1 Wednesday, 6 March 2013
2 (10.00 am)
3 DR JOSEPH DEVLIN (called)
4 Questions from MR WOLFE
5 MR WOLFE: Good morning, sir. I understand the next witness
6 is Dr Joseph Devlin.
7 Good morning, Dr Devlin.
8 A. Good morning.
9 Q. The inquiry has received from you two statements,
10 WS027/1 and WS027/2. The first statement is undated,
11 but I understand it was received by the inquiry in or
12 about 2005 or 2006.
13 THE CHAIRMAN: 2005. It would be probably about June 2005.
14 MR WOLFE: Yes. Your second statement was dated
15 15 November 2012, doctor.
16 A. That's correct.
17 Q. We tend to ask witnesses at the commencement of their
18 evidence whether they wish to adopt their witness
19 statements as part of their evidence. In other words,
20 do you wish to put that statement forward as an accurate
21 account of what you were aware of in relation to
22 Raychel's case?
23 A. There may be a few areas that will require some
24 clarification, but in the bulk, yes.
25 Q. Do you want to provide that clarification now?

1 A. Well, I was speaking to Mr Stitt this morning and there
2 may be some question about the prescription of the IV
3 anti-emetic, Zofran. Just to be clear about that
4 I understood that to be what we would call an
5 anticipatory medication that had already been prescribed
6 by Dr Gund and I had just administered it rather than
7 prescribed it myself, you know. And I want to make
8 clear at this stage too that at that time I was a JHO
9 rather than an SHO.
10 THE CHAIRMAN: Thank you.
11 MR WOLFE: Yes. Dealing with the medication point --
12 THE CHAIRMAN: So we'll just deal with that when we get to
13 it.
14 MR WOLFE: That might be convenient, yes.
15 THE CHAIRMAN: Thank you for alerting us to those points.
16 MR STITT: I might say, sir, having been referred to by the
17 doctor, this is a matter which he brought up with me
18 this morning --
19 THE CHAIRMAN: Of course.
20 MR STITT: -- and I suggested to him that it might be
21 prudent to at least mention it at the outset.
22 THE CHAIRMAN: It helps, thank you.
23 MR WOLFE: You have indicated in your first witness
24 statement, Dr Devlin, that until the inquiry asked you
25 to provide an account, no prior request was made of you

1 by anybody to provide an account in relation to your
2 dealings with Raychel Ferguson.
3 A. That's correct.
4 Q. So for the avoidance of doubt, the Trust didn't ask you
5 for a statement at the time?
6 A. No.
7 Q. The PSNI didn't ask you for a statement?
8 A. No.
9 Q. And you didn't give evidence at the inquest into the
10 circumstances surrounding Raychel's death?
11 A. No, that's my understanding.
12 Q. Yes. Quite apart from whether you were asked to provide
13 a statement to your employer at the time, the
14 Altnagelvin Trust, did anybody ever speak to you about
15 the nature of the care that you provided for her?
16 A. You mean in a formal setting?
17 Q. Let's deal with a formal setting first of all.
18 A. No, there was no -- I wasn't involved in any formal
19 meeting in relation to the care I provided.
20 Q. I'm conscious that you have told us in your witness
21 statement that you had a conversation with Dr Curran on
22 the day of Raychel's collapse, I understand it to be.
23 That I take to have been an informal discussion.
24 A. Absolutely. Dr Curran would be my friend, we would be
25 quite friendly, so he informed me of what had happened

1 and we had had an informal discussion.
2 Q. Okay. We'll come to that later, but I just want to, if
3 you like, clear the path by understanding the kinds of
4 informal discussions that you might have had. Can you
5 recall any other informal discussions with anybody
6 arising out of the care that you or others provided to
7 Raychel?
8 A. I don't recall any other specific informal discussion.
9 Q. Could we have your CV up on to the screen, please? It
10 can be found at 317-013-001. You studied for your
11 medical degree at Queen's University Belfast; isn't that
12 correct?
13 A. That's correct.
14 Q. And you emerged from your undergraduate studies in the
15 summer of 2000 and your first posting was a JHO posting
16 in Altnagelvin; is that correct?
17 A. That's correct.
18 Q. You then had a subsequent posting to Altnagelvin as
19 an SHO; is that right?
20 A. That's correct, yes.
21 Q. And the rest of your professional career is set out in
22 front of us. You're currently employed as a general
23 practitioner in the A&E department of Altnagelvin;
24 is that correct?
25 A. No.

1 Q. Has that changed?
2 A. That's not correct. As a matter of clarity, after
3 I finished as a JHO, I started on the GP training scheme
4 which was all organised through Altnagelvin Hospital.
5 So I did two years as part of the GP training scheme and
6 they were my SHO jobs. Then I did one year as a GP
7 registrar, I did a few years as a GP locum until
8 I became a GP principal at Abbey Medical, where I
9 remained until quite recently. I have recently changed
10 jobs, so I work in Limavady as a GP principal.
11 Q. Where are you currently employed?
12 A. Limavady Health Centre.
13 Q. So at the time that you cared for Raychel on
14 8 June 2001, you had almost completed your JHO year;
15 isn't that correct?
16 A. I had ten months done, yes.
17 Q. Does it run August to August?
18 A. Correct.
19 Q. Again, as I understand it from your statement to the
20 inquiry, the JHO year works in two blocks; is that
21 correct? You have a medicine or medical rotation which
22 lasts for six months and then you go into surgery, and
23 it also lasts for six months?
24 A. That's correct.
25 Q. The order in which you did it was medicine first and

1 then you started surgery in or about February of that
2 year?
3 A. That's correct.
4 Q. In order to equip you for the year ahead, Altnagelvin
5 provided some induction training; is that correct?
6 A. I can't remember exactly what induction we received. As
7 I said in my statement, I don't think there was any
8 specific medical induction training that we received.
9 I think it was more what I would call a housekeeping
10 induction as to how the systems in Altnagelvin worked
11 and how the bleepers worked and what our on-call duty
12 was and that sort of thing. I don't know if we --
13 I don't think we received any specific medical induction
14 per se.
15 Q. Perhaps we could illustrate that. If we could have up
16 on the screen, please, 316-004f-018. Could we take it
17 a page back, please? Could we keep both pages, 017 of
18 that sequence and 018, on the screen at the same time.
19 The Trust has provided us with a number of
20 documents, Dr Devlin. These are the induction type
21 documents that relate to 2001, which would have been for
22 the intake of JHOs the year after you, if you follow.
23 A. Yes.
24 Q. Because you can see in fact that on the left-hand page
25 you had obviously volunteered or had been commandeered

1 to deliver presumably a short lecture on "The House
2 Officer's Lot"; do you see that?
3 A. Yes.
4 THE CHAIRMAN: The rest of what appears in those two pages,
5 does that mirror closely enough the induction which you
6 had the previous year?
7 A. It's impossible for me to answer that question. I'm
8 sure I would have received something similar to that the
9 previous year, although I can't be 100 per cent sure.
10 THE CHAIRMAN: Of course, and it might not have been exactly
11 the same induction, but Altnagelvin have given us this
12 as an illustration of the sort of induction that JHOs
13 had and, unless they suddenly introduced it for 2001,
14 never having had it before, I'm invited to assume that
15 they had something along the same lines the previous
16 year.
17 A. Well, in 2001 -- there were changes fairly immediately
18 after the JHO year of 2001, but I think you're right in
19 assuming it would have been quite similar to what
20 we would have received.
21 MR WOLFE: To go back to the point you made before I put
22 those matters up on the screen, and these documents
23 perhaps illustrate your point, you were telling us that
24 the kind of induction that you received was more, if you
25 like, administrative in nature rather than heavy duty

1 medical in nature.
2 THE CHAIRMAN: I think housekeeping was the --
3 MR WOLFE: Housekeeping is the phrase you used. The topics
4 would seem to illustrate that; is that fair, Dr Devlin?
5 A. That's fair, yes.
6 Q. You would have received a Junior Doctors' Handbook
7 at the time of your induction; can you remember that?
8 A. I'm aware that there was a Junior Doctors' Handbook.
9 I don't remember receiving one and I don't remember
10 using one very much, would be the truth. But I'm aware
11 that there was one. It wouldn't necessarily have been
12 something I would have had with me at all times during
13 my time as a JHO.
14 Q. Let me put the document up on the screen and we'll see
15 where we go with it, 316-004g-001. That is the cover
16 page for a version I understand to have been in
17 existence in the late 1990s. I think that the Trust has
18 indicated that the document was updated from time to
19 time, but doing our best -- and I think the Trust doing
20 their best, they have put us in possession of this
21 version and the suggestion is that something like this
22 was in existence in 2001; do you recognise its cover?
23 A. I recognise it, yes.
24 Q. Could I maybe pick up on a few points within it?
25 THE CHAIRMAN: I understand that you wouldn't have had it

1 with you at all times. Where was it available to you?
2 Was there a library or a room where, if you needed to
3 refer to it or any other textbooks, it would be handy?
4 A. The book I mostly used as a junior doctor was the Oxford
5 Handbook of Medical Practice. I think that would be
6 reflective of most other JHOs at the time. This wasn't
7 particularly a book that we would have with us at all
8 times, the Junior Doctors' Handbook. So it may be that
9 I received this book, but I don't think I was carrying
10 it around the wards with me as a reference book.
11 THE CHAIRMAN: Was the Oxford Handbook small enough for you
12 to put in your pocket and carry around?
13 A. Yes.
14 THE CHAIRMAN: And that's what you and other JHOs did?
15 A. At that time, yes.
16 THE CHAIRMAN: Thank you.
17 MR WOLFE: Could we move into the substance of the book and
18 go to the next page, 002? It appears, doctor -- and
19 you'll see this as we move on -- that a lot of the book
20 is taken up with descriptions of broad principles, but
21 also contained within it is some particular practical
22 advice; is that your memory of the document?
23 A. I have no strong memory of this document.
24 Q. Okay. It sets out, on the left-hand side of the page,
25 a description of the ethics of a doctor; do you see

1 that?
2 A. Yes.
3 Q. Are these the kind of things that are taught at
4 undergrad level or is this the first time you're being
5 exposed to this kind of teaching, if you like?
6 A. No, we would have had this training at undergraduate
7 level too.
8 Q. Some of them stand out in particular. You're expected
9 to give patients information in a way they can
10 understand. You're supposed to listen to patients and
11 respect their views. So there's a whole area of how you
12 should communicate with patients, which is an area which
13 the inquiry is particularly interested in.
14 Could we move over to page 3 of this document?
15 We have on the bottom of the left-hand side page an
16 apparent definition of a junior house officer's duties;
17 do you see that?
18 A. Yes.
19 Q. That's the pre-registration house officer. Is that
20 simply another way of describing the JHO?
21 A. Yes.
22 Q. It says that:
23 "The role is unique in that it is primarily
24 a training and apprenticeship year and, as such,
25 represents a chance to put into practice what you have

1 learnt in theory."
2 Are you okay so far with that?
3 A. Yes.
4 Q. Is that an accurate statement of your understanding?
5 A. Yes.
6 Q. "It should be an exciting and challenging year, but
7 occasionally there can be problems and stresses, and for
8 this reason each of you has been assigned to
9 a supervisor. This is a consultant with whom you should
10 meet on a regular basis throughout the year to discuss
11 problems and career plans."
12 Who was your supervisor --
13 A. We had different supervisors.
14 Q. -- on the surgical side?
15 A. I had two different ones. At the time that I was
16 involved in Raychel's care, it would have been
17 Mr Mulholland, who was a urologist on Ward 7.
18 Q. Could we move forward two pages please to 005? I want
19 to look at that section headed "Nursing and
20 Paramedical"; do you see that?
21 A. Yes.
22 Q. It says:
23 "An important part of training of junior medical
24 staff lies in developing good working relationships with
25 nursing staff. Whilst the nursing staff (except the

1 clinical services managers) do not have managerial
2 seniority over you, it is important to respect their
3 advice and learn from their experience. The roles of
4 nursing staff are changing, with some nurses able to
5 carry out procedures formerly regarded as medical duties
6 (such as the administration of intravenous drugs).
7 It is important to show appreciation when this service
8 is offered, but not to show antipathy towards those
9 nurses who do not seek to extend their role.
10 "Communication with nursing staff is essential to
11 the efficient running of the ward and you must make sure
12 that any changes in management you recommend are
13 verbally passed on to the nurses in addition to
14 documenting them in the notes. Similarly, any
15 discussions with patients or relatives should be
16 mentioned to the nursing staff and recorded in the
17 notes."
18 MR STITT: Mr Chairman, the witness has said that he has
19 limited recollection and knowledge of this book.
20 THE CHAIRMAN: Yes.
21 MR STITT: It's accepted that the book says what it says and
22 we know what Dr Devlin's actual clinical input was.
23 I have a fair idea of the nub of the points that are
24 going to be put to him. Can I respectfully say -- I'm
25 saying this in ease of a witness who is obviously

1 spending time in a place which may be difficult for all
2 witnesses. It's simply this: would it not be, with
3 respect, more advantageous to actually deal with the
4 clinical procedures that were carried out by this
5 witness and put to him what he should have done and, if
6 he takes issue with that, then perhaps go back to
7 a book? Because the book is taken as read and the
8 witness can't add to the sum of knowledge by agreeing
9 with all these points that are being put to him.
10 THE CHAIRMAN: I think it's legitimate to set -- we're only
11 a few minutes away from getting with Dr Devlin in to
12 what he actually did with Raychel and what the extent of
13 his role was and what he was asked to do and so on.
14 I understand your approach, which is a slightly
15 different one, but I think it is legitimate to set this
16 background and confirm with Dr Devlin that that's what
17 he was expected to do, that he understood in this, his
18 first postgraduate job, that this is what was expected
19 of him and that he understood that from the handbook or
20 from the undergraduate training he received. Mr Wolfe
21 will be through this in a few moments and then we'll be
22 into the actual exchanges of what happened. Okay?
23 MR WOLFE: The book emphasises the importance of the working
24 relationships with nurses; isn't that right?
25 A. That's right, yes.

1 Q. I quite take counsel's point that you can't recall this
2 book, but in terms of the working relationships that you
3 did have with nurses, was it emphasised that in order to
4 progress through your junior house officer year there
5 was a need to develop good working relationships with
6 nurses?
7 A. I had a very high regard for all of the nursing staff
8 that I worked with and I respected their views, and
9 I understood that in many cases they were a lot more
10 experienced than me in lots of clinical areas. I often
11 would look to them for guidance as to how to approach
12 different problems with patients.
13 THE CHAIRMAN: So whether you remember page 1 or page 5 or
14 page whatever of the handbook, the principles in the
15 handbook are principles that you understood and
16 principles which you followed as best you could during
17 your year as a JHO?
18 A. Absolutely.
19 MR WOLFE: In terms of the importance of note making and
20 recording your actions as a doctor, again quite apart
21 from this book which you may or may not remember, was
22 the importance of note making and recording emphasised
23 to you in your training?
24 A. I think over recent years the importance of good note
25 keeping has become increasingly more important. I think

1 a lot of communication between doctors and particularly
2 junior nurses at that time would have been verbal
3 communication and it would not necessarily have been
4 written down in the patient records. I think if you
5 look back over the years, I mean as time has gone by
6 doctors have wrote more and more into the notes, but
7 I think at this time, in 2001, by those standards,
8 I think a lot of the work that we did was on verbal
9 direction by senior nurses or other members of our
10 medical team.
11 Q. So although the message was being put out in clear and
12 unequivocal terms that dealings with nurses and patients
13 should be the subject of accurate recording in the
14 notes, the culture at that time was something different?
15 A. Not different, we all -- that was ... Best management,
16 was obviously to record everything. But to put it in
17 context, custom and practice at that time was that as
18 a JHO or PRHO we were extremely busy doctors and we
19 had the ward work to do for several different surgical
20 wards and custom and practice at that time was that some
21 of the tasks that we did we wouldn't necessarily make
22 a record of in the notes. If the task was deemed as
23 straightforward or routine, it would be impossible to
24 make a record in the notes sometimes because of the
25 numbers of jobs we were expected to do.

1 Q. We'll come on and look at that in the context of
2 Raychel's particular case in due course. What you seem
3 to be reflecting in summary is a difference between the
4 principles set out on paper and what you might call the
5 practical reality of being able to do that in every
6 case.
7 A. Yes, that's fair.
8 Q. You started your surgical rotation in or about February,
9 as we saw earlier. By that stage, had you had many
10 dealings with paediatric surgical patients?
11 A. When I started my surgical rotation?
12 Q. Yes. Sorry, let me put the date again. By June 2001,
13 by the time you were caring for Raychel, what was the
14 extent of your involvement with paediatric cases on the
15 surgical side?
16 A. Just whatever I'd done in the previous four months and
17 maybe a little bit at undergraduate level as well on the
18 paediatric attachment.
19 THE CHAIRMAN: Does that mean really that -- I understand
20 that there was no paediatric surgeon in Altnagelvin,
21 I think; is that right?
22 A. That's right.
23 THE CHAIRMAN: And we've heard over the last week or so that
24 there was a concern, which emerged more clearly after
25 Raychel's death, which was there before in the nursing

1 side, that the surgeons were, by necessity, more focused
2 on the adult patients. So would your paediatric
3 experience have been really bits and pieces rather than
4 anything sustained?
5 A. It's very fair to say my paediatric experience would be
6 limited.
7 THE CHAIRMAN: Thank you.
8 MR WOLFE: In terms of the duties of a JHO on the surgical
9 side, could you give us a snapshot of a typical day, the
10 kinds of duties that you would have undertaken?
11 A. It's hard for me to remember in detail, but at that time
12 junior house officers would do all of what I would call
13 the ward work, which would be all the routine tasks on
14 the ward. So things might include change of catheters,
15 change of Venflons, blood tests, writing up kardexes.
16 We spent a lot of time following out the instructions of
17 a consultant for that day and they may have requested us
18 to get a CT scan organised or some radiological
19 investigation, and we would have had to go down to the
20 radiology department and try to organise that sort of
21 thing. We went on ward rounds as well with the
22 consultants. But primarily, our job was not to direct
23 medical or surgical management of patients, but to act
24 in a -- really as an assistant. We were really acting
25 as medical assistants and we were learning by

1 observation. Our task, I don't feel, as JHOs was to
2 what I would call direct medical or surgical care of
3 patients. But we did all the ward work and we were
4 very, very busy.
5 Q. Yes. Just to put this in context, you say you were
6 very, very busy.
7 A. Mm-hm.
8 Q. Raychel, as we know, was a patient in Ward 6, which was
9 the main paediatric ward in the hospital.
10 A. The only paediatric ward.
11 Q. Yes. The impression which nursing evidence to the
12 inquiry has created is that there were very few
13 paediatric patients on Ward 6 by comparison with the
14 number of medical patients.
15 A. Pardon, very few paediatric?
16 Q. Very few paediatric surgical patients on Ward 6 by
17 comparison with the number of paediatric medical
18 patients that would have to be treated on an average
19 day.
20 A. I don't know.
21 THE CHAIRMAN: We've been told that effectively the number
22 of operations on children in Altnagelvin was quite
23 small, so on any day in Ward 6 there'd be far more
24 medical patients than there would be surgical.
25 A. Okay.

