited

more, I think I would have done something differently as opposed to just prescribing IV fluids.

THE CHAIRMAN: And the reason that you would have done something differently was because you'd be worried that you were moving beyond what would not be unexpected post-operative vomiting into an area of unexpected vomiting?

A. From my experience, yes.

THE CHAIRMAN: Thank you.

MR WOLFE: Okay, doctor, so in terms of the tasks that you were performing that morning, assuming that you were either told or saw the fact that Raychel had vomited twice, do I understand you as saying that that would not have inhibited you from prescribing the further fluids?

A. That's right.

Q. Because vomiting at that time would not have been regarded as unusual?

A. From my knowledge, it wouldn't have.

Q. In terms of whether you actually attended the child and examined her, I think you've told us in your witness statement that the fact that the notes are silent on that, there is no note to reflect the fact that you had carried out an examination, that the likelihood is that you didn't carry out an examination.

A. That's correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

on the surgical side in 2001 on Ward 6, the evidence that the inquiry has heard would suggest that the majority were paediatric medical patients.

A. That's right, yes.

Q. And really, if we look at your statement, you seem to be confirming that:

"Three or four patients at any one time would have been surgical."

A. That would have been about average, yes.

Q. You've said in your witness statement that -- perhaps if we can go to WS053/2 at page 2. At the bottom of the page you're asked to quantify the experience you had gained of working with patients on a paediatric ward by June 2001. You set out the kinds of experience that you had and they're typical medical problems that would be catered for by the paediatricians.

A. Yes.

Q. You say you also learnt that:

"Caring for children is a lot different than caring for adults inasmuch as their bodies' responses to illness and trauma."

A. Yes.

Q. So what you're doing there is helpfully comparing your experience as an adult nurse with the experience that you had gained as a children's nurse.

A. Yes.

Q. And what exactly are you trying to convey, staff nurse, when you say that there's a difference "inasmuch as their bodies' responses to illness and trauma"?

A. Children react differently, it's in their make-up. Dealing with trauma or illness would -- there's just a different protocol or different guidelines on how to treat them. You also learn that when you're caring for children as much as the child, you're caring for the whole family.

Q. Yes.

A. But anatomically, they respond differently, so their treatment would be different.

Q. So what you're highlighting there is the fact that children's nursing is a specialism, it involves a particular type of knowledge, a particular type of skill set --

A. Yes.

Q. -- which is different to the adult setting?

A. Yes.

Q. In caring for children, do you have to be more watchful, more sensitive to changes than in the adult setting?

A. I would say you would do because children tend to cope better with illness for a while before becoming unwell quickly, whereas adults would tend to become unwell

gradually over a period of time.

Q. So if you're right, if a child can just drop off and become ill without much in the way of warning --

A. Yes.

Q. -- does that necessarily suggest that, as a children's nurse, you have to be careful with your observations and your monitoring --

A. Yes.

Q. -- and you have to look for telltale signs?

A. Yes.

Q. One of the things, staff nurse, that the inquiry is interested in is to try and log or chart the extent to which nurses -- and indeed clinicians, for that matter -- had a knowledge by 2001 or an experience of managing children's fluid requirements. In general terms, how would you describe your experience or skills at that point in time?

A. Sorry, in dealing with what?

Q. In dealing with, let's be fairly specific, post-operative fluid requirements for a child.

A. Well, generally at that time it would have been usual that a child would be on IV fluids post-operatively until their oral intake dictated that the fluids were to be reduced and then stopped.

Q. I don't wish to deal with this with you in any great

detail, but was it your experience that the practice at Altnagelvin at that time was for preoperative fluids to be prescribed post-operatively without any change?

A. Yes.

Q. Just to flesh that out: a prescription would be written preoperatively by the surgeon, typically --

A. Yes.

Q. -- the child would have her or his operation --

A. Yes.

Q. -- and then unless something exceptional happens, the nurses would pick up the prescription again post-operatively and apply the same fluid at the same rate?

A. Yes.

Q. And that was your experience?

A. Yes, it was.

Q. And typically, the fluid would be Solution No. 18?

A. It would, yes.

Q. And in surgical cases, is it fair to say also that your experience was that the person or the team who had responsibility for the post operative fluids was the surgeon, unless the anaesthetist made a specific intervention?

A. Yes, it was, yes.

Q. In terms of managing a child's fluid balance, you were

aware -- and indeed we'll look at it in terms of the entries you made -- that at that time there was a fluid balance chart that required to be completed --

A. Yes.

Q. -- every hour?

A. Yes.

Q. And as part of a child's care plan, if they were in receipt of intravenous fluids post-operatively, it would be typical to record on that fluid balance chart items such as urinary output; yes?