1 THE CHAIRMAN: Does that make sense?
2 A. If that's what ...
3 THE CHAIRMAN: That's the idea we've been given.
4 A. Okay.
5 THE CHAIRMAN: For instance, on the Friday morning after
6 Raychel had been operated on on Thursday night, the
7 surgical ward round consisted apparently of Raychel,
8 full stop, whereas the paediatric ward round would have
9 involved many more patients.
10 A. I didn't know that.
11 THE CHAIRMAN: Okay.
12 MR WOLFE: But of course, your responsibilities, to go back
13 to your point that you were very busy, as a JHO on the
14 surgical side weren't, of course, limited to Ward 6.
15 A. No, I was actually at that time based on Ward 7. That's
16 where my primary responsibilities were at that time.
17 Q. Is that one of the main surgical wards?
18 A. It's the main urology ward in the hospital, yes.
19 Q. As a JHO on any given day, again the inquiry understands
20 that a nurse in the children's ward might need to get
21 a JHO to that ward, so they would use the switchboard
22 system to bleep for a JHO. What other wards could
23 you have been asked to come to within the hospital?
24 A. Well, when you're on call you would have covered all the
25 wards. During the day you were supposed to be mostly

1 looking after patients on Ward 7, but for the on call
2 you had five or six different wards to cover and you may
3 have been called to different areas as well. You
4 sometimes were what they call surgical outliers in
5 general medical wards as well and sometimes you were
6 called to see them as well. You had the orthopaedic
7 wards, all the general surgery wards, you had the
8 paediatrics ward and you had these outliers to cover at
9 night, so you were busy.
10 Q. I'm conscious that you weren't on call on the day that
11 you attended to Raychel, and we'll come to there
12 presently. Just dealing with the on-call bit, if you
13 can help us on this. The impression is that the JHO on
14 call is busy. Is it right to say that they would be, if
15 you like, constantly mobile, moving from different ward
16 to different ward as they're contacted for assistance by
17 nurses?
18 A. That's exactly right, yes.
19 Q. And the geographical layout of Altnagelvin at that time,
20 was it spread out?
21 A. Well, the main surgical wards were Ward 9, Ward 8,
22 Ward 7, the paediatric surgical children on Ward 6, and
23 then they were all on top of each other, together.
24 Q. Not a tower block perhaps but a stack?
25 A. Absolutely. But theatres would have been on Ward 1 or

1 on the first floor and the orthopaedic wards would have
2 been on wards 41 and 42. They were quite a distance
3 away from the other surgical wards. So you would be --
4 we would be covering quite a lot of ground on a night on
5 call, yes.
6 Q. In terms of your support or supervision as a JHO, where
7 would that come from? So if you needed assistance or
8 advice on how you were to deal with a particular
9 patient?
10 A. That would come from senior medical or nursing staff.
11 Q. Right. Was there an arrangement whereby you would, for
12 example, report initially to an SHO or could you go
13 higher up?
14 A. I suppose you could report to the registrar or
15 consultant, but in practical terms you usually went to
16 your next in line, which would be the SHO.
17 THE CHAIRMAN: Do I get the impression that that didn't
18 happen, that wouldn't have happened very often because
19 the nature of the work that you were doing was the
20 standard administrative medical assistance work that
21 you've described, so there weren't that many occasions
22 on which you'd need to refer up?
23 A. Initially we had to involve the SHOs all the time
24 because we couldn't do the standard medical assistant
25 type role, we couldn't get the Venflons in or we didn't

1 know how to give an intravenous medication, and that
2 sort of thing, so initially we were often in contact
3 with the SHOs. But I suppose as the year went on, most
4 of that type of work we could do by ourselves,
5 absolutely.
6 THE CHAIRMAN: Thank you.
7 MR WOLFE: Was there a difference in approach between your
8 rotation in medical and the rotation in surgical in
9 terms of how you were supervised and how you worked?
10 A. Yes. The difference would be that I suppose the
11 surgeons were often in theatre so they could, on
12 occasion, be harder to get, whereas the medical doctors,
13 certainly the medical SHO tier, were always much more
14 readily available in my experience.
15 Q. One of the concerns that's been expressed by the
16 surgical experts who have looked at this case is that
17 where a nurse needed to get a surgical doctor to the
18 bedside, the first port of call at that time tended to
19 be the junior house officer.
20 A. It depends very much what the issue was, who would be
21 contacted. When I was contacted, it was to give an
22 intravenous anti-emetic, which I did, but it would be my
23 experience in cases whereby the nurse was concerned for
24 the well-being of the patient that they would go
25 directly to the surgical SHO because they would be aware

1 of the limitations in contacting a JHO.
2 THE CHAIRMAN: Yes.
3 MR WOLFE: I think you pointed there specifically by your
4 example to what happened in Raychel's case. Can I just
5 probe that a little, but make it more general?
6 Something like administering an anti-emetic, are you
7 describing something that would be regarded as routine
8 and straightforward and, if you like, viewed as being
9 within the capabilities of a JHO?
10 A. I think in a general case, yes, that'd be the case, yes.
11 Q. If you were asked to do something like that and there's
12 probably other examples you could think of, of
13 straightforward interventions such as that, is that
14 something you would be expected to report to your SHO,
15 "I've been asked by a nurse to do that and I did it and
16 the child looks fine, hopefully the child will settle"?
17 Were you expected to give that kind of report back to
18 your SHO or not?
19 A. No, you wouldn't give a blow-by-blow account of your
20 activities during the day to your SHO. You would only
21 involve your SHO if you felt you were outside your area
22 of competency.
23 Q. That's helpful. So contact with the SHO was in
24 a situation where you felt outside your comfort zone,
25 where you needed advice, where things perhaps are more

1 complex than you would have, at that stage, understood?
2 A. That's right.
3 THE CHAIRMAN: In the second half in the surgical side, your
4 supervisor was Mr Mulholland, who was a consultant.
5 A. At that time, yes.
6 THE CHAIRMAN: In the exchange you have just had with
7 Mr Wolfe and he's talked about reporting it to your SHO,
8 on a day-to-day basis was there somebody who was your
9 SHO?
10 A. It would have been a urology SHO that I would have had
11 a closer working relationship with. The on-call rota
12 was different; you wouldn't have worked as closely with
13 the on-call SHO as you would with your ward SHO.
14 THE CHAIRMAN: Thank you.
15 MR WOLFE: Could I ask you about a number of specific events
16 in the surgical day? Could I ask you first of all about
17 ward rounds? You said verbally this morning and in your
18 statement that you would attend at ward rounds.
19 A. That's correct.
20 Q. You've told us in your statement that consultant
21 surgeons would teach on ward rounds.
22 A. That's correct.
23 Q. On 8 June -- help us if you can -- do you think you
24 participated in the ward round on that day?
25 A. If there was a ward round on the urology ward that day,

1 I would have participated on it, yes.
2 Q. So that was, if you like, a staple start of the JHO's
3 day?
4 A. Well, that's where you would often get your tasks for
5 the day, that would be on the morning ward round.
6 THE CHAIRMAN: When you talked earlier on about outliers,
7 would you regard a child who's on Ward 6 as an outlier?
8 A. Not really. I don't think that would be an outlier. An
9 outlier to my mind would be a surgical patient on
10 a medical ward rather than a paediatric surgical patient
11 on a paediatric ward.
12 THE CHAIRMAN: Thank you.
13 MR WOLFE: If a child has been admitted overnight, such as
14 Raychel was, and has had her surgery in the early hours
15 of the morning, would you expect a ward round to take
16 place early the next day?
17 A. Yes.
18 Q. Who would you expect to attend at such a ward round?
19 A. My recollection of the time was that the ward rounds
20 were usually taken by the consultant and/or the surgical
21 registrar.
22 Q. In circumstances where the child is admitted under the
23 care of a consultant, but the consultant hasn't seen her
24 for the purposes of surgery, would you expect the
25 consultant to attend at the ward round if he could?

1 A. If the consultant hadn't done the surgery?
2 Q. Yes.
3 A. Well, consultants are in charge of overall care for all
4 their named patients, so yes, I would normally expect
5 the consultant to attend the ward round to see his
6 patients, whether he or she had operated on them or not.
7 Q. Obviously from day-to-day the surgical lists might be
8 heavy, they might be light, there may be factors that
9 affect a consultant's ability to attend.
10 A. That's right.
11 Q. If a consultant can't attend, who should attend in his
12 stead?
13 A. Really it's not for me to say how the ward rounds should
14 be organised because it wasn't my responsibility, but my
15 understanding is the most senior clinician available
16 at the time would take the ward round.
17 Q. In that post-surgical situation, post-operative
18 situation I should say, what are the kinds of things you
19 would be expecting the attending clinician to do with
20 the patient?
21 A. It's a very variable question and depends what the
22 patient has come in with, how long they've been in,
23 what's wrong with them, what their co-morbidities are --
24 there's no single answer to that question.
25 Q. With a standard appendix operation -- first of all, had

1 you any experience of dealing with the aftermath of
2 appendicectomies back then?
3 A. First of all, I don't know if there is a standard
4 appendicectomy operation because no person is standard
5 and no one operation is the same as the next operation
6 and no two people recover in the same way. Can you
7 repeat your question, sorry?
8 Q. If a child has had an uncomplicated appendicectomy and
9 is about to start the first post-operative day, what
10 would you expect to happen, broadly, in a ward round?
11 A. Normally on the ward round the senior surgeon, or
12 whoever was available, would come around and examine the
13 child and, if things were going according to plan, they
14 would make a decision to reduce the IV fluids or stop
15 the IV fluids over the next day or two and to encourage
16 the child to mobilise or to increase oral intake.
17 Q. The inquiry has heard evidence about the approach that
18 was taken to post-operative fluids in Altnagelvin at
19 that time. The standard fluid post-operatively appears
20 to have been Solution No. 18; is that your recollection?
21 A. That's my understanding.
22 Q. In terms of the approach to post-operative fluids as
23 compared to preoperative fluids, can you assist us with
24 this: broadly speaking, the approach seems to have been
25 to recommence precisely the same fluid at precisely the

1 same rate post-operatively as had been in place
2 preoperatively. I see you nodding. Is that something
3 you experienced?
4 A. I had very little involvement in the management of
5 paediatric surgical fluids. I understand from this case
6 that that was what was in common practice at the time,
7 but in 2001 I don't know if I would have been aware of
8 that or not.
9 Q. Okay. Could I ask you about handover arrangements
10 in the morning? At the start of a typical day in the
11 surgical side of the hospital, where you have patients
12 who have come in overnight and had surgery, was there
13 a method or a mechanism by which the consultants under
14 whose care a patient has been admitted are informed
15 about that patient?
16 A. Normally, it would have been the responsibility of the
17 doctor who had seen the patient or performed the surgery
18 to keep the consultant abreast of what was going on.
19 Obviously, it would be very important that whoever had
20 been mainly dealing with the patient would speak to the
21 consultant about that because they would have much more
22 information than the likes of me could provide to
23 a consultant about a patient who had come in overnight
24 who probably wouldn't have been to theatre or had any
25 involvement in the surgery or the management of the

1 patient from a surgical perspective.
2 Q. So obviously there would be notes available, but what
3 you seem to be describing is that the best approach
4 would be for the surgeon who performed the operation to
5 have a word with the consultant coming on duty.
6 A. That's what I would think, yes.
7 Q. Was that approach that you describe formalised in any
8 way? Was it part of the practice at that time?
9 A. I think again it was custom and practice. I don't know
10 if it was written down anywhere. I mean, that is what
11 normally happened.
12 Q. Yes. I want to ask you some questions about the whole
13 issue of hyponatraemia and fluid management. The
14 inquiry has been told that at that time, 2000/2001, the
15 hospital at Altnagelvin had organised a lecture
16 programme as part of a strategy to assist junior doctors
17 with their education, with their further education.
18 Can you remember that?
19 A. I think that the postgraduate dean would have expected
20 some form of ongoing training or education for
21 pre-registration doctors. So I think that there were
22 lectures that were given by the hospital, by the
23 consultants in the hospital, but they were not ... You
24 wouldn't necessarily attend all of them, you wouldn't be
25 able to due to work commitments. But for all the junior

1 doctors in the hospital there was an education programme
2 that was provided that you attended if you could.
3 Q. There's something that appears in the documentation
4 which is curiously named "the surgical journal club";
5 can you tell us what that was?
6 A. I can't shed a lot of light on that. I think the
7 surgical journal club -- certainly it would have
8 happened infrequently in my opinion -- or in my
9 recollection -- and I think what the surgical journal
10 club was was that the surgeons would present between
11 themselves interesting cases or interesting literature
12 at that time and discuss that then between themselves.
13 It certainly wasn't a regular occurrence that I recall.
14 Q. There was something called a "case note audit". Do you
15 know what that was, have you any recollection?
16 A. I had no involvement with that. I don't know what that
17 was.
18 Q. Could I have up on the screen, please, a letter which
19 was sent from Altnagelvin to the postgraduate dean
20 in relation to the issue of education? It's at
21 316-004e-001. This is a letter issued by Altnagelvin on
22 6 July 2005 to the postgraduate dean. You can see the
23 heading halfway down the page, "Whole Hospital
24 Training". It says:
25 "From 1995 [that's five years before your JHO year]

1 there have been teaching sessions timetabled each year
2 on fluid balance and electrolyte disturbance within the
3 medical division teaching and training programme. This
4 formal training is delivered during the lunchtime
5 teaching programme and aimed at all PRHOs and all other
6 junior medical staff. This is considered a general
7 hospital education opportunity. The lectures on fluid
8 balance was given by an anaesthetist and the lecture on
9 abnormal biochemical tests, including electrolyte
10 disturbance, by our clinical biochemist. Both these
11 lectures would have been very much aimed at adult care."
12 And then it goes on to rehearse what happened in the
13 period after Raychel's death. In 2002 it seems that
14 Dr Geoff Nesbitt developed a lecture programme which the
15 inquiry has heard something about. It's certainly in
16 the witness statements.
17 Can I ask you about the first sequence of that? It
18 appears that within the medical division there was an
19 attempt to deliver education to junior doctors
20 in relation to fluid balance and electrolyte disturbance
21 issues in the context of adult care. Have you any
22 recollection of that?
23 A. I don't recall being at that lecture, although it
24 doesn't mean that I wasn't there. If that's what the
25 hospital said, then that must be the case.

1 Q. You can't call to mind any particular recollection of
2 that at this stage?
3 A. No.
4 Q. You've told us in your witness statement that --
5 THE CHAIRMAN: Sorry. Pause there. Do you remember the
6 following year when you were an SHO that there was
7 a talk which Dr Nesbitt prepared in light of the lessons
8 learned on Raychel's death?
9 A. Everything changed after Raychel's death, I would say,
10 and people were much more aware of the dangers of
11 hyponatraemia and better fluid management at that time.
12 THE CHAIRMAN: Was part of the way you learned about that
13 through the talk that's referred to at the bottom of
14 this page?
15 A. Yes, part of the way, yes.
16 THE CHAIRMAN: When you finished your surgery six months in
17 2001, you didn't go back into surgery, sure you
18 didn't --
19 A. No, but I remained in Altnagelvin.
20 THE CHAIRMAN: Yes, you did, that's the point, you were
21 an SHO for the following year in Altnagelvin and you
22 were there longer. So you were part of the specific
23 post-Raychel education in Altnagelvin, were you?
24 A. I know that there was a lot more knowledge about
25 hyponatraemia after Raychel.

1 THE CHAIRMAN: Thank you.
2 MR STITT: I don't know if it would help, sir, but there may
3 well have been a number of meetings. The evidence would
4 seem to be that this was an illustrated talk --
5 THE CHAIRMAN: Yes.
6 MR STITT: -- by Dr Nesbitt and I wondered if that would
7 help the witness, if that could be put to him to help
8 his recollection at all.
9 THE CHAIRMAN: Do you recall that?
10 A. I don't recall being at Dr Nesbitt's lecture. That
11 doesn't mean that I wasn't there, I just don't recall.
12 THE CHAIRMAN: I understand that. Because you ended up,
13 I think, two years later in paediatrics for six months.
14 A. That's right.
15 THE CHAIRMAN: You were aware after Raychel's death of the
16 hospital having learned lessons, which they were passing
17 on through the ranks to JHOs, SHOs, nurses, et cetera?
18 A. Yes.
19 THE CHAIRMAN: Thank you.
20 MR WOLFE: In ease of Mr Stitt's point, he refers to
21 Dr Nesbitt's lecture series being an illustrated event.
22 Could I have up on the screen, just to confirm that
23 point for him, 316-004e-035? So it continues for
24 a number of pages. This is part of the lecture which
25 Dr Nesbitt delivered; do you see that?

1 A. I see it, yes.
2 Q. Is it --
3 A. It's not ringing any bells, but I may have seen it
4 before. I don't know.
5 THE CHAIRMAN: I'm sorry, I'm jumping ahead a bit, doctor,
6 but just to tie this point up. When you were in
7 Altnagelvin over the following couple of years, did you
8 become aware not only of the lessons that had been
9 learned internally, but that the Department of Health
10 had issued guidelines on hyponatraemia? Can you
11 remember those coming in?
12 A. I remember that there were new guidelines issued about
13 hyponatraemia, yes.
14 THE CHAIRMAN: Thank you.
15 MR WOLFE: Could I have up on the screen, please, an extract
16 from Dr Devlin's witness statement, WS027/2, page 15?
17 In the course of your witness statement you were asked,
18 doctor:
19 "Were you aware of the factors [taking our base line
20 of June 2001] that could cause an electrolyte imbalance
21 in a paediatric patient following surgery?"
22 And then you're asked to identify the factors if you
23 could. And you said:
24 "In 2001 I would be aware of some factors that could
25 cause electrolyte imbalance in post-operative patients.

1 Bleeding, infection, vomiting, diarrhoea, fluid
2 administration, hormonal response to surgery, bowel
3 obstruction, medications could all cause electrolyte
4 imbalance."
5 And you note Raychel had some vomiting and was on IV
6 fluids. We'll come to look at her specifics in just
7 a moment. But is it fair to say that you had
8 a reasonably developed knowledge or consciousness of the
9 issues that could give rise to an electrolyte imbalance?
10 A. I think I had the same knowledge as most JHOs at my
11 stage would have had at that time. I don't think I was
12 particularly ...
13 THE CHAIRMAN: You weren't ahead of the game?
14 A. No. I would hope I wasn't particularly behind the game.
15 THE CHAIRMAN: That's the point I'm making. You had the
16 knowledge that you would expect most JHOs to have?
17 A. Yes.
18 MR WOLFE: That knowledge that you've set out here, perhaps
19 in summary form, in front of us, did you acquire that
20 knowledge from undergraduate teaching?
21 A. As to exactly where the knowledge was acquired, it's
22 hard to say. Certainly some of it would have been
23 undergraduate teaching and then some of it would have
24 been learned through ward attachments and then through
25 observation and ward rounds and from listening to more

1 senior staff.
2 Q. You've gone on to say in your witness statement that you
3 were taught basic fluid management during your
4 paediatric undergraduate training.
5 A. That's right.
6 Q. You've added that, as a JHO, you didn't have
7 responsibility for writing up fluids for children.
8 A. That's correct.
9 Q. And you can't recall any specific training offered by
10 Altnagelvin in that respect?
11 A. In regard to writing up fluids for children?
12 Q. Yes.
13 A. Definitely not.
14 Q. At that time, Solution No. 18 seemed to have been the
15 most common maintenance fluid for a child in
16 Altnagelvin; isn't that right?
17 A. That's right.
18 Q. And at that time, would you have been aware of other
19 fluids that were available in the hospital to use for
20 maintenance purposes?
21 A. Absolutely. And from my work, I worked mostly in adult
22 wards, so I knew that No. 18 was only used in the
23 children's ward.
24 Q. It was only used in children's?
25 A. I have no recollection of it being used in adult

1 treatment.
2 Q. Were you aware of its chemical composition by comparison
3 with other fluids?
4 A. Yes.
5 Q. And you would have appreciated that it was low sodium in
6 composition?
7 A. Yes. It was a fifth normal saline, yes.
8 Q. Whereas Hartmann's solution, for example, was similar in
9 composition to blood?
10 A. Hartmann's was a closer to normal saline. I think
11 normal saline was 150 millimoles of sodium and I think
12 Hartmann's is 130.
13 Q. 130, yes. And given your knowledge of the factors that
14 could cause an electrolyte imbalance, you're not quite
15 sure where you developed that knowledge, but can I ask
16 you this: in practical terms, when bringing medical care
17 to adults and children during your JHO year, did you
18 have to deal with issues involving electrolyte
19 imbalance?
20 A. Occasionally there would have been some issues, but
21 mostly in adult patients and mostly when there were
22 other co-morbidities fluid management could get more
23 difficult in adult patients with renal problems or with
24 heart failure or I suppose burns cases have special
25 fluid management and things like that. So my experience

1 of electrolyte abnormalities and difficulty with
2 electrolytes would be mostly in adult medicine. I think
3 that there was a bit of, maybe a complacency, that if
4 a person was young and healthy and they had normal renal
5 function and normal kidneys, that maybe one had to be
6 slightly less cautious with fluids than one would be in
7 patients with other pre-existing co-morbidities that
8 came into the word. And often in those cases we needed
9 specialist advice from the medical team or that sort of
10 thing, a renal doctor maybe.
11 Q. At that time, use of electrolyte profiling, from
12 evidence which the inquiry has so far heard, seems to
13 have been more prevalent on the medical side as opposed
14 to the surgical side.
15 A. In terms of paediatrics?
16 Q. We have heard evidence in relation to paediatrics, yes.
17 And let me illustrate that for you and ask for your
18 comments. On the paediatric medical side, the
19 impression which some of the evidence may have created
20 is that electrolyte profiling for a child on intravenous
21 fluids would be a staple of the day, it'd be something
22 that would be done certainly once in a 24-hour period.
23 Whereas the arrangements for surgical patients on
24 intravenous fluids would be altogether looser.
25 A. I don't know if that's the case or not. I think that it

1 may have been at that time in paediatric medical
2 patients that they would not necessarily have had an EP
3 done every day, I don't know. Maybe one of the
4 paediatric consultants could answer that question.
5 I suppose the thing about the paediatric medical
6 patients is that often they were thought to have higher
7 ongoing losses and be at higher danger than surgical
8 patients would be of electrolyte abnormalities, you
9 know, because some of these children were much sicker
10 when they came into hospital and then when they went on
11 to IV fluids, I suppose the paediatricians may have
12 taken the view that they could be at higher risk, that
13 there were other conditions that could place them at
14 higher risk, so had a more regular EP sampling.
15 Q. Yes.
16 THE CHAIRMAN: These other conditions might be any variety
17 of infections?
18 A. Well, gastroenteritis. A child can have severe vomiting
19 and diarrhoea with very high sodium and potassium losses
20 with severe gastroenteritis. Or in little babies,
21 conditions like pyloric stenosis whereby they literally
22 vomit with every feed that they take and close EP
23 monitoring would be required of those types of children
24 as well. So I suppose the medical doctors from
25 experience, you know, would have been probably -- it's