A. Yes.

Q. Any intake such as oral fluids would be recorded.

A. Yes.

Q. And output such as vomit would have to be recorded.

A. Yes.

Q. And the expectation would be, with regard to each of those matters, that a nurse would record them throughout the patient's stay in hospital.

A. Yes.

Q. You look as if you want to add something to that; no?

A. No, it's okay.

Q. In terms of your own education in the area of fluid management, can I ask you this: the experts that have looked at this area from the nursing angle for the inquiry have advised us, advised the inquiry, that in

nursing syllabuses, nurses were taught about issues relating to the body's ability to maintain fluid balance and they were told about the disease processes that would cause disturbance of it. Can I ask you whether, in the nursing education that you had before 2001, you would have received that kind of teaching in your training?

A. I would say I would have done, but it was 1984 when I started my training, so I can't remember specifically what training I had about fluid balance.

Q. I think you've told us that in terms of what was handed down to you in terms of formal training at Altnagelvin changed after 2001 in that you received specific training from Dr Nesbitt; isn't that right?

A. Yes.

Q. But before 2001, there wasn't anything in terms of formal training or instruction to be had at Altnagelvin in this broad area of fluid management?

A. No.

Q. Leaving aside what you might have had in your training as a nurse, presumably you learned a lot from working on the ward day-to-day.

A. Yes.

Q. Have you read the report of Ms Sally Ramsay, which was prepared for the inquiry?

A. Yes.

Q. She has said that at a minimum she would expect a registered nurse to be aware that fluid loss from vomiting, if not replaced intravenously, can result in dehydration and electrolyte imbalance.

A. Yes, I've read that, yes.

Q. Thinking back to 2001, would that accurately summarise your state of knowledge at that time?

A. Well, at that time, I believed if a patient was receiving maintenance intravenous fluids then that would make up for any losses that they had either through vomiting or diarrhoea.

Q. So breaking that down, what that means is that if a child was receiving Solution No. 18 -- because that was the maintenance fluid of choice at that time, isn't that right?

A. Yes. That's correct.

Q. You thought that if a child was vomiting, but in receipt of intravenous fluids such as Solution No. 18, they would be okay?

A. That's what I believed, yes.

Q. Leaving aside this issue of what fluid a child might get, but just dealing with the issue of an electrolyte problem, you would have recognised that at that time that a child vomiting on a prolonged basis would be at

risk of suffering an electrolyte problem?

A. At that time I believed that the major issue would have been dehydration rather than electrolyte imbalance. In 2001, that's what I believed.

Q. In terms of a nursing response to prolonged vomiting, how would you characterise your role if a child was vomiting repeatedly during the day, perhaps having a mixture of small, medium and large vomits? What is the nursing function if that is happening?

A. Well, it would be to record the vomits, first of all, and then I would seek medical advice and ask medical doctors to come and assess the child or see a child and go on their instruction.

Q. The inquiry has heard some evidence that in terms of carrying out electrolyte profiles on children who might have diarrhoea or might have vomiting, that wasn't something that was part of the surgical arrangements that, to put it bluntly, the surgical team were less regular in terms of arranging electrolyte profiling for their children.

A. Well, in 2001, the electrolyte profiles would be done on medical patients at least 12-hourly. The surgical patients, they would not have been done -- every 24 hours. So ... Sorry, 24-hourly, I meant to say, for medical patients.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a setting where she's, in recent times, just had an anti-emetic. Were you aware at that time that the vomiting that had started at 8 am that morning had preceded an initial phase after her surgery where she appeared to be recovering quite well? In other words, after her operation finished at midnight the night before or 1 o'clock the night before, she didn't vomit and had appeared to be coping very well. Were you aware of that at that time?

A. Well, post-operative vomiting wouldn't have been that unusual. It did happen. Not in every case, obviously, but her prolonged vomiting or periods of vomiting, whenever I was with her that evening, prompted me to phone the doctor to assess her.

Q. Yes. We'll come to that in stages. But just pausing at or about 8.30 in a usual case or in a case which might be thought typical of a mild appendicitis, would you have thought or envisaged that she should have been mobile at that point, not vomiting, consuming maybe some light food and generally being up and about?

A. I wouldn't have thought she would be eating. I thought at that time a post-operative child might have been tolerating sips, but every one of them are completely different, so I couldn't really say that most children would have been, no.

THE CHAIRMAN: Okay.

MR WOLFE: You say that Raychel vomited shortly after the incident where she'd vomited on the bed linen. That's the first vomit that you record then on the fluid balance chart, is it?

A. Yes.

Q. And could we have that up on the screen, please? It's to be found at 020-018-037. You make an entry:

"Vomiting coffee grounds plus plus."

Is that right?

A. Yes.

Q. So this is the first time that you pick up this document and you make that entry. So in terms of what you knew at that time, you've had the nursing handover and then you're getting, if you like, a more detailed picture from this document; is that fair?

A. Yes.

Q. And in terms of what had gone before, you would have seen a vomit at 8 o'clock, a large vomit at 10 o'clock or thereabouts, and the fact that she passed urine at that point. And then later in the day at 1 o'clock, "vomited plus plus", followed by the same description at or about 3 o'clock.

A. Yes.

Q. What would the "vomited plus plus" have meant to you as

you read it that night?

A. That would have meant a medium vomit to me and I would have estimated that at about 150/180 ml, approximately. Very approximate.

Q. A doctor then came at 6 o'clock to give the anti-emetic. Were you aware of the time at which he came from what you knew at that time?

A. I can't recall if I was aware of the time, no.

Q. And it would appear that you wouldn't have been aware that Raychel was vomiting at that time because it was nowhere recorded.

A. No.

Q. And then you identified a vomit at or between 8.00 and 8.30. If you'd been writing that vomit into the notes, the vomit that appeared on the bed linen, how would you have described it?

A. I would have had to go on my estimation of what I thought it had been, if it had been a mouthful or appeared to be a mouthful. But I ... I can't recall exactly.

Q. Well, in the nature of things you'd have had to make an estimate --

A. An estimate.

Q. -- because the vomit didn't appear in a receptacle.

A. That's correct, yes.

Q. And you'd have had to make a judgment based on, I suppose, how widespread it was on the bed linen. Was that a coffee-ground vomit?

A. Not that I recall, no.

Q. But the vomit that you then detected at 9 o'clock was a coffee-ground vomit?

A. It was, yes.

Q. And it was medium in terms of its volume?

A. Yes.

Q. Was that produced into a receptacle?

A. Yes, it was.

Q. And by medium, I think you've described something in the region of about 150 ml; is that fair?

A. Approximately, yes.

THE CHAIRMAN: 150 to 180.

MR WOLFE: On the chart in front of us, there's a further entry in your hand:

"Vomited small amount X 3."

A. Yes.

Q. In terms of the time between those two entries or between those two vomits, was that a short period of time? It was certainly within the hour, was it, based on this record?

A. Yes. But I couldn't say if it was like 55 minutes or half an hour because it's just written on the hour.

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

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

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

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

duty, and also bearing in mind the fact that she's had an anti-emetic and bearing in mind the fact that she now has a headache and is pale -- that wasn't a normal situation for a child who has just come through a straightforward appendix operation.

A. Well, as I say, it wouldn't have been unusual for children to vomit for up to 24 hours after an appendicectomy. So the fact that she was pale was because she'd just had several vomits.

Q. Are you saying that all of those things that I've put into the mix -- the vomiting, the headache, the fact that an anti-emetic hasn't worked, and there's also the fact that she hasn't passed urine, at least according to this record -- are you saying none of that was terribly unusual?

A. I'd say it's unusual, but it was not unheard of. And all those reasons, that's why I contacted the surgical doctor.

Q. We'll just maybe bring up on the screen, before we move on, the observations that you carried out. We can find those at 020-015-029. At the bottom of the page you make an entry at 9.15.

A. Yes.

Q. And you have recorded -- is that "colour flushed to pale"?

A. Yes.

Q. "Flushed to pale"?

A. Yes.

Q. And is that conveying an observation that her colour's changing from red to white --

A. Yes.

Q. -- and is varying? Is it going red to white and back again?

A. No, no.

Q. Is that that she had been flushed and was now pale?

A. Well, it would have been over a short period of time -- I would say about seconds, I'm not too sure -- but I thought the paleness would be due to the vomiting. As I've recorded there, she was vomiting plus plus, so I was writing down exactly what I observed.

THE CHAIRMAN: Sister, does the vomiting plus plus at 9.15 mean she was vomiting at that point or that she had vomited earlier? Do I take it this is a 9.15 observation?

A. Yes.

THE CHAIRMAN: So she's got a headache, she's vomiting and she's going from flushed to pale?

A. Yes.

THE CHAIRMAN: Right.

MR WOLFE: So at this stage you're face-to-face with the

child for the purposes of doing these observations?

A. Yes.

Q. And you have recorded temperature, pulse and respiratory rate.

A. Yes.

Q. You didn't record blood pressure?

A. No.

Q. Blood pressure, it seems, hasn't been recorded since 7 am the previous morning or early that morning. Are you aware of Ms Ramsay's observation that blood pressure in the presence of ongoing vomit would have been a sensible thing to be recording?

A. I have read her report, yes.

Q. Is she right on that? Should you have been recording blood pressure?

A. Yes.

THE CHAIRMAN: Because the nurses who started these observations did record blood pressure and then it looks after that as if you're the third one in a row not to take it. Was there a reason for that? It looks a bit curious about why you would start taking blood pressure and then stop. In fairness to you, Staff Nurse Roulston hadn't taken it, nor had Staff Nurse McAuley or Nurse Rice as she was at that time. Why would that be?