1 probably fair to say that they would have been more
2 cautious by checking EPs than the surgical team at that
3 time.
4 MR WOLFE: Let me pick up on that. In a gastroenteritis
5 case, it would be standard, I think you're saying, to do
6 an EP and electrolyte profile.
7 A. If the child was on IV fluids?
8 Q. Yes.
9 A. I don't know if there was any written protocol about
10 that at that time. I think it was common practice that
11 one would be done every 24 hours, but I don't know if
12 that was a definite guideline or not at that time.
13 Q. But there would be presumably, depending on the severity
14 of the case, a need to see just how severe any
15 electrolyte depletion was?
16 A. Well, these children would have had a baseline blood
17 done, the ones that came in with gastroenteritis, and
18 you would have had cause for concern from the outset
19 because their EP may have been deranged, you know, they
20 may have been dehydrated as soon as they came into the
21 hospital. So because you were starting from an EP that
22 was deranged, it would make sense to monitor it more
23 carefully when they are on IV fluids.
24 Q. In terms of the IV fluids that would be used in a case
25 where there was an electrolyte imbalance, such as low

1 sodium or low potassium, would it simply be a case of
2 using Solution No. 18 in those cases or would something
3 else be added to the mix typically?
4 A. I've read the evidence about this. I think that No. 18
5 Solution at that time was the only solution that was
6 used on the paediatric ward, for all cases, surgical and
7 paediatric.
8 Q. So there was no attempt to top it up or mix it with
9 Hartmann's or to add potassium or sodium to the fluid?
10 A. Prior to 2001, I don't believe so. I don't believe so.
11 The rate would be adjusted, the paediatric doctors may
12 have adjusted the rate of fluids as determined by the
13 EP. They would have administered medications to try and
14 slow down the vomiting and they would have addressed the
15 issues in that way. But I think that was the only fluid
16 that was used. There was a fear at that time of
17 giving -- I think there was a concern about giving
18 normal saline to children. There was a concern,
19 I remember from my pre-graduate days that children's
20 kidneys couldn't cope with a high solute load, they
21 couldn't cope with high volumes of sodium the way that
22 adult kidneys could.
23 Q. Could you perhaps just help us on this: if there is
24 evidence of an electrolyte imbalance with low serum
25 sodium at that time, you've indicated that the standard

1 response would be to retain IV fluids, perhaps adjust
2 the rate, but the fluid itself would be Solution No. 18?
3 A. That's correct.
4 Q. You would also bring to the mix drugs to try to stop the
5 vomiting.
6 A. That's right.
7 Q. Could you illustrate for us how that plan would work in
8 terms of restoring the correct electrolyte balance?
9 A. Well, I think the concern in most healthy children with
10 gastroenteritis would be one more of dehydration rather
11 than hyponatraemia. So the use of a hypotonic solution
12 seemed to work well for the vast majority of children
13 because there was some sodium -- there was still
14 30 millimoles of sodium in the No. 18 Solution -- and
15 over time, as the vomiting or diarrhoea stopped
16 naturally or due to the use of medications, the child's
17 own kidneys would kick in and would filter out excess
18 fluid and retain the sodium. I think that was the
19 rationale at the time.
20 In the vast majority of children, that seemed to be
21 exactly what would happen. After three or four days --
22 two or three days with gastroenteritis on No. 18
23 Solution, the vomiting and diarrhoea would stop and
24 their EPs would normalise and the concern would have
25 been more dehydration than of hyponatraemia.

1 Q. The evidence that you're giving this morning is in
2 contrast, I suppose, to some of the expert evidence
3 which the inquiry has received in reports from
4 anaesthetists, paediatricians and indeed surgeons who
5 are telling the inquiry in the reports that where there
6 was evidence of electrolyte imbalance, the proper
7 approach should have been to replace gastric losses, if
8 you like, with the appropriate measure of normal saline
9 or at with a higher percentage of sodium in the fluid.
10 A. Well, I wouldn't -- I'm not in a position to argue with
11 expert opinion, but I can tell you that that was custom
12 and practice at that time in Altnagelvin. That was the
13 main fluid that was used.
14 Q. You're describing the practice in Altnagelvin at the
15 time?
16 A. Yes, and the majority of children with gastroenteritis
17 or losses through vomiting or diarrhoea were treated
18 with Solution No. 18 and treated the vast majority of
19 times successfully too.
20 Q. Could I have up on the screen another extract from the
21 doctor's statement, WS027/2, page 15. Just at the top
22 of the page there -- I think I can fill in the gap. You
23 were asked in the question, I think, something about
24 whether you were in a position to calculate maintenance
25 rates for patients in 2001. That's something you

1 understood how to do?
2 A. In 2001, I was aware of the way it should be done, but
3 I wasn't using that knowledge or applying that knowledge
4 at that time. But I had had -- well, not the practical
5 training, the hypothetical training on how to prescribe
6 fluids to children.
7 Q. And you usefully set out there the proper approach.
8 A. Yes, for maintenance fluids.
9 Q. Yes. In terms of post-operative fluid prescription, had
10 you received any teaching to the effect that, in the
11 post-operative period, normal maintenance fluid should
12 be reduced by something in the order of 20 per cent?
13 A. Until I read that information, I wasn't even aware of
14 that today. I certainly didn't know that at the time.
15 Q. Very well. Could I bring you now to the events of
16 8 June 2001, when you were asked to attend to
17 Raychel Ferguson?
18 Could I ask you, first of all, about your
19 recollection of that day? Apart from an entry in the
20 drugs kardex, you didn't make any note, and indeed you
21 didn't make any statement for four years after the
22 events. What is your recollection of that day as you --
23 A. My recollection of the day in its entirety or the --
24 Q. I think we can safely limit it to your input with
25 Raychel.

1 A. Well, I think I -- I was finishing up my duties for the
2 day. I happened to be on Ward 6 at that time. I've
3 tried to think why I was on Ward 6, but I believe that
4 there would have been some urology patients on Ward 6 as
5 well and I must have been down either to clerk them in
6 for routine surgery the following day or maybe to write
7 a letter for an urology patient. I'm not quite sure why
8 I was on Ward 6 at that time, but I wasn't the doctor on
9 call and Ward 6 wouldn't normally have been my ward, but
10 I did happen to be there at that time.
11 Now, my recollection -- and it is 12 years ago, but
12 my recollection of what happened on the day was that
13 I was approached by one of the staff nurses, who
14 I couldn't remember at the time who it was, but I see
15 now it was Nurse McAuley, and I was advised that Raychel
16 had come in the previous day and that she had had some
17 vomiting during the day, but that they were happy enough
18 with her progress and that she had been written up for
19 an anti-emetic and would I administer the anti-emetic,
20 they were having some difficulty contacting one of
21 surgical team. So I said that I would do that, okay.
22 So I went over to Raychel, I talked to the nurse, I went
23 into the nurses' station, I was given the Zofran to
24 administer, I went over to Raychel. Raychel, as I said
25 in my statement, had a vomit at the time that I visited

1 her. I administered the anti-emetic to her. I believe
2 her mother was with her at the time that I saw her,
3 although I may be wrong about that, but I think her
4 mother was there at the time.
5 So I gave the anti-emetic to Raychel, I think
6 I said, "I hope that that helps". Then I left after
7 that and I put the stuff away in the sharps box -- I'm
8 sure that would have been custom and practice at the
9 time -- and probably would have said to Nurse Rice or
10 one of the nurses at that time, "Hopefully that will
11 help and if it doesn't help please contact the on-call
12 team". That's my recollection of my involvement in
13 Raychel's case.
14 Q. Approximately, if you can, how long did you spend with
15 Raychel?
16 A. I was only asked to administer an anti-emetic, so to be
17 honest, now, I would have gone, had a look at Raychel.
18 I believe I would have looked at Raychel's chart at the
19 bottom of her bed, about the amount of vomits that she'd
20 had and her observations. I would have given Raychel
21 the anti-emetic, I would have had a brief word, I think,
22 with Raychel or her mammy and then -- so the whole thing
23 might have been two or three minutes. It wouldn't have
24 been a long visit.
25 Q. Raychel, you may recall, was being nursed in one of the

1 rooms in Ward 6, room I.
2 A. That's right.
3 Q. Raychel was otherwise a patient under the care of
4 Mr Gilliland, the consultant.
5 A. That's right.
6 Q. And you've said that you weren't on call?
7 A. No.
8 Q. She was otherwise the responsibility of one of the other
9 JHOs or SHOs on call; is that the way it should have
10 worked?
11 A. That's the way it should have worked, yes.
12 Q. In terms of the role of a nurse in this context, you've
13 explained, doing the best you can, that you believe
14 Nurse Rice approached you, gave you something of the
15 history: post-appendicectomy, some vomiting, had been
16 doing well, but now she needed an anti-emetic. The
17 nurse's suggestion to you of an anti-emetic, could we
18 focus on that? Was she telling you that that's what she
19 wanted you to do or, alternatively, was she suggesting
20 that and leaving it for you to apply your medical
21 judgment?
22 A. I think the nurse told me that the child had been
23 written up for an anti-emetic and would I administer the
24 anti-emetic? So I think it was even more
25 straightforward than that. I must say I didn't remember

1 that at the time, but I can see from the kardex that it
2 was written up by Dr Gund and I had administered it.
3 Q. Let me see if I can find that record for you.
4 THE CHAIRMAN: 020-017-034.
5 MR WOLFE: So when you say the drug had been written up,
6 we can see the second entry down --
7 A. Mm-hm.
8 Q. -- "Zofran, 2 milligrams, if required" --
9 A. That's correct.
10 Q. -- and then the signature of the anaesthetist who
11 performed the surgery.
12 A. That's right.
13 Q. Then while it's convenient, if we go over to the next
14 page, please.
15 THE CHAIRMAN: Doctor, in your experience then and now,
16 is that standard for a drug to be written up, to be
17 given if required, and then for somebody like you to be
18 asked to administer it?
19 A. That was my experience at the time. That would have
20 been one of the main duties that we would have had,
21 would be to administer medication that was prescribed by
22 more senior doctors.
23 THE CHAIRMAN: Right. Thank you.
24 MR WOLFE: If we can, just over the page, please, 035.
25 You have made the entry at line C; is that right?

1 A. That's my writing, yes.
2 Q. Is it your writing all the way across?
3 A. Yes, it is.
4 Q. The document appears to allow you an opportunity to tick
5 when the drug is prescribed; is there a distinction in
6 this context between prescribed and administered?
7 A. Well, when I look back on this now, actually, I think
8 that what I should have done rather than record the drug
9 in that area was for Dr Gund to have written it, just to
10 write the time that I had given it and sign my name.
11 I suppose it's a sign of my lack of experience at that
12 time that what I actually did was to write the drug in
13 a different area. I think I might have wrote down the
14 time that I gave it at if there was opportunity for me
15 to do that. But on this particular line where I've
16 recorded it, there is nowhere really to write what time
17 you gave it at.
18 THE CHAIRMAN: If we go back one page to 034, then looking
19 back on it, what you might have done was just to fill
20 in the last two columns on the second line where Dr Gund
21 has prescribed Zofran and the alternative way for you to
22 do this was just to insert the time given and you sign
23 it?
24 A. That would have been a better way to do it, yes.
25 THE CHAIRMAN: Okay.

1 MR WOLFE: Could I bring you to a document at 020-017-036?
2 This is termed the drug administration record. And you
3 can see on the right-hand half of the page, if you like,
4 references, for example, 1 and 3. That's a reference to
5 the line on which a drug has been pre-prescribed by, for
6 example, Dr Gund, and then you have underneath it the
7 time of administration. So to go to the second line, it
8 says "2 at 9.30 pm". That's a reference to the
9 paracetamol which was given by Staff Nurse Noble at
10 9.30 pm. It's something the inquiry has heard evidence
11 about. Is this the document that you should have
12 completed?
13 A. I don't believe so. I believe I should have signed it
14 where Dr Gund had written it. I have no recollection of
15 ever writing anything in that particular page.
16 Q. In any event, doctor, should you have written a rather
17 fuller note than simply to enter a signature in the
18 kardex?
19 A. Well, I didn't think so at the time, but obviously with
20 the benefit of hindsight I should have done. It would
21 have been better practice for me to have done that. But
22 I can tell you that custom and practice at that time
23 was, where a medication was written up like that, it
24 would certainly have not been uncommon for a JHO like me
25 to administer that medication and make no other record

1 other than that I had administered the medication. That
2 would have been custom and practice at that time.
3 Q. You would accept that your record keeping is vulnerable
4 to the criticism that anybody coming after you simply
5 wouldn't have known when the drug was given?
6 A. They wouldn't have known when it was given? That's
7 correct, yes.
8 Q. So anybody trying to assess the effectiveness of the
9 drug over time would be altogether lost?
10 A. No, I wouldn't say that. I mean, the nursing staff are
11 there and the nursing staff knew what time the
12 medication was given at and they, in my experience,
13 would be well able to relay that information to the next
14 doctor that came on.
15 THE CHAIRMAN: Except they're going to go off shift in a
16 couple of hours.
17 A. But they do a more formalised handover.
18 THE CHAIRMAN: The other obvious gap, which I think you
19 might have to face up to, is there was a vomit in your
20 presence which wasn't recorded.
21 A. That wouldn't have been my responsibility to record that
22 vomit. Raychel was sitting in a four-bed room, ward,
23 beside the nursing station. She was in plain view of
24 the nursing staff.
25 THE CHAIRMAN: Was there a nurse with you?

1 A. Not that I recall. There was a nurse in close
2 proximity.
3 THE CHAIRMAN: Did she vomit into one of the kidney bowls?
4 A. She did.
5 THE CHAIRMAN: And did you take that away?
6 A. No.
7 THE CHAIRMAN: So your point is it would have been available
8 for somebody -- it would have been there for a nurse to
9 spot and write up? But you're saying it wouldn't have
10 been your function to write "vomit" into the fluid
11 balance chart?
12 A. Maybe now I might do it, but certainly at that time the
13 doctor wouldn't commonly record in the fluid balance
14 chart like that.
15 THE CHAIRMAN: Thank you.
16 MR WOLFE: Would you have expected the nurse to have made
17 a full note of your attendance?
18 A. I would have expected the nurse to record that I had
19 administered the IV anti-emetic, yes.
20 Q. Would you have expected the nurse to have noted the time
21 of the administration?
22 A. That could have been possible, yes. That would be good
23 practice.
24 Q. Would you have expected the nurse to have made a note of
25 Raychel's condition at that time?

1 A. Really now, it's a question for the nurse, it's not ...
2 I mean, what would be expected, I don't know what would
3 be expected of a nurse. It would be good practice,
4 I suppose, to say that -- I think to be fair now,
5 Nurse McAuley did make a comment in relation to the
6 administration of the IV anti-emetic.
7 Q. In terms of your record keeping, why do you say there
8 was no obligation on you to record Raychel's history and
9 her condition at the point at which you attended?
10 A. Well, I felt that this was a routine task. I felt that
11 the task that I had been asked to do was not to assess
12 Raychel or there were no concerns expressed to me that
13 Raychel's recovery was anything but what would be
14 expected by the nursing staff at that time. And my
15 duty, or what I was expected to do, was to administer
16 the IV Zofran. I was not asked to assess Raychel or no
17 concern was expressed to me that Raychel was more
18 seriously unwell than post-operative nausea and
19 vomiting.
20 Q. Have you read the report of Mr Foster?
21 A. I've read it.
22 Q. Have you seen his criticism of your failure to make what
23 he would describe as adequate notes?
24 A. I think -- I've also read Mr Orr's report. He again
25 would have no such criticism of me. I certainly would

1 feel that I acted in a reasonable manner given the
2 information that I had at that time.
3 THE CHAIRMAN: So to be blunt, do you think Mr Foster's
4 being harsh?
5 A. It's not for me to make that decision.
6 THE CHAIRMAN: In a sense, you're pointing me towards the
7 fact that although Mr Foster has criticised you, Mr Orr
8 hasn't, and there's a degree of distinction between
9 them.
10 A. Yes.
11 MR WOLFE: Mr Orr, to be absolutely accurate, has said that
12 the absence of a note was poor practice, but he went on
13 to say it would appear consistent with the culture and
14 practice on that ward at that time, which is a rather
15 different matter perhaps than saying there's an excuse
16 for not making a full note.
17 A. I'm not making an excuse. I accept that it would have
18 been better practice for me to have made a note at that
19 time and I regret that I didn't make a note at that
20 time, but what I'm trying to do is to defend my actions
21 at that time and the only way I can defend it is to say
22 it would have been custom and practice at that time not
23 to make a note when we administered a pre-written up
24 intravenous medication. And to put it in context that
25 day maybe I administered 30 other pre -- anticipatory

1 medications and also didn't make a note at that time of
2 the patients that I administered those anticipatory
3 medications to. Because at that time, nurses gave much
4 less IV medications than they do now and most, if not
5 all, of the IV medications were given by the junior
6 doctors at that time.
7 THE CHAIRMAN: If the custom and practice is at fault, you
8 might say, "I was a JHO, this was my first year and if
9 the custom and practice has been established in the
10 hospital, then look to the people who established the
11 custom and practice, not to the people who were
12 following it as junior doctors"?
13 A. I suppose that would be one way of looking at it, yes.
14 MR WOLFE: Could I put up on the screen, doctor, the
15 statement that you gave to the inquiry in 2005, WS027/1,
16 page 2? I just want to focus, if we can for a short
17 time, on just what you were told by the nurses and see
18 if you can help us a little further. In your witness
19 statement at that time you've set out what you believe
20 you were told. You start by saying you have a vague
21 recollection, but go on to say that you were told she
22 was then 24-hours post-appendicectomy:
23 "She had apparently vomited on a few occasions that
24 afternoon, but had been drinking fluids earlier in the
25 day."

1 Is that something you think you were told by nursing
2 staff?
3 A. It's hard for me to remember a conversation like that
4 13 years ago. At the time that I wrote that in 2005,
5 that is what I remembered, that is what I remembered,
6 but of course it was only a conversation that was had
7 at the time and I can't be 100 per cent sure that that's
8 what was said, but that's what I remembered at the time.
9 Q. Could I look at what you say in your second witness
10 statement, doctor, at WS027/2, page 6, please?
11 If we highlight the answer at (r), please. In this
12 document you are asked:
13 "When you attended with Raychel, what was your
14 understanding of each of the following matters: the
15 duration of Raychel vomiting? Raychel had one vomit
16 in the morning and two in the afternoon. The amount of
17 her vomiting. From the records, she had a large morning
18 vomit and two small vomits that afternoon."
19 Could I just ask you to tell us, what record were
20 you referring to when you said that?
21 A. That's what was on the fluid balance sheet or maybe ...
22 I may have made a mistake in my statement. It might
23 have been one large vomit in the morning or -- was it
24 three smaller vomits in the afternoon when I looked at
25 it again?

1 Q. Let's look at the fluid balance chart. Before we do so,
2 is that something you think you would have looked at
3 before administering the medication?
4 A. Yes.
5 Q. Why are you confident about that?
6 A. Custom and practice at the time. That would have been
7 what I would normally have done --
8 MR QUINN: He actually confirms it in paragraph (n) on the
9 same page.
10 MR WOLFE: I'm conscious of that.
11 That was your general approach and that's why you're
12 confident about it?
13 A. That's what I would normally do, yes.
14 Q. Would you have looked at anything else prior to
15 administering?
16 A. I think I looked at her obs chart, too.
17 Q. Okay. So if we put up the fluid balance chart, please,
18 020-018-037. By the time of your attendance with
19 Raychel, four vomits had been noted by nursing staff;
20 isn't that right?
21 A. That's right.
22 Q. In terms of the large vomit, that's clearly marked at
23 10 o'clock; isn't that right?
24 A. Mm-hm.
25 Q. In terms of small vomits, where are they marked?