A. I don't know why they would have stopped doing it and

I don't know why I didn't do it.

THE CHAIRMAN: Okay. Thank you.

MR WOLFE: Are you telling the inquiry that it should have been done?

A. Sorry?

Q. Are you telling the inquiry that you think now that it should have been done?

A. Looking back now, yes, it should have been done.

Q. The observations that you did carry out were within the normal range; isn't that right?

A. Yes.

Q. But while the observations were normal, you had a child in front of you who was looking sick; isn't that right?

A. Yes, she'd been vomiting and, as I say, that's why I contacted medical help.

Q. Yes. Did you think about the headache and what it might signify?

A. I didn't, no.

THE CHAIRMAN: Is that because, if any of us are sick and vomiting, having a headache wouldn't be unusual to go with it?

A. That's what I thought at the time, yes.

THE CHAIRMAN: So you didn't think of that as a sign of something separate or extra, it was just part of being sick?

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

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

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

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

we have repeat vomiting, significant vomiting, a significant volume of vomiting, and vomiting as attested by this witness that was so severe that it burst a blood vessel.

That leads on to the next question. Number one --

THE CHAIRMAN: Sorry, at what point did the witness say that?

MR QUINN: Page 74, line 16 [draft transcript] --

THE CHAIRMAN: Just give me one second.

MR QUINN: -- where she says "torn a wee vessel" or something similar. So the first question is that she agrees that it is a blood vessel she's referring to.

The second question I have to ask is: did she ever tell the parents about that because that would be something that would concern them. They say no, so it seems that she is also confirming that that is the case that never told the parents. But the third and more alarming feature is that she had never told the doctor.

THE CHAIRMAN: If that's what you thought at the time and that does indicate forceful vomiting, is that not something that you would pass on?

A. Well, that's what the coffee ground -- coffee grounds indicates that there's blood.

THE CHAIRMAN: So are you saying that the reference to the possibility of a burst blood vessel is the same as

coffee grounds?

A. I'm talking about a minute blood vessel. I'm not talking about a huge vessel --

THE CHAIRMAN: Because otherwise there would be blood flowing freely --

A. -- and it'd be fresh blood as well.

THE CHAIRMAN: -- so I understand that.

So do you say that the small burst blood vessel is in effect the same as coffee grounds, that that leads to the coffee-ground vomit?

A. Yes.

THE CHAIRMAN: And you then say your note, the note you made, shows that coffee-ground vomit was recorded?

A. Yes.

THE CHAIRMAN: Okay.

MR WOLFE: I'm going, sir, to move into the area that focuses particularly on the reasons for getting the doctor in and what was said to the doctor. Would it be an appropriate time now to break?

THE CHAIRMAN: Yes. We'll come back at 2 o'clock.

Sister, your evidence will be finished this afternoon. Okay? So we'll hear you for as long as necessary -- I don't think it will be necessary to sit terribly late to finish your evidence.

There should be some developments this afternoon,

Mr Lavery, about documents and privilege.

MR LAVERY: We should be in a position to outline any developments when Mr Stitt arrives.

THE CHAIRMAN: We might do it after -- if he is here at about 1.45, could he have a word with Ms Anyadike-Danes and Mr Wolfe? I don't want to start a debate at 2 o'clock which prevents this witness finishing, so we might do it the other way round -- finish the witness and then do the privilege argument -- but I'm not going to keep Sister Gilchrist in the witness box overnight because we're arguing about documents. If I have to sit late today, it will be sitting late to do the documents issue, not to finish the witness.

(12.57 pm)

(The Short Adjournment)

(2.00 pm)

MR WOLFE: Good afternoon, sister. I want to bring you straight to the decision to contact Dr Curran and bring him to see Raychel. In terms of why you thought it was necessary to contact a junior house officer, could you explain the factors that you took into account when deciding to make that contact?

A. The fact that Raychel had suffered the large vomit -- sorry, the medium vomit, I beg your pardon -- and then the three small vomits as well and the fact that it was

causing her distress prompted me to contact him.

Q. Would you have made that contact, do you think, regardless of whether the vomiting was coffee-ground in nature?

A. No, I don't believe I would. Because of the vomiting, the four vomits, the medium vomit and the three, I would have contacted him anyway.

Q. Right. So the fact that there was coffee-ground vomit wasn't a factor in your decision; it was the fact that there were four vomits in quick succession?

A. Yes.

THE CHAIRMAN: And that this would be causing Raychel distress?

A. Yes.

MR WOLFE: In terms of what you wanted the doctor to do, did you give that any consideration?

A. Well, I wanted him to come and see her and examine her and see if maybe another anti-emetic would be appropriate at that time.

Q. In your witness statement to the inquiry you have told us that you spoke to Ann Noble about the continuing vomiting being experienced by Raychel --

A. Yes.

Q. -- and you discussed contacting the doctor so that he could administer an anti-emetic to see if it could give

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

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

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

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

and given an anti-emetic on my say so, no; I presumed that in his role that he would have examined her and assessed her as well as that.

Q. But when you talk about wanting that doctor who would come to assess Raychel, was that to assess whether an anti-emetic was necessary or whether she was suitable for an anti-emetic or was it more generally than that?

A. Well, at the end of the day it would have been his call what he would do.

Q. Yes.

A. And as a staff nurse, we weren't able to administer anti-emetics. So even if it was written up "as required", we wouldn't have been able to do that.

Q. Yes.

A. So it would have been on his call to do that. And if he was assessing her, I would think that he would take into consideration her observations, her output, and a physical examination.

Q. Of course. But I want to focus on this issue about assessment. Did you think she required assessment?

A. I don't expect a doctor just to come and give an anti-emetic or a drug and just leave again.

Q. Yes. But if I have understood your evidence so far, you're saying to the inquiry you weren't particularly concerned about her, you simply wanted her to be

considered for the administration of an anti-emetic because here we had a number of vomits quickly and this is causing the child some distress.

A. Yes, but I wanted him to come and see her.

Q. Yes.

A. Not just to administer an anti-emetic, but to come and see her.

Q. So can I interpret what you are saying as follows: you felt that she probably needed an anti-emetic, but that was for a doctor to decide upon?

A. Yes.

Q. And secondly, you felt she would benefit from a general assessment in relation to her well-being?

A. I think the assessment would come first.

Q. Yes. How did you make contact with the doctor?

A. I would have rung the switchboard in the hospital and asked them to bleep the surgical JHO on call for Ward 6.

Q. And a doctor, Michael Curran, picked up on this communication?

A. Yes.

Q. Did you speak to him?

A. Yes, on the phone, yes.

Q. Did you speak to him at any other point apart from on the phone?

A. No.

Q. And you're quite sure about that?

A. As sure as I can be, yes.

Q. So the only communication you had with him was on the phone, you didn't speak to him on the ward at all?

A. No.

Q. Either before or after he saw Raychel?

A. No.

THE CHAIRMAN: Sister, when you spoke to him on the phone, that was to give some detail about why you wanted him on the ward; isn't that right?

A. That's correct, yes.

THE CHAIRMAN: Would that conversation be on the basis that you would expect to talk to him when he comes to the ward?

A. I would have been available, but at that time of the evening when we were doing observations on other than children, there's 23 children on the ward, so from the time I spoke to him on the ward until the time he came, you know, it could be half an hour, it could be 10 minutes, so I was going on doing observations on the other children, waiting for him to come.

THE CHAIRMAN: Would you keep an eye out for him coming so that, assuming he's going to spend five or ten minutes with Raychel, if you saw him coming in and you were doing observations on another child, there's a good

chance that you'd be able to finish that and still get to speak to him before he leaves?

A. If I had seen him, yes, I would have done.

THE CHAIRMAN: Or if you can't see him before he treats Raychel, you'd want to speak to him after he's treated her to know what his take on it is.

A. As I say, if I'd have seen him afterwards, I would have asked him, yes.

THE CHAIRMAN: Was it common for doctors to be bleeped to Ward 6 to come in and see a patient and not speak to a nurse before they saw the patient or during their assessment of the patient or before they left?

A. Well, they would have some contact with somebody, but it wouldn't necessarily have to be me because there was only the three of us there -- and that's myself, Nurse Noble and Nurse Bryce -- knew that I'd contacted the doctor, so he could have spoken to either one of us.

THE CHAIRMAN: Okay.

MR WOLFE: It's right to say that, when the doctor arrives, he will require some direction in terms of where the patient is.

A. Yes.

THE CHAIRMAN: He has to get into the ward?

A. Yes.

THE CHAIRMAN: The starting point is it's almost certainly

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes, Dr Trainor, sorry. Because at that stage I thought we need more senior input than what we had at the time.
Q. Right.
A. And he was just about to lift the phone and Dr Trainor came up the corridor with Dr Johnston.
Q. Could I just pause there. Staff Nurse Noble's recollection is that you bleeped Dr Trainor, that was her recollection in her statement. But that's not the case?
A. That I bleeped her?
Q. Yes.
A. No.
Q. You instructed Dr --
A. I was with Raychel so I asked Dr Curran to bleep Dr Trainor, the paediatric registrar, to come to the ward immediately.
Q. Yes.
A. But before I had time to lift the phone, Dr Trainor came up the corridor with Dr Johnston.
Q. So at that stage, you realised matters were sufficiently serious as to call for more senior input?
A. Yes.
Q. And you were concerned that that senior input wasn't there at that time for whatever reason?
A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to the inquiry, so unless there's anything you want to add before you leave the witness box you are now free to leave.