1 A. I thought that if it was writ as "vomited plus plus"
2 rather than "large vomit", that the "vomit plus plus"
3 wasn't as big as the large vomit. But there's an issue
4 about standardisation of how the vomits are being
5 recorded.
6 THE CHAIRMAN: Yes. So far, vomit plus plus has been
7 interpreted as everything from small to large. So in
8 fact, it doesn't seem to me -- I understand the
9 difficulty in defining how large or how small a vomit
10 is. At what point do you take away a plus or at what
11 point do you add a plus? I think the difficulty is that
12 that then makes the records a bit more difficult for
13 somebody coming along later to understand.
14 A. Sure, but --
15 THE CHAIRMAN: The only consistent thing that seems to
16 emerge from the records is the number of times that
17 she's recorded as having vomited.
18 A. Pardon?
19 THE CHAIRMAN: The only thing that I think that can clearly
20 be taken from the records is the number of times she
21 vomited.
22 A. Sure, but there was also the information that
23 Nurse McAuley had given me that she had had a big vomit
24 and smaller vomits as well, you know. And I think she
25 told me that at the time. When I look then at the fluid

1 balance charts there's also that information that would
2 lead me to draw my final conclusion.
3 THE CHAIRMAN: Can I ask you this, doctor, obviously with
4 hindsight: what difference would it make if you were
5 told she had one large vomit and two small as opposed to
6 being told she had three large? Would that make any
7 difference to you when you're coming along on the basis
8 that I'm doing a standard procedure here, I'm giving an
9 anti-emetic which has been prescribed by somebody else?
10 A. It probably would have made no substantive difference.
11 MR WOLFE: You would have read the obs chart; isn't that
12 right?
13 A. Yes, that would be a custom and practice.
14 Q. And again if we could briefly have that up on screen,
15 please, it's at 020-015-029. You would have noted that,
16 during the course of that day, there had been three
17 entries made -- starting at 9 o'clock, three entries
18 from that point to the point of your attendance at
19 shortly after 5.30; is that right?
20 A. Yes.
21 Q. What impression would you have formed having read that
22 document?
23 A. I wouldn't have formed an impression that would give me
24 cause for concern at that time, from reading that
25 document.

1 Q. Taking into account that document and the information
2 that you'd received both orally and in the fluid balance
3 chart in relation to vomits, what overall impression
4 would you have formed?
5 A. I think my overall impression was that Raychel had
6 post-operative nausea and vomiting and that it would be
7 a good thing to give her an IV anti-emetic to try and
8 stop that.
9 THE CHAIRMAN: Which fits in with what had been anticipated
10 by Dr Gund as a possible outcome?
11 A. Exactly right.
12 THE CHAIRMAN: Let me ask you then: what might have caused
13 you to hesitate before just giving the anti-emetic? If
14 whichever parent was with her had said something that
15 raised concerns or if she looked particularly poorly or
16 there was something unexpected on the observation or the
17 fluid balance sheet, might that have caused you to
18 hesitate?
19 A. Any of those things. If any concerns had been raised to
20 me at the time, I think I would have -- or I may have
21 responded differently.
22 THE CHAIRMAN: Can you remember how Raychel appeared to you?
23 I don't want you to guess if you can't.
24 A. No, I do remember. She was sitting up on the bed. She
25 wasn't lying in bed, she was sitting up in bed and she

1 had vomited into a kidney dish when I saw her.
2 THE CHAIRMAN: As you understood it, within the last few
3 minutes? Sorry, did she vomit in your presence?
4 A. I think she vomited -- she vomited I think when I was
5 there, yes.
6 THE CHAIRMAN: Right. Sorry, is that in addition to a vomit
7 which was in the kidney dish?
8 A. No.
9 THE CHAIRMAN: Okay. So when you were there, she vomited
10 and you had, from the fluid balance chart, a list of the
11 vomits which had been recorded and the observations.
12 She didn't flag up any concerns?
13 A. No.
14 THE CHAIRMAN: So in fact, perhaps the very fact that she
15 vomited might have confirmed in your eyes the need for
16 the anti-emetic?
17 A. Yes.
18 THE CHAIRMAN: Thank you.
19 MR WOLFE: You seem to recall the mother, that is
20 Mrs Ferguson, being present.
21 A. I can't say definitively if Mrs Ferguson was present or
22 not. It is my recollection at this time that she was,
23 but if she wasn't, I wouldn't be surprised to hear that.
24 Q. Would it be your custom and practice to seek to extract
25 information from the parent about the condition of the

1 child?
2 A. It would very much depend on the scenario that had been
3 set for me and the task I had been asked to perform.
4 I think for this particular task, I think -- I mean,
5 I would have said something along the lines of
6 "Raychel's been vomiting, nurse has asked me to give an
7 anti-emetic. We'll try this, hopefully this will help
8 her". But again, I can't recall the exact conversation
9 that would have took place, but I'm sure something like
10 that was said.
11 Q. I think, just to put this point, Mrs Ferguson doesn't
12 recall you saying anything to her in terms of informing
13 her of what the position was or what she might expect.
14 A. But I must have said something. I must have said,
15 "Hello, I'm here to give Raychel an anti-emetic". There
16 must have been some --
17 MR QUINN: We agree that he did say, "Hello, I'm here to
18 give Raychel an anti-emetic". That's about the height
19 of it.
20 THE CHAIRMAN: In a sense, that cuts both ways a bit,
21 Mr Quinn. It means that Mrs Ferguson had some
22 opportunity to speak to him. I know that some people
23 are more confident than others in the setting about what
24 they might say to a doctor. Some people would feel
25 quite relaxed and confident to speak out, other people

1 mightn't. But she was there when the doctor was there?
2 MR QUINN: She was there and she has a vague recall of the
3 doctor just saying, "Hello, I'm the doctor, I'm going to
4 give Raychel something for her sickness". I don't think
5 she recalls the words "anti-emetic", just the --
6 THE CHAIRMAN: Would you have necessarily used the term --
7 A. No, I probably used the words "something for her
8 sickness".
9 MR QUINN: And that he saw the vomit in the bowl and that
10 she was vomiting at the time when he arrived. That's
11 the most of the recall that --
12 THE CHAIRMAN: Can I ask: does Mrs Ferguson agree that
13 Raychel was sitting up at that time?
14 MR QUINN: She was sitting up and vomiting at the time, yes.
15 She was vomiting -- as Mrs Ferguson has told me, as the
16 doctor came in to administer the drug, Raychel was
17 vomiting in a kidney bowl, sitting up and vomiting with
18 her mother with her.
19 THE CHAIRMAN: So in a sense there's very limited dispute
20 about this. The doctor has described it as two or three
21 minutes and that fits.
22 MR QUINN: That fits.
23 THE CHAIRMAN: Thank you.
24 MR WOLFE: In terms of information gathering, you could have
25 examined the child, but didn't.

1 A. That's correct.
2 Q. Did you think it unnecessary to examine the child?
3 A. I did.
4 Q. And why was it unnecessary?
5 A. Because the scenario had been set for me and all of the
6 information that I had seen up until that point gave me
7 reassurance that the diagnosis was post-operative nausea
8 and vomiting, the medication had been anticipated and
9 that's why I gave the medication. I didn't feel an
10 examination was necessary. Again, custom and practice
11 at that time would be that often we would have performed
12 tasks on patients without conducting full history and
13 examination. It would be impossible for us to do the
14 jobs that we had to do, all of the jobs we had to do,
15 and fully examine and take an accurate history on every
16 patient.
17 THE CHAIRMAN: Okay. Let's take a break.
18 Doctor, we have to take a break for the
19 stenographer. We'll resume in 10 minutes and I'm fairly
20 confident your evidence will be finished by lunchtime.
21 (11.52 am)
22 (A short break)
23 (12.02 pm)
24 (Delay in proceedings)
25 (12.08 pm)

1 MR WOLFE: Doctor, we are at that point in the sequence when
2 I've been asking you questions about the sources of
3 information that were available to you so that you could
4 establish, before you administered the anti-emetic, just
5 what Raychel's condition was.
6 If I could summarise, leaving aside the notes that
7 you say you looked at, you appear to have been told by
8 the nurse that Raychel had had three vomits that day,
9 one large and two small ones; is that the best of your
10 recollection?
11 A. She may have said one large and three small ones, but
12 I accept that.
13 THE CHAIRMAN: Whatever she told you, by looking at the
14 fluid balance chart you have the opportunity to see if
15 there's anything more than what she told you because if
16 there's a fourth vomit or a fifth vomit, it'll be on it?
17 A. That's what I would have thought.
18 MR WOLFE: Yes. Could I have up on screen, please, WS027/2,
19 page 6? Just at (p), we're asking you:
20 "Did you have access to Raychel's notes and, if so,
21 did you read them? If you read the notes what did you
22 learn about Raychel's history or condition?"
23 You say:
24 "I don't think I looked at Raychel's notes. I could
25 have accessed them if I felt necessary at the time."

1 What did you mean by that?
2 A. Medical notes were kept in sister's office, so there
3 would be information there about the admission and
4 demographic details about Raychel and that sort of
5 thing. But actually, I suppose to clarify that, the
6 notes really in the paediatric ward -- I mean, I suppose
7 they were divided really between the end of the bed and
8 sister's office in that there was useful information
9 about the child's current condition that could be
10 gleaned from reading the notes at the bottom of the bed.
11 The medical notes per se were in a file that were in
12 sister's office I didn't look at, but other records
13 about Raychel's care and progress that were at the end
14 of the bed, which could be construed as notes, I looked
15 at them.
16 Q. Yes. So when you answer that question there, that's
17 a reference to the notes that are kept behind the
18 scenes, if you like?
19 A. Well, not behind the scenes, but in sister's office.
20 Q. Yes. So the notes that you had access to, as you
21 described earlier, were the fluid balance chart and the
22 obs and the kardex?
23 A. Yes, the kardex, yes.
24 Q. The inquiry has received expert opinion on how Raychel
25 ought to have been in terms of her condition by that

1 time of the afternoon, all things being equal. Can
2 I put it in this way to you: Raychel had had an
3 appendicectomy and a mildly congested appendix was
4 found. Would you have been aware of that at the time
5 you saw her?
6 A. No.
7 Q. She had initially had a smooth recovery, in other words,
8 there was no nausea or vomiting overnight.
9 A. I think she had an unusual directly post-operative
10 recovery. I've read that she was in recovery for quite
11 some time, you know, which would be slightly atypical,
12 I suppose. But then she slept, that is right, during
13 the night.
14 Q. She slept through the night without any pain or without
15 any nausea or vomiting.
16 A. I suppose she was recovering still from the effects of
17 the anaesthetic, you know, so it would be quite a heavy
18 sleep she would have been under, you know.
19 THE CHAIRMAN: Sorry, can you just help me with this: when
20 you talk about post-operative nausea and vomiting, is
21 what happened with Raychel, is that an unexpected
22 example in that she's operated on at around midnight,
23 1 o'clock, and the first recorded vomit is at 8 o'clock?
24 Would there be cases when the vomiting starts much
25 earlier than that?

1 A. Again it's a question that I can't give a good answer
2 to. My own opinion, I fully acknowledge, I had at the
3 time was she probably would have slept from the
4 anaesthetic quite deeply and it might not be until the
5 next day that the vomiting started, I suppose.
6 THE CHAIRMAN: Thank you.
7 MR WOLFE: Is it a common situation in your experience when
8 a child mobilises post-operatively, that that can
9 sometimes be the trigger for vomiting?
10 A. Again, I would have no particular expertise in that
11 area. I don't know.
12 Q. Nevertheless, as I've said, the expectation of Raychel's
13 progress suggested by some of the experts is that by the
14 time you were coming to see her at or about 5.30 in the
15 evening, all things being equal, Raychel might have been
16 mobile, consuming oral fluids and perhaps eating
17 something light?
18 A. I suppose if Raychel had made a very good recovery like
19 the one you describe, I wouldn't have been going to see
20 her at all.
21 Q. That's right.
22 THE CHAIRMAN: What Mr Zafar had expected at the ward round
23 in the morning -- well, what he had advised is: things
24 look fine, as the day goes on, starts giving her oral
25 fluid and wind down the IV fluid.

1 A. Sure.
2 THE CHAIRMAN: And maybe, in the late afternoon, maybe she
3 might be able to eat something as well.
4 A. And that would be a textbook recovery, but not every
5 child would progress in that way. Everybody would be
6 different.
7 MR WOLFE: Clearly, doctor, you could only work with the
8 information available to you on the documents or based
9 on what you were told. The inquiry has to deal with
10 a factual dispute in terms of the severity of Raychel's
11 vomit during the day. We've heard what you have said
12 about the extent to which vomit was reported to you.
13 You reached a conclusion that this was normal or
14 straightforward post-operative vomit; is that fair?
15 A. Again, I reached the conclusion that her vomiting was
16 probably due to her operation and anaesthetic. I don't
17 know if there's such a thing as normal or
18 straightforward post-op vomiting.
19 Q. Okay. It was vomit associated with the fact that she
20 had been through an anaesthetic procedure?
21 A. If the question is, "Did I think that the vomiting was
22 due to hyponatraemia?", I don't think that that would
23 have been, at that time, high on my list of potential
24 diagnoses.
25 THE CHAIRMAN: Just to be precise, would it have been

1 anywhere on your list of diagnoses?
2 A. At that time, there would be much less understanding or
3 knowledge of hyponatraemia. I may have known at that
4 time that hyponatraemia could be a cause of vomiting,
5 but certainly it would not have been something that
6 I would have ever encountered before and certainly not
7 in this situation.
8 MR WOLFE: You have told us earlier that it was within your
9 state of knowledge at that point that an electrolyte
10 imbalance could occur in the presence of vomiting, for
11 example, or following surgery, or in relation to
12 intravenous fluid. Given what you were able to read and
13 what you were told about Raychel's condition, did you
14 give any consideration to whether she was at risk of
15 electrolyte imbalance at that time?
16 A. I certainly didn't think at that time that the cause of
17 her vomiting was an electrolyte abnormality. I suppose
18 my view on it was that maybe she could develop an
19 electrolyte abnormality if we didn't administer some
20 medication to her, so that's what I was hoping to
21 achieve in giving the Zofran.
22 Q. So your thinking was: let's get the vomiting stopped,
23 using an anti-emetic, and any potential for an
24 electrolyte abnormality occurring could be eliminated?
25 A. Could be reduced, yes.

1 Q. Another aspect of this, of course, is that she is in
2 receipt of intravenous fluids, and by that time at or
3 about 6 o'clock in the morning [sic], to deal with round
4 numbers, she had been on fluids from 10 o'clock the
5 previous evening --
6 THE CHAIRMAN: 6 o'clock in the evening. You said 6 o'clock
7 in the morning.
8 MR WOLFE: 6 o'clock in the evening. In round numbers, she
9 had had intravenous fluids for about 18 hours. That's
10 something that would have been obvious to you from the
11 fluid balance charts. Again, in surgical patients,
12 is that a normal period of time to still be on
13 intravenous fluids?
14 A. Again, from my level of knowledge at the time as
15 a doctor for 10 months -- I mean, it didn't seem
16 unreasonable to me that a child would be on fluids less
17 than 24 hours after surgery. Certainly it would have
18 been my experience in cases that I had seen in adult
19 wards and as an undergraduate doctor that patients could
20 be on IV fluids sometimes for long periods, up to a week
21 or 10 days.
22 Q. The rate of fluids that she was on at 80 ml per hour has
23 been reckoned by expert opinion retained by both the
24 Trust for the purposes of this inquiry and by other
25 experts, such as Mr Foster, to have been excessive for

1 the post-operative phase. Have you considered those
2 opinions?
3 A. I think the fluids were not hugely excessive and
4 I think -- I read what Mr Foster said, that the fluids
5 should be reduced post-operatively to allow for ADH.
6 I think I might have thought if she was vomiting she
7 might need slightly more than maintenance fluids, she
8 might need a degree of replacement fluid as well. So
9 I would say that at the time I didn't pay much attention
10 to it. I would have been aware at an it was 80 ml per
11 hour, but I wouldn't have any strong opinion that that
12 would be too much or the wrong type of fluid at that
13 time.
14 Q. When you think about all of this now, what information
15 would you have needed to receive for you to decide that
16 an electrolyte profile was necessary?
17 A. I think at that time I would have needed -- there would
18 have needed to have been a clear protocol in place that
19 children would need their fluids checked or I would have
20 needed to have received guidance from senior staff at
21 that time that a fluid check should have been done. At
22 my level of experience at that time, that would not have
23 been something that would have occurred to me to check
24 on my own initiative, given the information that I had
25 in this case.

1 Q. Yes. But given your state of knowledge, which included
2 information that factors such as vomiting, intravenous
3 fluids and what have you could cause an electrolyte
4 imbalance, why was that not indicated in Raychel's case
5 at the time of your visit?
6 A. Why was it not indicated to do?
7 Q. Yes.
8 A. Because I thought the steps I was taking were
9 appropriate steps, stop the vomiting. If the vomiting
10 doesn't stop and I had been back to see Raychel a second
11 time, I might have considered an electrolyte profile at
12 that time.
13 THE CHAIRMAN: Let's suppose you might not have been going
14 off duty at 5.30, let's suppose you had been on call and
15 you were called back at 8 or 9 or 10 or whatever and she
16 was still vomiting. That might have made you think,
17 "Well, the anti-emetic hasn't worked, she's still
18 vomiting another four or five hours later", and it might
19 have raised a flag about whether it would be appropriate
20 to get the bloods checked.
21 A. I think if I had seen Raychel twice, if I had been the
22 doctor on call that evening, I think that it's quite
23 likely that I would have checked some bloods if I had
24 seen her for a second time. I must say that if I was
25 seeing Raychel for the first time later that evening and

1 I hadn't seen her before, it might be a different
2 situation. But I think if I was seeing her again, and
3 I had knowledge that she had continued to vomit, I might
4 have approached things differently.
5 THE CHAIRMAN: I think we're back to one of the problems in
6 Claire's case, Mr Quinn, which is a succession of
7 different doctors seeing a patient.
8 MR QUINN: Yes.
9 THE CHAIRMAN: And not having their own continuity about
10 what's going on.
11 MR QUINN: Yes, as I said in Claire's case, there's a lack
12 of joined-up thinking.
13 THE CHAIRMAN: I think it's maybe a bit more than that. If
14 I take Dr Devlin's point that if he himself had seen
15 Raychel for the second time later on, he might have
16 a different impression than somebody else coming in to
17 see her for the first time later on.
18 MR QUINN: In one respect that's why I asked my learned
19 friend to concentrate, if he would, a few questions on
20 the notes and note taking because if there had been
21 sufficient notes -- and probably it's down to what the
22 custom and practice was at the time, but if the notes
23 had been there, then doctors like Dr Devlin and those
24 who followed later, Dr Curran, perhaps would have had a
25 better chance of identifying what was wrong.

1 THE CHAIRMAN: And we have what he says about the note
2 taking. Thank you.
3 MR WOLFE: Next point. The situation was that by the time
4 Dr Curran attended at or about 10.15 that night, he
5 didn't have anything from you, the last doctor to have
6 seen her, apart from this small entry in the kardex.
7 A. Well, he would have had the information from the nurse
8 too, I presume.
9 Q. But can I put it to you in these terms? You had
10 administered an anti-emetic which you hoped would reduce
11 the problem, if not wholly eliminate the problem, the
12 problem being vomiting and nausea. As you sit here
13 today you're telling us that if you'd seen her for
14 a second time and she had continued to vomit in the
15 interim period, you would have considered doing bloods.
16 A. I could have considered. It's a hypothetical situation.
17 Q. Is it not part of your responsibility, even as a JHO, to
18 set down on paper a plan for the way forward?
19 A. In retrospect, I very much wish that I had made a note
20 and discussed Raychel's case specifically with
21 Dr Curran. My feeling at the time that I saw Raychel
22 was that she was not seriously unwell, that she had been
23 administered this -- she had been written up for this
24 Zofran that I had administered to her. I had absolute
25 confidence in that time of my nursing colleagues'

1 ability to relay on any concerns to the oncoming doctor
2 and I suppose at that time in my career I had felt that
3 the safety net would lie with the senior staff, you
4 know, that systems and things would be in place to
5 prevent the tragic outcome that happened in Raychel's
6 case. And if there had been, I would have adhered to
7 them.
8 Q. Let me come to the senior staff in just a moment. If
9 I could tease out with you in relation to how you would
10 have approached Raychel at 10 o'clock -- put it this
11 way: if you had been approaching Raychel for the first
12 time later that night, as you have just said, you've
13 indicated that you possibly wouldn't have taken bloods
14 if it was your first visit.
15 A. It would depend exactly again on the exact scenario that
16 I was presented with and how I found Raychel at the
17 time. There are too many variables to give a definitive
18 answer to the question.
19 THE CHAIRMAN: It's more likely that you would have
20 considered that taking bloods is an option if you'd been
21 seeing her for the second time --
22 A. Absolutely.
23 THE CHAIRMAN: -- than you would be if you see her for the
24 first time --
25 A. Absolutely.