A. Thank you.

THE CHAIRMAN: Thank you very much indeed.

MR CAMPBELL: Sir, just before you rise, I think that now concludes the evidence from my seven nurse clients. First of all, can Sister Gilchrist withdraw from the witness box?

(The witness withdrew)

THE CHAIRMAN: Of course.

MR CAMPBELL: My clients have asked me to say a few words on their behalf, Mr Chairman, and just for the record --

THE CHAIRMAN: Let me hear what line you're going down, Mr Campbell.

MR CAMPBELL: It's merely by way of an expression of regret and sympathy.

THE CHAIRMAN: Of course. Go on ahead.

MR CAMPBELL: For the record, my clients are staff nurses Noble, Patterson, Bryce, McAuley, Roulston and sisters Gilchrist and Millar. The giving of evidence by these ladies, you will have observed, Mr Chairman, has been at times emotional and difficult for them and although you did give each of them the opportunity to say something towards the end of their evidence, none of them felt

able or in a position to do so. That is quite simply because they were devastated and remain devastated by the very tragic outcome of Raychel's case. Each and every one of them is a mother and, from that point of view, can well understand the depth of loss that the Ferguson family have been suffering for the 12 years since her tragic and untimely death. The nurses wish me to express their deepest sympathies to the Ferguson family.

THE CHAIRMAN: Thank you very much, Mr Campbell.

Mr Quinn, over lunch a revised, reduced list arrived from DLS in which they've cut back on the documents for which they're claiming privilege. And they've confirmed that it's advice privilege, not litigation privilege they're claiming. I'm going to break for 15 minutes and let you look at the list. I want to look at it for a few minutes. I think Ms Conlon now has it to distribute. I'll come out again in 15 or 20 minutes after you've had a chance to look at it.

(3.35 pm)

(A short break)

(4.30 pm)

Discussion on privilege

THE CHAIRMAN: Have we made progress?

MR STITT: Yes, Mr Chairman, we have.

THE CHAIRMAN: Let's do it in order. There was the old Altnagelvin file 1 and 2, or our files 21 and 22. I think Ms Dillon has agreed a note on this with Mr Johnson and that's been circulated.

Mr Doherty, Mr Quinn if there are any queries about that, could those be picked up tomorrow morning when Ms Dillon is back. I hope there aren't any queries, but if there are, she can deal with those tomorrow morning in conjunction with Mr Johnson. So let's leave that for now.

Mr Stitt, we have a truncated claim for privilege on the Altnagelvin inquest file, also known as the DLS inquest file; isn't that right?

MR STITT: That's correct.

THE CHAIRMAN: And I think Ms Anyadike-Danes was going to speak to you about --

MR STITT: They've all been dealt with.

THE CHAIRMAN: What more do I need to do on that? You wanted a bit of clarification?

MS ANYADIKE-DANES: I did and there were -- for example, there were some file notes where we didn't know who was involved in it. Mr Stitt has looked at the original file and he's provided me with that further information and I have shared that with Mr Quinn and his instructing solicitor. What I suggest happens is that gets

incorporated into this index to make sure we don't go too far adrift and people understand it. I am prepared to do it myself and e-mail that to Mr Stitt so that he can satisfy himself that I've got what he was telling me correctly and then we should have a final version of that. The only queries I raised related to the ones where they are still seeking to claim privilege. I haven't sought to raise those sorts of queries about other documents because every other document we're going to receive and people will see for themselves what the document contains.

MR STITT: In relation to that latter point, sir, the relevant persona are here this afternoon, as per your request.

THE CHAIRMAN: Thank you very much.

MR STITT: So the actual mechanics of replicating the original file will be done early tomorrow morning when all the relevant pages -- all the pages -- will be photocopied and numbered in the same manner as the final index. Then the pages for which no privilege is claimed will be handed and distributed and it will then be obvious as to which is the bundle for which privilege is claimed and which is not.

THE CHAIRMAN: Could I raise one issue? There's a side point and it might save some trouble tomorrow. On the

revised list I've been given, there's things like item 11, "Folder of Altnagelvin payments, letters and receipts". Is that relevant to anything? That's 21 pages of photocopying which will then be done many times over so that every interested party gets it.

MR STITT: I appreciate that, but by the same token, as I think I've alluded to before, it's a particularly complex file and there will be some unnecessary copying. We do feel, for the sake of completeness and to ensure that everyone can follow, every page should be photocopied so there's no room for ambiguity.

THE CHAIRMAN: If we receive a full copy of the documents which are not privileged, then a view can be taken about how many of those need to be copied and distributed.

MR STITT: Yes.

THE CHAIRMAN: I mean, there's one on the following page at item 21, a recorded delivery receipt to Ms Brown. Unless there's something dramatically interesting --

MR STITT: No it's not, it's spectacularly uninteresting. That having been said, if I may take you up on this, Mr Chairman, if we take item number 10, I'll take direction on this from any other interested party, "Inquest hearing notes", 62 pages.

THE CHAIRMAN: These are notes which were made at the two-day inquest; is that right? Are they 62 pages or

six?

MR STITT: 62.

THE CHAIRMAN: They are 62, are they? Right. Those are notes that were made as the inquest went along?

MR STITT: Yes, there's no added value to those notes. They're a note of the inquest.

THE CHAIRMAN: I suppose the safest way is, notwithstanding my concern since this issue has now reached this stage, if you can give us a full copy of the documents in respect of which there is no claim for privilege and we can have a discussion about how many of those documents can then be culled from the list which is photocopied and distributed.

MR STITT: I think if we start with everything, that's probably the better place.

THE CHAIRMAN: Okay. That then leaves the claim for privilege, which on the face of it looks to be advice privilege and on the face of it looks to be well-founded, unless Mr Quinn, do you have any initial reaction to the claim for advice privilege?

MR QUINN: No, I wouldn't have, and that is the category that I would have addressed your good self on today. I can see no argument that I could put up at this stage against that.

THE CHAIRMAN: Just to confirm that, there was a submission

made to us about the reports by doctors Warde and Jenkins and it came before you represented the Fergusons, Mr Quinn. It came through Mr Coyle and Mr Doherty on 30 October 2009. At page 51 they said:

> "We reiterate we do not wish to see the documents setting out any advice on foot of these reports as that is clearly covered by advisory privilege.

MR QUINN: That's the advice that I discussed with Mr Coyle at lunchtime and that's the line we are taking.

THE CHAIRMAN: That seems to be bringing this issue to an end and we can confirm that, with a bit more tidying up, between tonight and tomorrow morning.

MR STITT: Yes.

THE CHAIRMAN: Okay, great.

MS ANYADIKE-DANES: Mr Chairman, if I may just interject. It relates to something Mr Coyle communicated to me over the evening when he was obviously not seeing the reduced claim, but nonetheless thinking about what his position is. As I understand it, he is the person, on behalf of the family, who would be making any submissions. The issue that he had was to do with the possibility that there has been some sort of waiver or collateral waiver. There was an awful lot of documentation already out there. There's quite a bit of documentation that relates to particularly the experts, Dr Jenkins and

Dr Warde, and I think the slight concern, in fairness to him -- because I see he's not here -- is whether there might have been some waiver there and that might be something to be explored.

THE CHAIRMAN: That's on the basis that if the Trust has not claimed privilege for the reports by Dr Warde and Jenkins, can it then claim privilege for discussions or exchanges about those reports?

MS ANYADIKE-DANES: Yes, that's one, and I think he was also conscious of the fact that Staff Nurse Noble, as she was then, and Sister Millar have given evidence and have indicated certain things of what they believe the clinicians and Trust may have understood following on from the critical incident review meeting. For example, about the incidents of severe and prolonged vomiting, which was a point on which the Trust sought expert advice. So if that information has already been conveyed to us from the witness box in terms of what they think the clinicians and Trust knew on that question, then there may be an issue and I put it no higher because it's his point really for him to consider. I'm conscious that there may be something there that he may wish to address you on.

THE CHAIRMAN: If there is to be any issue about that, Mr Quinn, could we know about it quickly?

MR QUINN: We will know by first thing tomorrow morning.
THE CHAIRMAN: Thank you.
MR STITT: Can I come back on this point about reports, the Warde report and the Jenkins report. Of course, I wasn't involved, but I have obviously sought instructions in relation to what happened. Perhaps you, sir, could correct me if I've got this wrong. What originally happened is Altnagelvin Trust, when asked by the inquiry to provide their documentation, turned over their entire file in an attempt to assist. You have been kind enough to describe the Trust as a beacon in certain respects and that's the way they were operating. That's the Trust.

Then the legal team were in contact with the DLS and we have given legal advices and you've handed over stuff which is obviously privileged, and in fact you, sir, even pointed out to the Trust that they had handed over prima facie privileged documents. So they made a claim through you for a privilege, notwithstanding the fact that the documents had already been handed over, in relation to those two reports. And I understand that you held a hearing at which Mr Stevenson QC was involved and you made a ruling that they were privileged and privilege had not been waived. That ruling was subsequently challenged by the family, effectively --

THE CHAIRMAN: Yes.
MR STITT: -- and you reversed yourself.
THE CHAIRMAN: Well, no, what happened, it's not quite true that I reversed myself. Mr Coyle and Mr Doherty put in a submission and, after their submission had been received, it was then Mr Simpson QC was going to make a submission on behalf of the Trust. Instead of receiving a submission, we then got a letter from -- I'm just looking for now. It's a letter date 27 November 2009 from Ms Beggs on behalf of the Trust. The inquiry had sent her the skeleton argument submitted by Mr Doherty on behalf of the Fergusons. That skeleton argument was limited to whether the reports from Dr Jenkins and Dr Warde were privileged and Ms Beggs said:

"I would confirm on the advice of senior counsel the Western Trust does not intend to claim legal professional privilege in respect of these reports. In view of this, it is not our intention to submit a skeleton argument on behalf of the Trust."