1 THE CHAIRMAN: -- unless you form the view on the first
2 assessment of Raychel that there's something seriously
3 wrong --
4 A. Yes.
5 THE CHAIRMAN: -- and that didn't occur to you at 5 or
6 6 o'clock? And we'll hear from Dr Curran, who
7 I anticipate is going to say something similar about his
8 encounter with her later on that evening.
9 A. That's right.
10 MR WOLFE: By 10 o'clock, Raychel had had an anti-emetic
11 without effect.
12 A. I thought she had had an anti-emetic with effect.
13 Q. The anti-emetic that you gave her had fair effect,
14 according to Staff Nurse McAuley, and then she commenced
15 vomiting again within an hour on Mrs Ferguson's account.
16 And certainly when other visitors saw her at 8 o'clock,
17 she was vomiting, and nurses shortly after handover at
18 8 o'clock were asked to change the bedclothes because
19 she'd vomited on to them. How long would you have
20 expected the anti-emetic to be effective for?
21 A. I would have felt that if -- the anti-emetic would have
22 been immediately effective and that would have been the
23 end of the problem. That's what I would have imagined
24 or certainly the anti-emetic should have lasted maybe --
25 I suppose in cases where it is given recurrently,

1 certainly it should last for 6 or 12 hours, the
2 anti-emetic.
3 Q. That's why I put it to you in those terms that the
4 anti-emetic wasn't effective in that, by 9 o'clock, she
5 had coffee-ground vomits followed by three smaller
6 vomits, which then prompted Dr Curran's attendance. If
7 you were attending for the first time at 10 o'clock,
8 given all of that information: Raychel had started
9 vomiting at 8 o'clock in the morning, was still vomiting
10 at 10 o'clock at night, was now vomiting coffee grounds,
11 had had an ineffective anti-emetic, was still on
12 intravenous fluids, the records show that she hadn't
13 passed urine apart from one occasion --
14 A. The records show that it was only recorded once.
15 Q. Only recorded once. And she had now had a headache.
16 All of those factors taken together rather suggest that
17 her case should have been the subject of a thorough
18 review, including blood tests.
19 MR STITT: Mr Chairman, this is undoubtedly a valid line of
20 questioning but, I would respectfully submit, not to
21 this witness.
22 THE CHAIRMAN: I think it's also fair to say, Mr Wolfe, that
23 this witness has told us at the start of his friendship
24 with Dr Curran. So I think if Dr Curran is going to
25 face this line of criticism, it can come through the

1 experts or from our own probing of Dr Curran and not,
2 frankly, expecting his friend, who was a junior house
3 officer himself at the time, to comment on it.
4 MR WOLFE: The question was, of course, addressed at this
5 doctor's evidence as to what he would have done as
6 a first attender, but I quite take your point that it's
7 probably better addressed to --
8 THE CHAIRMAN: I think it's a general point. It must be
9 right that if you see a child at 5 or 6 and then you see
10 the same child again at 10 o'clock and you have all the
11 factors that you've just outlined, you might be more
12 alert to the problems than another doctor who sees her
13 for the first time at 10 o'clock. That doesn't mean
14 that the 10 o'clock doctor should not have more thinking
15 to do or have more concerns to take into account than
16 the 5 o'clock doctor.
17 MR WOLFE: Yes.
18 THE CHAIRMAN: Let's perhaps leave it at that.
19 MR WOLFE: In terms of senior input to Raychel's case, you
20 plainly didn't consider informing a more senior doctor
21 of Raychel's situation at or about 5.30 or 6 o'clock.
22 A. That's true.
23 Q. And what was your thinking there?
24 A. Well, I thought I had sort of made this point --
25 THE CHAIRMAN: I think I'm okay on that. You would say that

1 you wouldn't go back to your senior house officer
2 routinely and tell him everything you have done unless
3 there was something specific that you thought you needed
4 to bring to his attention?
5 A. Exactly.
6 MR WOLFE: Have you considered the report of Dr Simon Haynes
7 to the inquiry?
8 A. Yes, I've seen Dr Haynes' report.
9 Q. He has reflected upon the fact that, by that time
10 in June 2001, you had no formal experience of paediatric
11 medicine. Judging by your statement, he says you were
12 mainly involved in the care of adult surgical patients
13 and would have had very little involvement with
14 children. And that's a fair summary, isn't it?
15 A. Yes.
16 Q. And he reflects upon the difficulties for you in coming
17 into this situation. He says essentially that you were
18 coming into a situation where it was the expectation of
19 the nursing staff that you would simply prescribe an
20 anti-emetic rather than giving your own thought to the
21 possible reasons why Raychel was still vomiting; is that
22 a reasonable point for him to make?
23 A. I think the expectation of the nursing staff was that
24 I would give an IV anti-emetic, yes.
25 THE CHAIRMAN: I think it's even lower than Dr Haynes

1 because Dr Haynes is there expecting you to prescribe
2 the anti-emetic and you saying, no, you didn't prescribe
3 the anti-emetic, you were administering the prescription
4 written by Dr Gund the previous evening.
5 A. That's correct, yes. In the morning, early hours of the
6 morning.
7 MR WOLFE: But to put the point directly, both Dr Haynes and
8 Mr Foster, and indeed Mr Orr, are of the view that by
9 that late afternoon Raychel's condition dictated that an
10 electrolyte profile ought to have been conducted. And
11 what Dr Haynes says is that it appears that you were out
12 of your depth in this situation, given your lack of
13 exposure to paediatric cases. Has he got a point?
14 A. I don't know, I was doing the job that was asked of me
15 the best that I could at that time. That's really for
16 the expert to make that judgment call. It didn't occur
17 to me that an EP was necessary at that time and that's
18 all that I can say, you know.
19 THE CHAIRMAN: In effect, as I understand it, one of things
20 that happened afterwards on the paediatric surgical
21 patients was that, partly at the instigation of the
22 nurses, the JHOs were no longer called on; it was the
23 SHOs. Is that your understanding?
24 A. Well, often the SHOs, as I said earlier, were called
25 directly if there was -- if a patient was unwell, and

1 often when I attended an unwell patient the SHO would
2 already be there.
3 THE CHAIRMAN: Yes.
4 A. So it would be my opinion at the time that rather than
5 being a first port of call and then the JHO reports on,
6 if a patient was unwell, senior staff would be sought
7 immediately rather than JHOs.
8 THE CHAIRMAN: Just so that you don't walk away feeling
9 aggrieved at this, the point that Mr Wolfe has just put
10 to you about what the experts say -- that's Haynes,
11 Foster and Orr -- isn't a criticism of you as a junior
12 doctor; it's effectively a criticism of the system which
13 operated in Altnagelvin, whether the system had been
14 thought through well enough and what more might be
15 brought by calling an SHO or even a registrar rather
16 than a JHO. Okay?
17 A. Okay.
18 MR WOLFE: Could I immediately balance this up as well by
19 saying that Dr Orr in his report has said that it would
20 be unreasonable to expect pre-registration house
21 officers to have identified that Raychel was suffering
22 from a serious medical problem such as hyponatraemia,
23 that it would require a doctor of some experience or
24 some knowledge to have detected that.
25 THE CHAIRMAN: Yes, okay.

1 MR WOLFE: You didn't have any discussion with any of the
2 junior house officers on call that night about Raychel's
3 condition --
4 A. No.
5 Q. -- or, for that matter, as you've clarified, any senior
6 practitioner. You did have a discussion the next day
7 with Dr Curran.
8 A. Yes.
9 Q. He had obviously brought care to Raychel during the
10 night when you were off duty and obviously there was
11 a tragic turn of events overnight. Is that what he
12 discussed with you?
13 A. Yes. Dr Curran, I must say, was quite distressed and
14 shaken by the events that had happened, as I was, to
15 hear how this situation had ended, or what had happened.
16 I think we were both shocked, quite shocked.
17 Q. Did he tell you what he thought had happened?
18 A. I can't recall the specifics of the conversation that we
19 had at the time. I think his understanding was that
20 Raychel had had a fit and that they were looking -- that
21 they weren't 100 per cent sure at that time what the
22 cause of the fit was.
23 Q. As one of the doctors who was involved in Raychel's care
24 at a stage when at least, with the benefit of hindsight,
25 there was an opportunity to arrest her condition, are

1 you surprised that you weren't spoken to by the Trust
2 in relation to the input that you'd had?
3 A. I suppose I'm surprised now, looking back at it, but as
4 a JHO at that time, you know, that was at the discretion
5 of the Trust to make that call. It wasn't really for me
6 to have an opinion on that, I don't think, one way or
7 another.
8 MR WOLFE: I have no further questions for this witness.
9 THE CHAIRMAN: Mr Quinn? Mr Lavery? Mr Campbell?
10 Doctor, thank you very much for your time, unless
11 you wanted to say anything more.
12 A. I would just like to say to the Ferguson family that
13 I have children of my own now and I probably didn't
14 appreciate at that time because I wasn't aware of
15 exactly what had happened at that time, but I really am
16 very sorry for your loss and I can only imagine what
17 that can be like. I want you to -- I feel that ... I'm
18 dreadfully sorry to have had involvement in this case,
19 but I feel now that I tried to do the best that I could
20 at the time. I'm sorry about -- I'm just sorry about
21 the way things turned out.
22 THE CHAIRMAN: Thank you very much. I hope that helps.
23 Thank you for your time.
24 MR QUINN: The family would like to thank the doctor for the
25 words that he said at the end.

1 THE CHAIRMAN: Thank you, doctor.
2 (The witness withdrew)
3 THE CHAIRMAN: It's 12.40. Two options. We take an early
4 lunch and resume at about 1.45 or start Staff
5 Nurse Roulston now. Is Staff Nurse Roulston here? When
6 you leave today, your evidence will be complete. So
7 it's only a question of whether we start and do 20
8 minutes to half an hour before lunch, or whether we come
9 back. Does it matter to you, can I ask you? Okay,
10 we'll go for lunch first. Good choice. 1.45.
11 (12.42 pm)
12 (The Short Adjournment)
13 (1.45 pm)
14 THE CHAIRMAN: I'm going to start Staff Nurse Roulston's
15 evidence in just a few moments. Just before we do that,
16 Mr Stitt, I understand that there is a degree of
17 confusion on the privilege issue. There's a degree of
18 confusion about what documents have been made available
19 to the inquiry and about the listing of those documents.
20 MR STITT: Yes.
21 THE CHAIRMAN: As I understand it, there's Altnagelvin files
22 which Altnagelvin called files 1 and 2 when they sent
23 them to us. I think they were also referred to as the
24 Ms Brown files.
25 MR STITT: Yes.

1 THE CHAIRMAN: There's an inquest file which we were calling
2 the DLS inquest file and it exists because, in 2003, DLS
3 acted as the solicitors for what was then the
4 Altnagelvin Trust.
5 MR STITT: Yes.
6 THE CHAIRMAN: But I understand now that there's also
7 a Brangam Bagnall inquest file because, in 2003,
8 Brangam Bagnall represented what was then the
9 Royal Trust.
10 MR STITT: That's correct.
11 THE CHAIRMAN: Okay. We were discussing yesterday afternoon
12 whether the Western Trust or, I think we should add by
13 extension, the Belfast Trust, claim privilege was going
14 to claim privilege for anything and then, if they were
15 going to claim privilege for anything, what documents
16 they would claim privilege for and the basis of that
17 claim.
18 As a starting point for that, we need to know what
19 documents exist. What I was going to do, once Staff
20 Nurse Roulston has started to give her evidence, was to
21 allow some discussions to take place involving Ms Dillon
22 and Ms Conlon on the inquiry side because I think there
23 is some uncertainty about exactly which documents there
24 are.
25 MR STITT: Yes, Ms Dillon was kind enough to point that out

1 to us. It comes as a surprise to me. I thought, as
2 I indicated yesterday, that the index which we have
3 compiled and was ready yesterday is identical to the
4 index to the papers from 1995, with two exceptions, and
5 I referred to those, the two reports. But I'm told that
6 that's not the case and I have sought urgent
7 instructions. I have got Ms Brown here, she has the
8 files with her, but that's not really the point. The
9 point is that she had spent quite a lot of time doing
10 a new index or checking the index against the papers.
11 So all I can say is that it's something which we are
12 obviously looking into urgently.
13 THE CHAIRMAN: Okay. There's no reason why that can't be
14 done as we sit in the chamber hearing evidence.
15 MR STITT: That's exactly what I proposed.
16 THE CHAIRMAN: Then there's the other general issue. Do you
17 yet have a position from what is now the Western Trust
18 as to whether it intends to assert a claim for
19 privilege?
20 MR STITT: The position is this: the transcript that I had
21 referred to yesterday when you dealt with that section,
22 sir, has been sent to the Trust. I have advised the DLS
23 as to the different types of legal professional
24 privilege. I'm waiting for a response. The difficulty
25 is I wanted to go to a high level in the Trust --

1 THE CHAIRMAN: Yes.
2 MR STITT: -- for the points that you've raised. And
3 because of pre-existing and unbreakable commitments, the
4 person to make the final decision will not be able to do
5 so until tomorrow afternoon. That may be unsatisfactory
6 and I can understand --
7 THE CHAIRMAN: It's less of a problem when we don't have the
8 documents sorted out, but it would be -- well, this
9 makes it all the more valuable perhaps for us to try to
10 sort out between this afternoon and tomorrow morning
11 what exactly the documents are because that helps you
12 and your clients decide, if there is to be any claim for
13 privilege, what specific documents the claim might
14 extend to. The sooner this is dealt with, the better,
15 but we've got another two weeks and perhaps a little
16 more of evidence to hear, so as long as we keep on top
17 of it and we get it pinned down.
18 MR STITT: Yes, indeed. I can report progress insofar as
19 a result of good work by my instructing solicitor,
20 Mr Johnston, with a little help from myself, I have
21 indicated against every document -- 290 or something --
22 the nature of the possible claim or no claim. So that's
23 been identified.
24 THE CHAIRMAN: Sorry, just to help me: is that in relation
25 to what we have been calling the DLS inquest file?

1 MR STITT: Yes, the Altnagelvin files. The Western Trust
2 files have already been given in many years ago.
3 THE CHAIRMAN: And there's no claim for privilege from them?
4 MR STITT: Not retrospectively, no.
5 THE CHAIRMAN: And there's the DLS inquest file and ...
6 There is -- I think I'm right -- an issue about whether
7 there is a Brangam Bagnall inquest file.
8 MR STITT: I think there is one, I'm told there is one, I
9 haven't seen it, and obviously the same procedure will
10 have to be gone through in relation to that.
11 THE CHAIRMAN: Okay. Let's see what can be done outside the
12 chamber while we push on with this.
13 MR STITT: May I make one observation: I have taken the
14 trouble to read, for the first time, the portion of the
15 Francis report to which you referred me yesterday.
16 Indeed, you're absolutely accurate, sir, when you say
17 that the legal advisers were called to give evidence
18 because there was the Trust official and a solicitor who
19 gave unsatisfactory accounts as to why a report from
20 a Mr Phair was held back. As first blush I thought that
21 had great relevance and application, but correct me if
22 I'm wrong, but when I read through it it seemed to me --
23 in fact it's clear to me that Mr Phair hadn't done
24 a report, he'd actually done what we call a statement of
25 evidence, and he was the head of the A&E department and

1 an employee and an involved clinician. He didn't treat
2 the individual, but he was the one in charge of the
3 department where he or she had been treated.
4 So I could see immediately -- because this is to do
5 with the Warde report -- when one looks at the
6 transcript and one can understand the connection. But
7 just for the record, we're not suggesting that
8 a statement from -- perhaps Mr Gilliland -- would that
9 be a good example, somebody, the head of the surgical
10 department -- that we would hold back a statement for
11 some reason. And I will be submitting that an
12 independent opinion report is entirely different to
13 a factual record in a statement.
14 THE CHAIRMAN: Well, you're aware of the point that when my
15 earlier decision to allow privilege to extend to
16 Dr Warde's report and to two reports from Dr Jenkins was
17 challenged and a submission was received from the
18 lawyers representing the Ferguson family, the then
19 Altnagelvin Trust -- or maybe it was the Western Trust
20 by then, it doesn't matter -- it did not resist that
21 application. So the Trust did not resist an application
22 which challenged whether any privilege attached to an
23 expert report which it obtained for the purposes of
24 inquest.
25 MR STITT: That, I'm sure, is an accurate account of it, but

1 that having been said, a decision made in relation to
2 a specific report at a specific moment in time can't be
3 binding in relation to any future decisions.
4 THE CHAIRMAN: But it's exactly why I raised the issue about
5 urging the Trust to consider why it should assert
6 a claim for privilege for some documents when it has not
7 maintained a claim for privilege for other documents.
8 I know it doesn't follow that if you abandon a claim for
9 privilege for one thing that means you abandon privilege
10 wholesale, but it seems to me to be something which the
11 Trust should bear in mind when deciding what to do.
12 MR STITT: The matter is being considered and taken
13 seriously.
14 MR COYLE: If the list has been compiled, could that be
15 compiled in a chronological order? Because the list
16 given to us and given to the inquiry wasn't
17 chronological. It was impossible to correlate to the
18 previously discovered and disclosed documents. I'm sure
19 it would assist Ms Dillon.
20 THE CHAIRMAN: We'll do what we can. I'm reluctant to ask
21 for another list to be produced because I understand
22 from the work that's being done within the inquiry this
23 morning that there's already confusion about the lists
24 not tallying and, rather than ask for another list to be
25 done, since the inquiry staff have this morning been

1 going through comparing whether a document on this list
2 is also on that list and so on, let's see how that
3 develops, Mr Coyle, and then, if needs be, we can go
4 into the chronological problem.
5 MR COYLE: It would help to solve the problem which we were
6 having ourselves, sir. Thank you.
7 MR STITT: I'm conscious of the time, but very briefly. In
8 answer to my friend's point, the list is as close to
9 chronological as it's possible to get. The reason being
10 that for reasons which I have never understood,
11 solicitors' files are bulky and unwieldy, and this is
12 a classic one. It's no different to any other solicitor
13 in the country. That's the way that they work and they
14 work form the oldest date at the back of the file and
15 they work forwards. We have dealt with these documents
16 like this (indicating), they are original documents,
17 we've gone through them all and that's the same order as
18 in the file. But it's more or less chronological.
19 There are some dates that are in front of other dates,
20 but they are no more than two or three days apart.
21 THE CHAIRMAN: Thank you.
22 MR COYLE: Sir, that isn't correct. I leave it to you and
23 your staff to determine that, but it jumps around all
24 over the place. It really is quite unsatisfactory.
25 THE CHAIRMAN: We'll have a look at that when the time

1 comes. We'll update the position tomorrow morning, but
2 in the meantime we'll push on with the evidence because
3 I'm determined -- Staff Nurse Roulston is today and two
4 witnesses tomorrow. We can't continue to have
5 part-heard witnesses coming backwards and forwards.
6 MS AVRIL ROULSTON (called)
7 Questions from MR WOLFE
8 MR WOLFE: Good afternoon, Staff Nurse Roulston. So far,
9 you have provided to the inquiry two witness
10 statements --
11 A. Yes.
12 Q. -- one dated 25 June 2005, the second dated
13 4 September 2012.
14 A. Yes.
15 Q. Would you like to adopt those witness statements as part
16 of your evidence?
17 A. Yes.
18 Q. Some witnesses from whom the inquiry has heard on the
19 nursing side also provided statements to the Trust
20 at the time of Raychel's death. Some have given
21 evidence to the coroner as part of the inquest. And
22 some further nurses still have given statements to the
23 PSNI. You have made no other statement; is that right?
24 A. As far as I know, no.
25 Q. At the time when Raychel was cared for in the

1 Altnagelvin Hospital in June 2001, you were employed
2 there as a staff nurse; is that correct?
3 A. Yes.
4 Q. What grade were you at that time?
5 A. Back then, an E grade.
6 Q. That's a slightly -- the next grade up from D, it works
7 that way, does it?
8 A. Yes.
9 Q. So you're a more senior nurse than a D grade?
10 A. Yes.
11 Q. By that time, you had been qualified for 17 years or so
12 as a nurse, by 2001?
13 A. Yes.
14 Q. Perhaps we could just briefly look at your CV, which we
15 find at WS052/1, page 1. You have set out in this list
16 the fact that you were a staff nurse on Ward 6 at the
17 time.
18 A. Yes.
19 Q. And then we see all of the various training that you had
20 received. If we go forward into page 3, please.
21 THE CHAIRMAN: That's just to show Ms Roulston that she
22 qualified in 1984, you then worked for two years in the
23 Royal Belfast Hospital for Sick Children, and then you
24 moved to Altnagelvin in 1986 and thereafter worked on
25 the paediatric ward.

1 A. Yes.
2 THE CHAIRMAN: So all of your post-qualification experience
3 was with children?
4 A. Yes.
5 MR WOLFE: In terms of experience on a paediatric ward, you
6 would have been exposed to both surgical and medical
7 patients; is that correct?
8 A. Yes.
9 Q. And nursing for a post-appendicectomy patient wouldn't
10 have been unusual for you.
11 A. No, it wasn't.
12 Q. In terms of your exposure to fluid management issues in
13 children by 2001, can the inquiry take it that you would
14 have had a fair bit of experience of working with
15 children who had the need for intravenous fluids?
16 A. Yes.
17 Q. Can I ask you this: in terms of children with such
18 diseases as gastroenteritis, severe vomiting, diarrhoea,
19 and that kind of thing, would you have had experience of
20 dealing with such patients?
21 A. Yes.
22 Q. And in the context of such a patient, what would you see
23 as being the nursing role as opposed to the medical
24 role?
25 A. In?

1 Q. In working with gastroenteritis-type patients.
2 A. In documenting what vomiting they had and --
3 Q. What kinds of tasks would you be carrying out as
4 a nurse?
5 A. Reporting their vomiting, seeing what vomiting they had
6 and what oral fluids they were able to keep down, and
7 recording their vomiting and ...
8 Q. So it would be observing --
9 A. Observing and recording their vomiting, yes.
10 Q. So you would observe and monitor a patient and keep
11 a good record --
12 A. Yes.
13 Q. -- of all of the relevant factors. So if a child is in
14 receipt of intravenous fluids, that would be recorded
15 hourly; is that right?
16 A. Yes.
17 Q. If a child passes urine, would that be recorded?
18 A. It would have been recorded.
19 Q. The inquiry understands that urine output wasn't
20 measured, but it was recorded.
21 A. It wasn't measured back then, no.
22 Q. It ought to be recorded?
23 A. Yes, it ought to be recorded.
24 THE CHAIRMAN: Can you tell me how it was done? Because
25 frankly, I know now that it wasn't done in Raychel's

1 case. And what I'm told is that it was regarded as
2 particularly significant to record the first time that
3 a child passed urine.
4 A. Yes.
5 THE CHAIRMAN: But after that, the arrangements for
6 recording seem to be a little bit haphazard. For
7 instance, in Raychel's case she wasn't recorded as
8 having passed any fluid, bar on one occasion, but she
9 was seen going to the toilet a couple of times.
10 A. As you're aware, I wasn't on the ward most of that day.
11 THE CHAIRMAN: Yes. But I'm just talking about generally.
12 I'm taking you away from Raychel's case and I'm saying
13 generally how -- I know you don't record volume or you
14 didn't record volume in those days. But how would you
15 record?
16 A. You would have communicated with the parents or the
17 parents would have came and told you that their child
18 had been to the toilet or you had seen the child going
19 to the toilet and ...
20 THE CHAIRMAN: But for the parents to come and tell you that
21 their child had been to the toilet, did they do that in
22 2001 because they were asked to tell the nurses if the
23 child had gone to the toilet?
24 A. You would ask the parents. In our dealings with Raychel
25 we had to do her drip every hour, we had to assess her

1 every hour, doing her drip, and then communication, what
2 the parents would ask, has she been to the toilet, just
3 general communication.
4 THE CHAIRMAN: So you would expect that to be part of the
5 hourly observations for a child who was on IV fluids?
6 A. Yes.
7 THE CHAIRMAN: Thank you.
8 MR WOLFE: Likewise, staff nurse, if a child consumes oral
9 fluids, would you expect that to be recorded in the
10 fluid balance chart?
11 A. Yes.
12 Q. And again, presumably same process, you have an
13 opportunity at the hourly observations of the
14 intravenous fluid --
15 A. Yes.
16 Q. -- to ask questions of a parent in relation to that?
17 A. Yes.
18 Q. And any sips or indeed bigger quantities should be
19 logged?
20 A. Yes.
21 THE CHAIRMAN: Mr Quinn, can I interrupt here? I want you
22 to help me with the impression I have, which was the
23 extent to which Raychel took oral fluids was very
24 limited.
25 MR QUINN: Very, very low. Her father will say, insofar as

1 he recalls, she had one sip of 7 Up. He would describe
2 it as a capful of 7 Up. That's his own words to me.
3 Her mother recalls maybe one sip of fluid, I think that
4 was it, of water.
5 THE CHAIRMAN: So to the extent that the records do not
6 record the fluid which Raychel took, there's an issue
7 that the records aren't complete, but in terms of her
8 fluid balance, it would have negligible effect in all
9 probability because the amounts taken were so small?
10 MR QUINN: The parents would say that they wouldn't think
11 the amounts that they saw her taking would have had any
12 effect on her whatsoever.
13 THE CHAIRMAN: And they can't say they were there for every
14 minute, but they were there nearly all of time.
15 MR QUINN: Yes.
16 THE CHAIRMAN: So the point about how much fluid she sipped
17 is almost certainly only a record keeping point and it
18 doesn't have any greater significance?
19 MR QUINN: No, it has no significance from that point of
20 view, but it does have significance when one looks at
21 the overall picture where a doctor may get the
22 impression that this child was taking oral fluids.
23 That's the point the parents want to make very strongly.
24 THE CHAIRMAN: That's the 5 o'clock typed entry?
25 MR QUINN: Exactly, and that gives the wrong impression

1 absolutely. That gives the impression this child is on
2 the path to normal recovery, whereas she wasn't taking
3 any fluids at all then orally.
4 THE CHAIRMAN: Thank you very much, that helps.
5 MR WOLFE: Just completing the types of things that a nurse
6 would be on the lookout for if managing a child on
7 intravenous fluids: would you be looking to record all
8 vomits that would occur?
9 A. Yes.
10 Q. In terms of your experience prior to and up to 2001 of
11 managing, say, a child with gastroenteritis, such
12 a child would likely to be on intravenous fluids;
13 is that correct?
14 A. It depends on their oral intake, if they were able to --
15 this is prior to -- yes. If they were drinking, they
16 wouldn't have needed IV fluids.
17 Q. Of course.
18 A. They would have had an EP done and that would have been
19 at the discretion of a doctor whether they needed IV
20 fluids or not.
21 Q. And the IV fluid that was typically used in Altnagelvin
22 at that time was Solution No. 18?
23 A. Yes.
24 Q. In your experience, did the use of that fluid vary
25 depending on the case? I'll put that more

1 straightforwardly. Were other fluids ever used when
2 managing cases, such as gastroenteritis-type cases?
3 A. No.
4 Q. The inquiry has heard some evidence from one of your
5 nursing colleagues that in such cases -- gastroenteritis
6 was the example we used to test the point at that
7 time -- one of your colleagues suggested that,
8 in addition to Solution No. 18, in a case where there
9 was evidence of electrolyte imbalance established via an
10 electrolyte profile, that another type of fluid,
11 a high-sodium type fluid, would be used in combination
12 with Solution No. 18 for replacement purposes.
13 A. That was the doctor's discretion, yes, to use that
14 fluid, but it was normally Solution No. 18 that was
15 used.
16 Q. It was normally Solution No. 18 that was used, but
17 you --
18 A. Depending on the sodium level.
19 Q. Yes. You are aware of cases where, in addition to
20 Solution No. 18, depending upon the extent of any sodium
21 depletion --
22 A. Yes.
23 Q. -- a doctor, at his discretion, could introduce another
24 fluid?
25 A. Yes.

1 THE CHAIRMAN: Is there another option? I'm sure there are
2 many, but is there another option that you might stick
3 with Solution No. 18 but give something extra in it? We
4 heard yesterday, for instance, that Solution No. 18
5 might be given with potassium.
6 A. It may have been, yes.
7 THE CHAIRMAN: But that doesn't ring a bell with you, does
8 it?
9 A. Back then, it could have, but I just can't recall.
10 THE CHAIRMAN: Okay.
11 MR WOLFE: In your nurse education, staff nurse, would you
12 have been taught or instructed in relation to issues
13 relating to fluid balance or maintenance in children?
14 A. The fluid balance as ... Sorry, I don't know what
15 you're ...
16 Q. Let me keep it as general as possible. You went through
17 a process of nurse education --
18 A. Yes.
19 Q. -- before qualifying. And that would have occurred in
20 or around the early 1980s; isn't that correct?
21 A. Mm-hm, mm-hm.
22 Q. Were you taught about the importance of maintaining
23 stable fluid balance in patients?
24 A. Yes, recording fluid balance, yes.
25 Q. Would you have been introduced to any of the

1 physiological concepts affecting fluid balance?
2 A. No, no.
3 Q. Would you --
4 A. As to the type of fluid it was, no.
5 Q. Would you have been aware, keeping this as broad as
6 possible, of the problems that might present themselves
7 for a patient who's suffering from vomiting or
8 diarrhoea?
9 A. No.
10 Q. Let me just push you, if I can, a little further on
11 this.
12 A. Going back then, I was concerned about dehydration and
13 that's what I was concerned about, and nothing -- if
14 a child was on IV fluids, I was happy, content or ...
15 I assumed that a child would be okay once a child was on
16 IV fluids.
17 Q. Sticking with your teaching or the teaching that was
18 available to you in the early 80s, you have said that
19 you were aware that with vomiting, diarrhoea, there was
20 a risk of dehydration.
21 A. Yes.
22 Q. Is that something you'd have been taught about?
23 A. Yes. If a child wasn't getting fluids and was vomiting,
24 dehydration would be the problem.
25 Q. And would you have been made aware of the fact that if

1 the fluid lost from vomiting, if that wasn't replaced,
2 that could cause an electrolyte imbalance?
3 A. No. It was dehydration that was my concern.
4 Q. Have you studied the --
5 A. On a post ... On a child who was vomiting, it was
6 dehydration I was concerned about.
7 Q. Right. And so in a situation like that, your anxiety as
8 a nurse would have been to get fluids into a child to
9 prevent dehydration?
10 A. Yes.
11 Q. And if you were with a child who was suffering prolonged
12 or severe vomiting, your instinct would be to try to get
13 hold of a doctor to carry out a review of the child's
14 condition?
15 A. Yes. If it was prolonged, yes.
16 Q. And it would be a matter for the doctor to assess the
17 child and make the appropriate fluid medication or fluid
18 prescription?
19 A. Yes.
20 Q. You've had an opportunity to study the report of
21 Ms Sally Ramsay, the nursing expert, and she said in her
22 report that, at a minimum, she would expect a registered
23 nurse to be aware that fluid lost from vomiting, if not
24 replaced intravenously, could result in dehydration and
25 electrolyte imbalance. Sticking with 2001, you're

1 saying "yes" to dehydration, but in terms of what
2 Ms Ramsay is saying, you're saying, "No, I wouldn't have
3 understood the risk of a electrolyte imbalance"; that's
4 what you are saying.
5 A. Yes.
6 Q. Just let me be clear about this: is that because you
7 didn't understand that when a child or anyone vomits,
8 you didn't understand that that vomit was rich in
9 electrolyte substances?
10 A. Sorry?
11 Q. Did you understand that when somebody vomits, they're
12 losing valuable fluids --
13 A. Yes, which I understood was made of salts and sugars or
14 whatever, but the consistency of it, I didn't know.
15 Q. You understood that?
16 A. Yes.
17 THE CHAIRMAN: So you knew that a child who is vomiting is
18 expelling something from their body, but you had
19 a general idea of what might be in that, but no more
20 than a general idea and that, as a result of that, you
21 thought that if we get the child on a drip and the child
22 is receiving IV fluid, then that will make things
23 better?
24 A. That's right.
25 MR WOLFE: You told us in your witness statement that, by

1 2001, you weren't aware of hyponatraemia as a particular
2 concept.
3 A. No.
4 Q. Are you saying there that you hadn't heard of the word?
5 A. Never heard of the word, no.
6 Q. But nevertheless, again just to broaden that out, you
7 had heard of the problems of sodium loss?
8 A. Yes.
9 Q. Even if it wasn't given the name "hyponatraemia"?
10 A. Fluid loss.
11 Q. Fluid loss?
12 A. General fluid loss.
13 Q. Yes. Since 2001, can you tell us whether your knowledge
14 in these areas has improved?
15 A. Immensely.
16 Q. In what ways?
17 A. Fluids have changed, the practice has changed, we're
18 more aware of hyponatraemia. Solution No. 18 has been
19 done away with, we are using different fluids. It's
20 necessary of doing electrolyte profiles more often
21 and ...
22 THE CHAIRMAN: Is this all as a result of Raychel's death?
23 A. Yes.
24 THE CHAIRMAN: Can I ask you just one question, I've asked
25 it of a number of nurses. As we understand it, on

1 Ward 6, the medical patients who were under the
2 paediatricians, they would be tested for electrolytes,
3 they would have blood tests to check their electrolyte
4 balance.
5 A. Yes.
6 THE CHAIRMAN: That seems to have been fairly common.
7 A. Yes.
8 THE CHAIRMAN: It would be done maybe every 24 hours. But
9 before 2001, that same test was not required by the
10 surgeons on the surgical patient?
11 A. That's right.
12 THE CHAIRMAN: Did it ever occur to you as to why there was
13 a distinction between the two?
14 A. Not at that time, no. No.
15 THE CHAIRMAN: Was it only children with gastroenteritis who
16 had the blood tests done by the paediatricians?
17 A. Every child who came in had a blood test done.
18 THE CHAIRMAN: And the follow-up blood test after about
19 24 hours.
20 A. On IV fluids?
21 THE CHAIRMAN: No, I'm talking about the paediatric patients
22 now.
23 A. Initially they would have an EP done whenever they came
24 in.
25 THE CHAIRMAN: Right. And after that?

1 A. Depending on the result of that, whether they needed
2 another one or not.
3 THE CHAIRMAN: I see. So some might get another one done
4 and some might not?
5 A. Yes.
6 THE CHAIRMAN: But if a child was on IV fluids --
7 A. They'd have had it done.
8 THE CHAIRMAN: Then there would have been a second test?
9 A. Yes.
10 THE CHAIRMAN: So a child who had gastroenteritis, there
11 would have been a blood test done when she came on to
12 the ward -- for the sake of argument about midday, one
13 day -- would she have a follow-up test done the
14 following morning?
15 A. Depending of the result of the EP.
16 THE CHAIRMAN: Thank you.
17 MR WOLFE: Can I bring you now to the events of 8 June 2001?
18 On that day, you worked the day shift.
19 A. Yes.
20 Q. And you were working in the company of Sister Millar,
21 who was in charge of the ward --
22 A. Yes.
23 Q. -- and Staff Nurse Rice.
24 THE CHAIRMAN: Can we keep calling her Staff Nurse McAuley?
25 She wasn't McAuley at the time. Let's call her by the

1 one name.
2 MR WOLFE: Yes. I'm reading from your statement. We'll
3 stick with McAuley and you'll understand who I'm talking
4 about, won't you?
5 A. Mm-hm.
6 Q. You tell us in your witness statement that other nurses
7 were on duty that day, but broadly speaking it was
8 yourself and Staff Nurse McAuley who had primary
9 involvement with Raychel during the day shift.
10 A. A nurse had gone off sick that morning in the baby unit,
11 and I was called in, I was sent in there at some stage
12 that morning to take over the care in there with the
13 babies and I was coming out then to relieve Staff
14 Nurse McAuley for her lunch break and her tea break.
15 Q. Yes. So the understanding that might be obtained from
16 what you have just said and from your statements is
17 this: that at the start of the day yourself and Staff
18 Nurse McAuley were allocated to rooms A to J.
19 A. Yes.
20 Q. She says A to I. I'm not sure it makes much of
21 a difference. Anyway, you were allocated to those 10 or
22 12 rooms. Are they rooms with patients in each of them?
23 A. There's one four-bedded room and two single rooms and
24 another four double rooms.
25 Q. So you started the day thinking it was going to be the

1 two of you working in tandem on those rooms?
2 A. Yes.
3 Q. And you would form, if you like, a team within a team?
4 A. Yes.
5 Q. Okay. Then, unfortunately, a nurse took ill and had to
6 go home.
7 A. Yes.
8 Q. And that was a nurse who had originally been dedicated
9 to work in the infant unit?
10 A. Yes.
11 Q. And presumably, it was Sister Millar who redirected you
12 to work in the infant unit?
13 A. Yes.
14 Q. So the resources that were available to deal with rooms
15 A to I were reduced by half their intended complement;
16 isn't that right?
17 A. Yes.
18 Q. Albeit, as we understand it, and we can see from the
19 various entries you make in the notes, that you very
20 properly relieved Staff Nurse McAuley during her breaks.
21 A. Yes.
22 Q. And that's because you were able to do that because
23 there was another nurse available in the infant unit?
24 A. That's right.
25 Q. Can you say whether the reduction of nursing resources

1 that were available that day would have had any impact
2 on the way that Staff Nurse McAuley was able to perform
3 her work?
4 A. Well, I can't answer for Michaela, but I wouldn't think
5 so because the observations were carried out on those
6 children and recordings were done as best as we could.
7 THE CHAIRMAN: The reason you're being asked that is that,
8 to an outsider, it would seem that if there were
9 supposed to be two of you covering rooms A to I or A to
10 J and then it's left that there's only one of you
11 covering those rooms, at the very least there is more
12 pressure on the person who's covering on their own
13 instead of covering with a colleague.
14 A. It wouldn't have been unusual for that to happen from
15 time to time.
16 THE CHAIRMAN: Okay. So it's not what you want, but it's
17 manageable?
18 A. Yes.
19 MR WOLFE: In other words, a nurse would probably have to
20 make some adaptions to how they were doing their job.
21 They may have to move a bit quicker, a bit more
22 efficiently.
23 A. You prioritised your tasks --
24 Q. Yes.
25 A. -- your patients, yes.

1 THE CHAIRMAN: Okay.
2 MR WOLFE: Moving on, you attended a handover that morning;
3 is that correct?
4 A. Yes.
5 Q. The inquiry understands that that handover was delivered
6 by Staff Nurse Noble --
7 A. Yes.
8 Q. -- who had delivered care to Raychel overnight.
9 You have no recollection of that handover.
10 A. No.
11 Q. Is that none at all or can I push you on it? Can I ask
12 you whether you have any recollection of what was said
13 about Raychel's condition?
14 A. To be honest, I have no recollection of it.
15 Q. The inquiry has received some evidence that it was
16 reported that Raychel had had, if you like, a good
17 comfortable overnight and there were no concerns raised
18 at the handover.
19 A. From reading that, yes.
20 Q. A ward round involving surgeons -- a surgeon, I should
21 say -- occurred shortly after the nursing handover and
22 Dr Zafar came in to see Raychel. He was quickly
23 followed by Mr Makar, the surgeon who performed the
24 appendicectomy on Raychel. Had you any dealings with
25 either of those doctors that morning?

1 A. No.
2 Q. Raychel was obviously in receipt of intravenous fluids
3 overnight and we know that those intravenous fluids
4 continued in place throughout your working day.
5 A. Yes.
6 Q. She was in receipt of Solution No. 18 at a rate of 80 ml
7 per hour.
8 A. Yes.
9 Q. And you would clearly have appreciated that and
10 understood that when you came to deal with Raychel.
11 A. Yes.
12 Q. Can I ask you this: had you been given any understanding
13 of how Raychel's intravenous fluids were to be managed
14 during the day? In other words, were you given any idea
15 of a plan to reduce the fluids or how was this to be
16 worked?
17 A. It would have been practice as to the amount of oral
18 fluids she was receiving that, if she had been drinking,
19 her IV fluids would have been reduced accordingly.
20 THE CHAIRMAN: That would be the common practice for a boy
21 or a girl who's had their appendix removed?
22 A. Yes.
23 THE CHAIRMAN: Gradually during the day, they start
24 drinking, and that means you wind down the IV fluids?
25 A. Yes.

1 THE CHAIRMAN: Right. So that's what you would have
2 expected or hope to have happened with Raychel as the
3 day went on. Do I take it that you have no specific
4 recollection of being given that advice in the morning?
5 A. No.
6 THE CHAIRMAN: If you had received advice in the morning,
7 that's what you would have expected the advice to be?
8 A. Yes.
9 THE CHAIRMAN: In fact, would it be one step further? Even
10 if the surgeon hadn't said that, that's what you would
11 have expected to have happened.
12 A. Yes.
13 THE CHAIRMAN: Would the nurses have taken that on
14 themselves for a child who'd had her appendix out to
15 be -- would you need that specific advice from a doctor?
16 A. If a surgeon had said in the morning, "IV fluids to be
17 reduced as oral intake --
18 THE CHAIRMAN: Then that's what happens?
19 A. -- increases. That's what happens.
20 THE CHAIRMAN: And you would expect the surgeon to say that
21 because it's standard and you would expect the nurse
22 who's with him when he sees the patient to then follow
23 that and for her, if it was Sister Millar, you'd expect
24 her to tell the nurses who were going to be in charge of
25 that patient?

1 A. Yes.
2 THE CHAIRMAN: Right.
3 MR CAMPBELL: Mr Chairman, I think a word was missed on the
4 [draft] transcript at line 18. It might be useful to
5 include it. The sentence that Staff Nurse Roulston was
6 finishing was "as oral intake increases". The dot dot
7 dot should be replaced there by the word "increases".
8 THE CHAIRMAN: Thank you.
9 MR WOLFE: Just on that, Staff Nurse Roulston, can I ask you
10 this: is there a particular point or a particular test
11 which nurses would apply to actually start the process
12 of reducing IV fluids? Is it, for example, when a child
13 has consumed a certain amount of oral fluids without ill
14 effect or is it --
15 A. Small, frequent amounts of oral fluids. Small, early
16 amounts of oral fluids and as that gradually is
17 tolerated, IV fluids can be reduced.
18 Q. We have heard various different pieces of evidence about
19 the extent to which Raychel had oral fluids. Mr and
20 Mrs Ferguson between them recall no more than a couple
21 of capfuls or a couple of sips, one of water, one of
22 lemonade. That wouldn't be enough to effect a change
23 in the intravenous fluids?
24 A. No.
25 Q. Would you be looking for a child to be taking more than

1 sips before you would effect a change in the intravenous
2 fluids?
3 A. Yes.
4 Q. Would you be looking to test that out over a period of
5 time, in other words to have the child drink a repeated,
6 say a glass or two of water, and to have held that down
7 over, say, an hour?
8 A. A small -- no, longer than that. Longer.
9 Q. So --
10 A. Lunchtime, early afternoon.
11 Q. So if you started small quantities of water at
12 10 o'clock, giving some more each hour, and if the child
13 managed to cope with that then you would then reduce the
14 fluids by about lunchtime?
15 A. Hopefully, yes. If they're feeling okay and weren't
16 feeling nauseated and were looking forward to having
17 something to eat, which would have been a --
18 Q. Would it be a case of gradually reducing the fluids --
19 A. Yes.
20 Q. Turning it down from 80 to 60 to 40, something like
21 that?
22 A. Yes.
23 Q. You have told us in your witness statement that you have
24 no recollection of dealing with Raychel before
25 1 o'clock.