Effectively, the Trust abandoned its claim for privilege.
MR STITT: I think that's right and I stand corrected. I thought that you had actually altered your own opinion, but obviously that letter speaks for itself.

Well, I will wait with interest to see what Mr Quinn has to say, if anything.
THE CHAIRMAN: Okay, that's that, which might be heading towards resolution.

The Brangam Bagnall file for the Belfast Trust on the inquest, we have an index for that, but I understand, Mr Stitt, that you're seeking more time before advising what the Trust's position is on claiming privilege for any of the documents that we have the index of; is that right?
MR STITT: Yes. The file is relatively straightforward, as I indicated to you last week. I can't see anything controversial and I'd hoped to be able to give you the final list today. Unfortunately, it requires a meeting with a senior member of the Trust and that cannot take place before Wednesday. I'm hoping that as soon as that person is advised as to the nature of what's happening, that should be hopefully a speedy decision. It's not directly within my control. I have urged all involved to expedite this as soon as possible. I will go on record as saying I don't see it as controversial, but that's just my view, obviously, and I may be wrong about that.
THE CHAIRMAN: I'd like to know at some point on Thursday what the position is about that.

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

then when all the work went into DLS, the MSC Daly files were forwarded to DLS. If that understanding is correct, any MSC Daly file should have gone to DLS and would be maybe subsumed into the DLS file or be ancillary to it.

MR STITT: I will make sure today that a further search is put in train in the DLS to see if there's an MSC Daly litigation file in relation to Raychel. I did read the transcript when Mr Simpson was addressing you in relation to the searches and the number of days it took at Mallusk. I think that's probably dead ground by now.

THE CHAIRMAN: The query was:

"Is there a Brangam Bagnall file from that era as well? Where you have a Brangam Bagnall inquest file query, is there a Brangam Bagnall litigation file for what would have been the old Royal Trust?"

MR STITT: I'm not aware of one. I doubt if I could put the Mallusk matter any further than Mr Simpson did last year when he addressed you on it.

THE CHAIRMAN: Okay. Let's keep on top of this. First of all, I'm grateful to everyone who's put a lot of work into this over the last week or week and a bit. I think it's a reminder to everybody that it's far better if you sort these issues out in advance rather than on the hoof

as we go through the hearings. The way this developed is unfortunate. It now seems to be on the way to becoming less controversial than it appeared to be last week. And as always with these things, the sooner we get them done the better, because it minimises the risk of any confusion or uncertainty. It also minimises the rather more serious risk of anybody who has given evidence having to be recalled to give evidence because there is new documentation which needs to be raised with them.

MR STITT: Nobody wants that.

THE CHAIRMAN: Okay, let me leave it like that until tomorrow. I am grateful as I understand that the chief executive of the Western Trust has come and I'm grateful to her for her attendance. I know there is --

MR STITT: Ms Way is at the back. She has come down and left her duties for the day, but she does believe that this inquiry is particularly important and she's intending, I think, to come back tomorrow again, such is her concern for the issues in question.

THE CHAIRMAN: I'm grateful to her because I'm sure there's other ongoing important things in the Western Trust to handle and I'm grateful to Ms Way for taking the time to be here and to everyone else who's put themselves out to catch up on something which we should all have taken

care of before now.

I will adjourn now until tomorrow morning. I think the timetable is changing a bit this week. We'll still be sitting Tuesday, Wednesday and Thursday. Tomorrow morning we have Dr Trainor first and then Mr Zafar. Mr Zafar is flying in tomorrow morning, so we'll start with Dr Trainor and go on to Mr Zafar. You'll recall he's a recalled witness because we didn't finish him before. I can't let that happen again with him because I have had significant difficulties in getting him back. We will have to get through Mr Zafar and Dr Trainor tomorrow.

On Wednesday it's Mr Makar and Dr McCord. On Thursday morning, it's Mr Bhalla and Mr Gilliland. Mr Bhalla is giving evidence by video link. We have that video link from 9.30 until 12.30, so I'd like everyone here on Thursday morning by 9.20. We have a three-hour time slot with him. That should be enough. And then we want to get into Mr Gilliland and try and get through his evidence so he isn't left hanging over the long weekend ahead.

So until tomorrow morning. Thank you very much.

(4.49 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X