1 A. No.
2 Q. And in that period of the morning up to 1 o'clock, had
3 you gone to the infant unit?
4 A. Yes.
5 Q. In other words, you'd gone to the infant unit shortly
6 after the handover?
7 A. Yes.
8 Q. There were a number of events affecting Raychel in the
9 morning, and I'm going to ask you some questions about
10 those. Raychel vomited at 8 am or between 8 am to 9 am,
11 according to the fluid balance chart. Were you notified
12 of that vomit at that time?
13 A. I would have seen it in her fluid balance, but I don't
14 remember.
15 THE CHAIRMAN: You'd have seen it in a fluid balance later
16 on when you were putting in your own entries?
17 A. Yes.
18 MR WOLFE: So in terms of your dealings with Raychel,
19 according to the records, 1 o'clock is the first time
20 that the notes show you as having an involvement.
21 A. Yes.
22 Q. Can we take it that that was likely then to have been
23 the first time that you would have picked up Raychel's
24 chart and to have had any look at it?
25 A. Yes.

1 Q. Moving along the timeline then, Raychel had a vomit at
2 10/10.25 am in the morning, which was described as
3 "large" in the records. Again, leaving aside your
4 opportunity to look at the notes when you first dealt
5 with Raychel at 1 o'clock, was that vomit brought to
6 your attention at any earlier at that stage?
7 A. Again, as I was dealing with her at 1 o'clock, I would
8 have seen it in the fluid balance.
9 Q. Raychel's state of wellness began to deteriorate after
10 about 11 o'clock, according to her mother, Mrs Ferguson.
11 Would you have known anything about that before
12 1 o'clock?
13 A. No.
14 Q. I'm going to ask obviously about what you saw at
15 1 o'clock, but before 1 o'clock were you given any
16 information about Raychel?
17 A. I don't remember.
18 THE CHAIRMAN: Can you tell me this: it's some time, what,
19 coming up towards 1 o'clock that you started to cover
20 for Staff Nurse McAuley. She went off on her lunch
21 break; is that right?
22 A. Yes.
23 THE CHAIRMAN: Does she pop in to you to the infant unit to
24 say, "I am off now, would you cover my rooms?"; is it
25 something like that.

1 A. It'd be something like that yes.
2 THE CHAIRMAN: When she does that, does she also then say to
3 you on a normal day -- or any other nurse, this doesn't
4 have to be Staff Nurse McAuley -- "Things are okay, but
5 would you keep an eye on Jim or John [or whoever] in one
6 of the rooms?" Would that be the sort of exchange you
7 would have?
8 A. Something abnormal or some really sick kid we had
9 in that area and I needed to keep an eye on, but I had
10 to keep an eye on all the kids in that area.
11 THE CHAIRMAN: If there was something that concerned her,
12 you would expect her to mention that to you as she went
13 off for her lunch for you to cover?
14 A. Yes.
15 THE CHAIRMAN: Do you remember her specifically mentioning
16 Raychel to you when she went off for her lunch and you
17 went on to cover it?
18 A. I don't remember.
19 MR WOLFE: Just finally before we get to 1 o'clock,
20 Raychel's fluid prescription was renewed by Dr Butler at
21 or about 12 noon. Again, that's not something you would
22 have been told about, is it?
23 A. No.
24 Q. Let's just look then at what you did at 1 o'clock.
25 Before doing that, you also saw Raychel at 3 o'clock.

1 A. I recorded a vomit at 3 o'clock.
2 Q. Right.
3 A. But I can't remember seeing Raychel at 3 o'clock.
4 Q. Okay. And you did, however, see her at 5 o'clock for
5 the purposes of observation.
6 A. Yes.
7 Q. Could we have up on the screen then, please, the fluid
8 balance chart, 020-018-037? You obviously recognise
9 this document.
10 A. Yes.
11 Q. And if we can take you to 1 o'clock, 1300 hours. Just
12 starting on the left-hand side of the sheet, do you
13 enter the "150" and then the running total of fluid
14 input; is that your task at 1 o'clock?
15 A. Yes. The IV infusion will bleep whenever 80 ml had gone
16 in, yes, on the hour. So you are going back to that
17 patient every hour to add in another 80 ml to go in --
18 Q. Right.
19 A. -- to reset the pump.
20 Q. Can I just ask you some questions about this -- sir,
21 Mr Quinn has asked me to look at this issue in a little
22 bit of detail because of particular instructions that he
23 has.
24 You are describing a situation, staff nurse, where
25 the pump is set to deliver 80 ml per hour; is that

1 correct?
2 A. Yes.
3 Q. And then after those 80 ml are delivered, what happens?
4 A. The pump will bleep.
5 Q. Right.
6 THE CHAIRMAN: Where is that bleep audible? If Raychel is
7 in room I, where will that bleep be heard?
8 A. You can hear it. It's quite audible to hear an IV all
9 over the ward.
10 THE CHAIRMAN: Okay.
11 MR WOLFE: It's essentially an alarm, is it?
12 A. It's an alarm, yes.
13 Q. And at that point when it bleeps, at the 60-minute
14 point, does it stop delivering further fluid?
15 A. Yes.
16 Q. And it won't continue to deliver fluid until a nurse
17 approaches it and resets it?
18 A. Yes.
19 Q. At that time in 2001, was it the practice to use this
20 preset approach both day and night --
21 A. Yes.
22 Q. -- in the ward?
23 A. Yes.
24 Q. And why was that?
25 A. To allow you to go back and check the IV site on the

1 patient, make sure it was okay and that the fluids were
2 running in accordingly.
3 THE CHAIRMAN: So effectively it's a safety measure --
4 A. Yes.
5 THE CHAIRMAN: -- which means a child has to be seen and
6 there's, effectively, a compulsory hourly observation?
7 A. Yes.
8 MR WOLFE: And if a child is mobile and walks down the
9 corridor with the -- I understand these drips are
10 connected up to a trolley.
11 A. Yes.
12 Q. Will the apparatus containing the alarm system -- does
13 that come with the trolley?
14 A. Yes. It comes on wheels, yes.
15 Q. Can I ask you this: Mr Ferguson, Raychel's father, has
16 a recollection that this alarm system, as you've
17 described, was in place at night-time, but not during
18 the day. Are you sure it was in place during the day?
19 A. It's always on, yes. It bleeps every hour.
20 Q. Are you saying that it was a practice adopted in Ward 6
21 in all cases where intravenous --
22 A. In all cases, yes.
23 Q. You entered the fact that there had been a vomit at
24 1 o'clock.
25 A. Yes.

1 Q. And --
2 MR QUINN: Just before we leave that point, the parents are
3 a little bit concerned about this point -- and I don't
4 want to labour it and I am mindful of the time. Could
5 I ask the question, do all of the alarms go off on the
6 hour together? And the second question is: does the
7 volume reduce during the day? That may explain why the
8 parents are saying they never heard an alarm during the
9 daytime.
10 THE CHAIRMAN: First of all, let's take the --
11 MR QUINN: That is the audible volume, not the volume of
12 liquid.
13 THE CHAIRMAN: Can I presume that on any one day there are
14 probably a number of children on IV fluids on Ward 6?
15 A. Yes.
16 THE CHAIRMAN: Would the fluid always run out at the same
17 point on the hour or does it just depend? If my fluid
18 is set up at 2.50 and your fluid is set up at 3 o'clock,
19 my alarm is going to go off at 2.50 and yours is going
20 to go off at 3 o'clock?
21 A. You try to get the pump to go off on the hour. There is
22 a way of setting the pump that each pump will go off on
23 the hour. You know to go and check the IV fluids on the
24 hour. If you had a pump going off at quarter to the
25 hour or quarter past the hour, you'd be all over the

1 place. So each pump should be set to go off on the
2 hour.
3 THE CHAIRMAN: Does that mean that on the hour on Ward 6,
4 for a couple of minutes, it's very noisy because there's
5 alarms going off?
6 A. Not very noisy, but you are tuned in that these IV
7 fluids need checked. If you know your IV fluids are
8 going to go off on the hour, you're going to ...
9 THE CHAIRMAN: The volume of the alarm, the audibility of
10 the alarm, is that turned down at all during the day or
11 always the same?
12 A. It's always the same.
13 MR STITT: I wonder would it be helpful to the inquiry --
14 it would certainly be helpful to me -- if we could find
15 out, in general, of the children in Ward 6 how many will
16 have been on IV fluids as a percentage, as a norm.
17 THE CHAIRMAN: As a guess. I think on this -- at the time
18 Raychel was there, the ward had about 42 beds or was
19 about half full, there were 23-odd children. As
20 a guess -- and I understand this would only be
21 a guess -- how many might have been on IV fluids? You
22 wouldn't be talking about 10, would you?
23 A. I wouldn't think so, no. That would be a lot.
24 THE CHAIRMAN: Might you be talking about three or four?
25 A. At a guess.

1 THE CHAIRMAN: That's a guess.
2 A. Yes. There might not have been any other ones at all,
3 I don't know, that day.
4 THE CHAIRMAN: Okay.
5 MR WOLFE: In terms of what you've recorded under the
6 "vomit" section of the chart; that's your handwriting,
7 isn't it?
8 A. Yes.
9 Q. "Vomited plus plus."
10 A. Yes.
11 Q. And what do you mean by that symbol?
12 A. Small to medium vomit. I would say plus is a small, and
13 a plus plus would be a medium.
14 MR CAMPBELL: Sir, could I go back to the previous point
15 briefly? I'm told that a possible source of information
16 regarding who may have been on IV fluids would be the
17 treatment book, which is in the possession of the
18 inquiry. It might be possible to work out from that how
19 many of the patients within the particular area ...
20 I understand there are confidentiality issues there,
21 but --
22 MR WOLFE: In its current form --
23 MR CAMPBELL: The names may have been redacted, but the
24 details of how many are on IV fluids may still be
25 available.

1 THE CHAIRMAN: I'm not sure if I need to go into this any
2 more.
3 MR QUINN: I'm not sure you do. I will take instructions.
4 MR WOLFE: You've described this "plus plus" in your witness
5 statement as amounting to a small to medium vomit; why
6 do you give us that range?
7 A. Well, when a vomit's not measured, it's hard to
8 calculate.
9 Q. Yes. Just thinking about the symbols first of all, is
10 a vomit that is a definite small a single plus sign --
11 A. Yes.
12 Q. -- and a vomit that's a definite large is three pluses?
13 A. Yes.
14 Q. Is that where the scale ends, you don't have an extra
15 large vomit with four pluses?
16 A. You could have, but it'd be very unlikely.
17 Q. Right. But would this plus plus plus system for large,
18 would that be understood by all nurses in your
19 experience?
20 A. Back then?
21 Q. Yes.
22 A. Yes.
23 Q. And in terms of your use of two pluses, why do you tell
24 us that that is small to medium when in fact two pluses
25 is intended to convey medium?

1 A. Well, small to medium. It's hard to say whenever the
2 vomit's not measured.
3 Q. Yes. Would it have been possible to measure it?
4 A. Yes, it would have been.
5 Q. Are there circumstances in the management of certain
6 patients where vomit is formally measured?
7 A. In the very sick child who's being specialled and they
8 need -- doctors require a very strict intake and output
9 of a child, yes, their vomits would have been measured.
10 Q. When you put this down on paper on that day, did you
11 intend to convey the message that that was a medium
12 vomit?
13 A. Probably. If I'd said plus, probably it would have been
14 a small vomit.
15 Q. Well, put it this way: if a nurse colleague coming to
16 read that document five hours after you'd gone off duty,
17 would they look at that and interpret that as a medium
18 vomit?
19 A. Yes.
20 Q. And likewise with the 3 o'clock entry; is that correct?
21 A. Yes.
22 Q. In terms of what you saw in order to make those notes,
23 dealing with the 1 o'clock entry first of all, did you
24 actually see the vomit?
25 A. I must have seen it when I recorded it, yes.

1 Q. You just have no recollection of having seen it?
2 A. I have no recollection of Raychel vomiting.
3 Q. Yes.
4 A. I have no recollection of seeing the vomit, but I must
5 have seen it to document it.
6 Q. Yes. It's just in your statement you say you have no
7 recollection of having seen it, but what you mean by
8 that is you now have no recollection, but sensibly you
9 must have seen it in order to make that entry?
10 A. Yes.
11 THE CHAIRMAN: Is this most likely to be because you heard
12 the monitor going off or the alarm going off so you go
13 in to reset it and you find there's vomit in the bowl?
14 Is that the likely explanation for this?
15 A. It could have been, I don't know.
16 THE CHAIRMAN: Okay, thank you.
17 MR WOLFE: The entries that you've made with regard to fluid
18 input on the left-hand side, would they tend to have
19 been made on the hour in the sense that the alarm has
20 been set for on the hour?
21 A. Yes.
22 Q. The vomit entry on the right-hand side of the page
23 needn't necessarily have been made at the same time;
24 is that fair?
25 A. No, that's right, yes.

1 Q. And in terms of how you might have been notified of the
2 fact that there had been a vomit, you have no
3 recollection at all about that?
4 A. Of?
5 Q. Of how you were notified that there had been a vomit so
6 that you could then record it in the note?
7 A. No.
8 Q. Could I just push you a little bit on that? Mr Ferguson
9 returned to the hospital, he says, at or about 1/1.30
10 that afternoon. Had you any dealings with him that day?
11 A. I have no recollection of having any dealings, no.
12 Q. He says that in the period between 1.30 and 3.00, he
13 took three kidney trays to the nurses, three kidney
14 trays containing vomit to the nurses. Indeed, he
15 thought the last of the three contained some blood in
16 the vomit and he was told at that point that Raychel
17 wouldn't throw up again and he was encouraged to give
18 the child a capful of 7 Up. Does any of that
19 information assist your memory?
20 A. No.
21 Q. It doesn't?
22 A. No.
23 Q. Would it be a common enough occurrence for parents to
24 report the fact of vomiting to nurses at the nursing
25 station?

1 A. To report?
2 Q. To report the fact that vomiting had taken place.
3 A. Yes.
4 THE CHAIRMAN: In fact, you would want them to do that,
5 don't you?
6 A. Yes.
7 MR WOLFE: In terms of that vomit at 1 o'clock, can you
8 recall reporting it to anybody?
9 A. No. It would have been best practice to have reported
10 it to Michaela, but I don't remember.
11 Q. In fairness, staff nurse, Sister Millar has given
12 evidence on this issue of communications in relation to
13 the vomits. She says that she didn't see the 1 o'clock
14 vomit, but you informed her about it, that it wasn't
15 a large vomit, and that Raychel didn't appear in any
16 distress or difficulty at that time. Does that sound
17 like something you might do?
18 A. Yes, but I don't remember.
19 Q. You don't remember?
20 A. No.
21 Q. Clearly, when one looks at the fluid balance chart, as
22 you must have done in order to make your entry at
23 1 o'clock, you would have seen that this was now the
24 third vomit in the space of four or five hours. One
25 described merely as a vomit, the other one was large,

1 and the one that you were recording was medium. And
2 plainly, if Sister Millar is right, you reported it.
3 Can you recall whether in reporting it there was any
4 discussion or any thought given to contacting a doctor?
5 A. I don't remember.
6 Q. Let me ask you something further about that: the nursing
7 expert, Ms Ramsay, has said that really after the second
8 vomit of the day, nurses should have been taking steps
9 to bring a doctor to Raychel for the purposes of
10 assessing whether she would benefit from anti-emetic
11 medication. Do you agree with her that certainly by
12 mid-morning, lunchtime at the latest, as Mr Orr, another
13 expert who's looked at this, has said, that a doctor
14 should have been brought to see her?
15 A. That depended on the amount of vomit and how she was
16 feeling at that time.
17 Q. Well --
18 A. And I hadn't got overall -- wasn't overall in assistance
19 with -- in that area all day, so I didn't have an
20 overall view of what was taking place.
21 Q. You were assisted to some extent by the fluid balance
22 chart --
23 A. Yes.
24 Q. -- which was available to you. You would have had some
25 experience of bringing doctors to patients in situations

1 where they were suffering from vomiting --
2 A. Mm-hm.
3 Q. -- and nausea. Can you help us at all as to why you
4 didn't in this particular case?
5 A. Because she was on IV fluids and I was happy she was on
6 IV fluids and I felt that IV fluids were going to
7 replace the vomits that she was having and I felt she
8 was safe and she wasn't going to become dehydrated.
9 Q. Yes, but that's one function of the IV fluids. IV
10 fluids are not intended to stop the vomiting, are they?
11 She needed an anti-nausea -- an anti-sickness drug,
12 didn't she?
13 A. Whether I passed it on or -- I don't know.
14 Q. Sticking with the issue of the vomit at 3 o'clock, can
15 you help us in terms of how that vomit was brought to
16 your attention?
17 A. No. I can't remember.
18 Q. Why were you still on the ward at that point? Were you
19 covering a break again?
20 A. Yes.
21 Q. What way did the breaks work? I understand that the
22 1 o'clock break that you were covering was --
23 A. Lunch, then teatime, at 3 o'clock for 15 minutes, and
24 then 5 o'clock for three-quarters of an hour.
25 Q. Very well. And again, you have entered "medium vomit".

1 Can you recall whether you reported that vomit?
2 A. No. I can't recall.
3 Q. So on top of the morning vomit, you now have a second
4 vomit within a space of two hours, a second medium
5 vomit. Would you accept that vomiting for a young child
6 is likely to be uncomfortable at best, if not
7 distressing?
8 A. Whenever I did her observations -- I had recorded that
9 she wasn't complaining of pain at 1 o'clock, and then at
10 5 o'clock she was asleep. So I didn't witness her
11 vomiting.
12 Q. Was she awake at 3 o'clock?
13 A. I don't know.
14 THE CHAIRMAN: Is that because you were doing the
15 observations four-hourly?
16 A. I wasn't doing observations at 3 o'clock. Whether I was
17 doing it ...
18 MR WOLFE: Let me bring you to the observation sheet because
19 I think we can dispense with this sheet. The
20 observation sheet is at 020-015-029. We can see from
21 that, staff nurse, that you made an entry at 1 o'clock;
22 is that right?
23 A. Yes.
24 Q. And that says, "Not complaining of pain".
25 A. Yes.

1 Q. The observations in terms of temperature, pulse and
2 respiratory rate, you entered those on the document?
3 A. Yes.
4 Q. And they're all reasonably normal?
5 A. Yes.
6 Q. And you were working on a four-hour schedule of --
7 A. Yes.
8 Q. -- observations. And at 5 o'clock you found the child
9 to be asleep?
10 A. Yes.
11 THE CHAIRMAN: Can I ask you this: although you're working
12 on four-hourly observations, you were with her at
13 3 o'clock, it appears, because you reactivated the
14 fluid; isn't that right?
15 A. I did her IV fluids.
16 THE CHAIRMAN: If there was an observation at that point
17 which concerned you, would that have found its way on to
18 the sheet that's on the screen at the moment?
19 A. It would have.
20 THE CHAIRMAN: In other words, you don't stick rigidly to
21 only doing this every four hours if there's something in
22 between that's of concern?
23 A. You would document it.
24 THE CHAIRMAN: On that sheet or somewhere else in the notes,
25 but you do document it?

1 A. Yes.
2 MR WOLFE: Could we jump quickly back to the previous
3 document? I want to come back to this observation sheet
4 as soon as I've asked one further question. Just in
5 terms of the 3 o'clock entry for the fluids, do you see
6 the signature on the right-hand side?
7 A. Yes.
8 Q. It was in fact Michaela Rice, as she then was,
9 Michaela McAuley who did the 3 o'clock fluids.
10 A. Yes.
11 Q. So what appears perhaps to have happened, we can only
12 surmise, but you were covering for Ms McAuley's break.
13 She's done the fluids, if you like --
14 A. Yes.
15 Q. -- you have come along, perhaps at some point later, and
16 addressed the issue of the vomiting because somebody's
17 brought that to your attention.
18 A. I don't remember.
19 Q. But somebody's clearly brought it to your attention?
20 A. For me to record it, yes.
21 Q. That's right. And would you agree with me that you
22 should properly have reported that to the nurse who had
23 responsibility for caring for Raychel?
24 A. Yes, in best practice, yes, but I don't remember.
25 Q. Obviously, the next time she went to the fluid balance

1 chart she would see the entry.
2 A. Yes.
3 Q. But in order to boost communications, it would have been
4 better if you had told her about it.
5 A. Yes.
6 Q. It would appear from Staff Nurse McAuley's account that
7 she was in fact told by Mrs Ferguson about ongoing vomit
8 at or about that time. That was the route via which she
9 discovered it. And that led her to contact
10 Sister Millar in order to in turn contact a junior house
11 officer to come. So it would appear that arising out of
12 the vomiting at or around that time a decision was made
13 by others to contact a doctor to prescribe an
14 anti-emetic; do you follow?
15 A. What are you asking me?
16 Q. Do you follow that sequence?
17 A. What I remember of it. I don't remember anything about
18 it.
19 Q. But the point is this: you should have been giving
20 consideration to contacting a doctor at that point;
21 is that fair?
22 A. Not necessarily, no, because I had no concerns regarding
23 Raychel at that time.
24 Q. We could see from the observation sheets the fact that
25 at 1 o'clock Raychel wasn't in pain. The observation

1 sheet says nothing about vomit.
2 A. If she had been vomiting, I am sure I would have written
3 it in.
4 Q. And then she's asleep at 5 o'clock. The observation
5 sheet doesn't deal with the interim period such as at
6 3 o'clock.
7 A. No.
8 Q. And you say you had no concerns at that point.
9 A. No.
10 Q. But what was going to stop the vomiting?
11 A. Eventually, we were concerned that the vomiting would
12 subside after the doctor came, whenever Michaela did get
13 a doctor at whatever time it was, and the anti-emetic
14 would stop her vomiting.
15 Q. But in terms of your activity, staff nurse, you've had
16 these vomits in the morning, which understandably you
17 weren't aware of until 1 o'clock.
18 A. Mm-hm.
19 Q. Then you have a 1 o'clock and roughly a 3 o'clock
20 vomit -- obviously the times are approximate -- but
21 you weren't applying your mind, were you, to how this
22 vomiting could be stopped?
23 A. Well, maybe I had passed it on to Michaela, I don't
24 remember. And there was lots of other kids in that area
25 that I had to deal with at that time as well.

1 Q. If I could have your statement up, please, WS052/2, at
2 page 12. If we could highlight question (f). You are
3 asked there:
4 "In 2001, what did you regard as the appropriate
5 nursing approach to children who were still experiencing
6 episodes of vomiting more than 12 hours after surgery,
7 and who were in receipt of hypotonic intravenous
8 fluids?"
9 You say:
10 "In those circumstances, it would be appropriate for
11 a nurse to inform the surgical team."
12 And that was your understanding of the proper
13 approach at the time. And plainly, you didn't do that.
14 A. It was probably my -- as I was looking after the
15 children in the baby unit, that I was waiting for Staff
16 Nurse Rice to come back from her duty to see what she
17 thought because she had an overall picture of what was
18 taking place in that area and I didn't have an overall
19 picture of what was happening.
20 Q. Are you saying that although you have no specific
21 recollection, you think you might have had communication
22 with Staff Nurse McAuley at that time?
23 A. I don't remember. But it would have been best practice,
24 if I was taking over from her, to report anything
25 untoward.

1 Q. Yes.
2 THE CHAIRMAN: From your perspective, would a second vomit
3 within about two hours, which brought the total number
4 of vomits up to four, be something to be getting worried
5 about?
6 A. Well, a doctor was being contacted at that stage.
7 THE CHAIRMAN: Yes. I think you're really being asked --
8 I know that there's some dispute about this, but I know
9 the nursing evidence is that the doctor was being
10 contacted or looked for from some point after 3 o'clock.
11 And is that something that would have concerned you,
12 that Raychel had now vomited for the fourth time or at
13 least the fourth time since 8 am?
14 A. Not when she was receiving IV fluids.
15 THE CHAIRMAN: Well --
16 A. And the vomit would have been replaced -- back then,
17 I understand the vomits would have been replaced by her
18 IV fluids that she was receiving.
19 THE CHAIRMAN: Yes, but the very fact that she's vomiting
20 would necessarily be distressing and upsetting for
21 Raychel, wouldn't it?
22 A. Yes.
23 THE CHAIRMAN: So if she's vomited at about 3 o'clock and
24 you know from the records that that is the fourth vomit
25 since around 8 am, then would you not think, "Maybe we

1 should be getting a doctor along"?
2 A. I left it with Michaela to make that decision, probably,
3 because she had the overall picture of what was going
4 on --
5 THE CHAIRMAN: Okay, thank you.
6 A. -- because I was in with the babies most of the day.
7 MR WOLFE: Yes. You've mentioned that a doctor was called.
8 I mentioned it to you --
9 A. Apparently so.
10 Q. -- and I think you confirmed that you were you aware
11 that day.
12 A. No.
13 Q. It wasn't brought to your attention and discussed with
14 you that day?
15 A. No.
16 THE CHAIRMAN: So this is something you know from all of the
17 inquiry and so on?
18 A. Yes.
19 MR WOLFE: We know from the observation sheet that, at
20 5 o'clock, you found Raychel to be asleep; is that
21 correct?
22 A. Yes.
23 Q. You carried out observations on her. Did you have to
24 wake her to do that?
25 A. No. You could have done her pulse and her respirations

1 and her temperature really without wakening her.
2 Q. Yes. Did she wake, do you recall?
3 A. Well, if she was asleep -- if I had documented she was
4 asleep, I can't say whether she opened her eyes or what.
5 To me, she was asleep.
6 Q. Can you remember whether her mother was present at that
7 time?
8 A. I don't remember.
9 Q. In that you were carrying out observations at that time,
10 plainly Staff Nurse McAuley was on another break --
11 A. Yes.
12 Q. -- and would that have left you in charge of all of the
13 observations that were needing to be done at that point?
14 A. Yes.
15 Q. And we may be guessing a little, but is it fair to say
16 that you hadn't seen Raychel in the period between
17 recording the vomiting at 3 o'clock or so and these
18 5 o'clock observations?
19 A. Yes.
20 Q. So you can't help us in terms of Raychel's condition
21 during that period?
22 A. No.
23 Q. When you attended at 5 o'clock, do I understand some of
24 your earlier answers as indicating that you wouldn't
25 have known that a doctor was being sought for Raychel?

1 A. I can't remember.
2 Q. In terms of good communications between nurses, that
3 would have been a sensible thing to --
4 A. Yes.
5 Q. Because with that information, you would then have
6 appreciated that your nursing colleagues had assessed
7 the situation and realised that Raychel needed some kind
8 of medical input.
9 A. Yes.
10 Q. How good were the communications between you and your
11 nursing colleagues on that day?
12 A. It would have had to be good, it would have had to be
13 good because I was relieving Michaela and she was
14 relying on me to pass on information and I was relying
15 on her to pass on information to me whenever I was
16 relieving her. So I would assume it was satisfactory.
17 Q. Is it noteworthy that while Staff Nurse McAuley was the
18 nurse with primary responsibility for Raychel that day,
19 you were the one who had picked up on two of the vomits
20 and she had only picked up on one, yet she was there for
21 a longer period of time?
22 A. Mm-hm.
23 Q. She was a young nurse, an inexperienced nurse. Did you
24 say anything to her on that day in terms of keeping
25 a close eye on Raychel?

1 A. I don't remember.
2 Q. Can you recall whether you were present when Dr Devlin
3 arrived?
4 A. I don't remember Dr Devlin being there, but again,
5 I can't ... I can't remember.
6 Q. So you can't recall any dealings with him at all?
7 A. No.
8 Q. In terms of the administration of an anti-emetic at that
9 time, in your experience as a nurse, what should be done
10 after the administration of the anti-emetic in terms of
11 monitoring a child's progress?
12 A. To ensure that she wasn't vomiting again, to make sure
13 the anti-emetic took effect.
14 Q. Yes. And we've seen something called an episodic care
15 plan, which was otherwise known as DM Nurse. Would you
16 agree with the evidence that we've heard so far, which
17 is that that is a document which can be adjusted or
18 evaluated with changing circumstances?
19 A. Yes.
20 Q. It's a document into which a nurse could, if she was so
21 minded, formulate a plan for increased observations and
22 monitoring of a child who was, for example, suffering
23 from continuing vomiting. That's something that --
24 A. Yes.
25 Q. -- that document could be used to do.

1 Raychel continued to vomit after the administration
2 of the anti-emetic and eventually suffered coffee-ground
3 vomits and another anti-emetic was administered.
4 Dealing with the situation back at 6 o'clock, you were
5 still on duty at that time, were you?
6 A. I was in the baby unit. I was on duty, yes, but not
7 in that area.
8 Q. So after carrying out the 5 o'clock observations, you
9 went back to the infant unit?
10 A. Yes.
11 Q. And went off duty at what time?
12 A. I can't recall.
13 Q. It would vary from day-to-day, would it?
14 A. I could have been off duty at 7 o'clock or I could have
15 went off duty at 8 o'clock.
16 Q. In terms of a nurse's interaction with a junior doctor
17 who comes to see a patient, say a JHO who you would
18 agree is relatively inexperienced, would nurses tend to
19 develop a special approach to JHOs in terms of how much
20 information they give him or her or what kind of prompts
21 they would give a JHO?
22 A. It depends on what information they were looking to --
23 they were asking. Whatever they were asking, we would
24 inform them.
25 Q. In Raychel's case, she was plainly still vomiting at or

1 about 6 o'clock -- and I'm conscious that you weren't
2 present at that time -- but in the context of what was
3 apparently a straightforward appendix operation, should
4 that have been regarded as slightly unusual that she was
5 still vomiting?
6 A. It probably was, yes.
7 Q. And in that context, should your nursing colleagues have
8 been pushing or prompting that junior doctor to obtain
9 the input of his senior colleagues?
10 A. No, it was his decision to make.
11 Q. It's his decision to make?
12 A. Yes. Going back then, it was his decision to make.
13 Q. And nurses would have no part in that?
14 A. Yes.
15 Q. Is it not the case that nurses have a responsibility to
16 be communicating to a doctor any unusual aspects in the
17 patient's recovery?
18 A. I think a doctor should have known at that stage about
19 the child and what they were treating and to take
20 further steps if needed.
21 Q. But dealing with the nursing responsibility, when
22 a nurse interacts with a doctor and is seeking the
23 assistance of a doctor for her patient, it's a nursing
24 responsibility, is it not, to give full information
25 about the history? So in Raychel's case -- I see you

1 nodding. Just for the record, if you agree with
2 something, please say "yes".
3 A. Yes.
4 Q. In Raychel's case, the doctor should have been told
5 about all of the vomits; isn't that right?
6 A. Yes.
7 Q. It may be obvious from the record on the fluid balance
8 chart, but he should be told that that is the history,
9 shouldn't he?
10 A. Yes.
11 Q. He might be told any other fluid management related
12 issues, such as whether the child has been drinking,
13 that would be an important thing to --
14 A. If he had asked, yes.
15 Q. Well, is it not the responsibility of the nurse to give
16 a history?
17 A. Yes, the doctor should know what was wrong with the
18 patient and what the patient had done and what was
19 occurring at that time.
20 THE CHAIRMAN: I think, Mr Wolfe, this comes back to the
21 point that the best position, the position that you
22 really want, is for the doctor and nurse to be there
23 together. I am not sure if we have that position,
24 certainly in relation to 5 o'clock. But if you had been
25 there when, for instance, Dr Devlin came along -- and

1 you know that from this morning's evidence, Dr Devlin
2 seems to have seen Raychel without any nurse being with
3 him. If you had been there with him, as an experienced
4 nurse, and Raychel's mother was with her too, would
5 you have expected some more discussion about how she was
6 than appears to have taken place?
7 A. I don't think it's right for me to answer that because
8 I wasn't there.
9 THE CHAIRMAN: Okay. Let's suppose you were with a patient
10 and the doctor is called. If you called the doctor to
11 see a patient because you were concerned, you would
12 prefer to be with the doctor when he sees the patient?
13 A. Get the -- yes.
14 THE CHAIRMAN: Because you want to make sure the doctor
15 understands the position and you also then want to know
16 what the doctor's response to it is --
17 A. Yes.
18 THE CHAIRMAN: -- so that the doctor might reassuringly say,
19 "The anti-emetic should sort it out", or, "I'm a bit
20 concerned here too, keep an eye on her and let the
21 on-call team know if you need us back".
22 But the evidence about what happened with Dr Devlin
23 is that he seems to have seen Raychel on his own and he
24 may have said to somebody -- I think on his way out --
25 "If you need any more, let us know".

1 A. It mightn't have been possible that day for a nurse to
2 go along with him because of the busyness of the ward.
3 THE CHAIRMAN: And because you were down a nurse in the
4 first place?
5 A. Yes.
6 THE CHAIRMAN: Okay.
7 MR WOLFE: I think you have already made it clear that you
8 didn't talk to the doctor, so any communication with him
9 about the plan wasn't with you.
10 A. No.
11 Q. In terms of the rate of fluid that Raychel was on, you
12 reflect in your evidence a position of simply checking
13 that the rate that had been prescribed was being
14 delivered through the pump --
15 A. Yes.
16 Q. -- and you sign off on that.
17 A. Yes.
18 Q. Would you in your nursing role have given any
19 consideration to whether the rate of fluid which was
20 being delivered was appropriate?
21 A. No. It was prescribed at 80 ml an hour and we gave it
22 as prescribed.
23 Q. So as a patient's situation changed, perhaps with vomit
24 upon further vomit, you wouldn't have regarded that as
25 a factor that ought to be brought to the attention of

1 the doctor?
2 A. To reduce or to --
3 Q. To reduce or revise the fluids.
4 A. No.
5 Q. In terms of the observations that you conducted at
6 5 o'clock when Raychel was asleep, Mrs Ferguson, in her
7 statement to the inquiry, has reflected the position
8 which is that while Raychel and her lay down on the bed,
9 Raychel was terribly uncomfortable during that period
10 and was nauseous and retching from time to time, and
11 eventually vomited at some time after 5 o'clock.
12 Indeed, when Dr Devlin arrived, Raychel had a vomit.
13 Were you aware of any further vomiting at the time you
14 saw Raychel for the purposes of observations at
15 5 o'clock?
16 A. After I documented it at 3 o'clock, no, no further --
17 no.
18 Q. In terms of your dealings with Raychel, do you have any
19 recollection of having any communications with mother or
20 father?
21 A. No.
22 Q. When a child is vomiting and has had repeated vomits,
23 would it be appropriate for a nurse to say something
24 perhaps by way of reassurance or explanation to family
25 members?

1 A. Of course, yes.
2 Q. What would your practice have been? If you can't recall
3 any specific conversations, would you have had
4 a particular practice?
5 A. You keep the lines of communication open with the
6 parents. You talk to them and make sure they had -- you
7 would say to them: if she had any more vomits, make sure
8 to come and tell us.
9 Q. Assessing your evidence overall, staff nurse, is it fair
10 to summarise that by the time you saw her at 5 o'clock
11 you had no particular concerns for Raychel?
12 A. I had no concerns, no. She appeared comfortable, her
13 observations were satisfactory.
14 THE CHAIRMAN: And your understanding at that time was that
15 if a child was getting intravenous fluids and was
16 vomiting, then the child was being protected by the
17 intravenous fluid from anything going wrong?
18 A. Yes.
19 MR WOLFE: Can you recall being told that Raychel had
20 suffered an unexpected turn and had died?
21 A. I don't remember anything about that, no. Whether they
22 thought I had been working in the infant unit most of
23 the day, maybe they thought I hadn't been looking after
24 Raychel at all, they didn't know I was covering
25 Michaela's breaks. So maybe they didn't think it

1 was ...
2 MR CAMPBELL: I think, in effect, this witness has answered
3 the question whether she was aware of the meeting of
4 12 June. If that could be clarified for her.
5 THE CHAIRMAN: Let's go back. I think Mr Wolfe's question
6 was whether the more general question, "Do you remember
7 being told that Raychel had taken seriously ill and then
8 that she had died?" Do you remember that?
9 A. I don't remember, no.
10 MR WOLFE: I don't mean by that question whether you were
11 formally advised by, for example, Sister Lyttle, who
12 appears to have been telephoning a number of nurses to
13 tell them that awful news. But at some point,
14 presumably you must have discovered the fact of
15 Raychel's death.
16 A. Yes. At some stage, but I don't remember who informed
17 me or how found out.
18 Q. When you received that news, presumably you were
19 shocked?
20 A. Devastated. Just couldn't believe how it could happen.
21 Q. You're quite right that you weren't in attendance at the
22 meeting that took place, the critical incident
23 meeting --
24 A. No.
25 Q. -- on 12 June. Were you invited to that meeting?

1 A. I was working that day, but I don't remember getting any
2 notification about that meeting.
3 Q. I think you said in your witness statement that an
4 incident review meeting was held, but you couldn't
5 attend.
6 A. Yes. Whether I was busy on the ward or . I don't ...
7 Q. Your use of the phrase -- the suggestion that you
8 couldn't attend suggests perhaps that you were invited
9 to attend, but weren't able to.
10 A. I don't remember getting any notification about the
11 meeting.
12 Q. Right. At or around that time, did you speak to any of
13 your nursing colleagues about what had happened to cause
14 Raychel's death?
15 A. I'm sure I did, but I don't recall.
16 Q. What memory do you carry with you of that time in terms
17 of your understanding of what had happened to her?
18 A. In all the years I've been nursing, that something
19 tragic like that took place ... and having an
20 understanding of hyponatraemia ... just didn't know
21 anything about it.
22 Q. Yes. But did you gain, at that time, an understanding
23 of what had happened? What were they saying had
24 happened?
25 THE CHAIRMAN: Put it this way: like the other nurses who

1 were involved in treating Raychel, even though your
2 involvement was very limited, you've told me how shocked
3 you were, how you couldn't believe what had happened and
4 can I take it, like the other nurses, you were
5 distressed about what had happened?
6 A. Of course.
7 THE CHAIRMAN: Did that then make you curious about what on
8 earth went wrong here, what was different in Raychel's
9 case, why did she die?
10 A. That's right.
11 THE CHAIRMAN: What did you learn or hear about what went
12 wrong?
13 A. That if she had had a blood sample taken --
14 THE CHAIRMAN: That would have made a difference?
15 A. -- it would have made a difference.
16 MR WOLFE: Sir, I have no further questions for this
17 witness. I see Mr Quinn has one.
18 THE CHAIRMAN: Just give me one second.
19 MR WOLFE: Through me, sir, Mr Quinn asks: a nurse in
20 Altnagelvin received information from a nurse in
21 Belfast, it would appear, which suggested that Raychel
22 had been given the wrong fluid in Altnagelvin.
23 THE CHAIRMAN: This is in the sense that Solution No. 18 had
24 been stopped in the Royal.
25 MR WOLFE: Yes.

1 Did you come across that information at that time?
2 A. No.
3 THE CHAIRMAN: But within a few days, Solution No. 18 did
4 stop being used in Altnagelvin?
5 A. Yes.
6 MR WOLFE: And there was the introduction of regular
7 electrolyte profiles?
8 A. Yes.
9 MR WOLFE: Very well.
10 MR QUINN: I just wanted to put two other issues through
11 you, Mr Chairman.
12 We know that there was a meeting on 12 June and we
13 know that there were decisions made about various issues
14 that should be changed. Could you ask this witness as
15 to what, in particular, she heard about the changes that
16 were going to be made? That is, did she hear that the
17 fluids were going to be changed? She has already told
18 us very frankly about the bloods, that there was
19 an issue about the bloods not being done.
20 The third issue, as I and the family see it, is
21 in relation to the overload of fluid. Did she hear
22 anything about that?
23 THE CHAIRMAN: Yes. In relation to what followed Raychel's
24 death, Solution No. 18 stopped being used, right, and
25 electrolyte testing was introduced. Did you hear any

1 discussion about the amount of fluid which Raychel had
2 received, about the volume of fluid?
3 A. Yes, I did.
4 THE CHAIRMAN: What did you hear about that?
5 A. I heard that she was overloaded with fluid.
6 THE CHAIRMAN: You weren't at the 12 June meeting.
7 A. No.
8 THE CHAIRMAN: Was that something that was being talked
9 about before that meeting, did that emerge after the
10 meeting, or what?
11 A. After the meeting.
12 THE CHAIRMAN: Did nurses who had been at the meeting tell
13 you what had been discussed?
14 A. I don't remember whether I heard it recently -- I know
15 it was recently when I heard that the fluid overload was
16 not -- not going back then.
17 THE CHAIRMAN: When you say "recently", do you mean in the
18 context of this inquiry?
19 A. Yes.
20 THE CHAIRMAN: Do you mean in the last week or two?
21 A. Yes.
22 THE CHAIRMAN: But you hadn't previously heard any debate
23 about the volume of fluid she'd received?
24 A. No.
25 THE CHAIRMAN: Just about the type of fluid and the failure

1 to carry out a blood test?
2 A. Yes.
3 THE CHAIRMAN: Okay.
4 MR QUINN: I'm not exactly happy with the answer, but in the
5 context it was given and the way it was reviewed. I can
6 really take it no further in the circumstances of this
7 inquiry.
8 THE CHAIRMAN: Okay. Any questions from the Trust?
9 Mr Campbell?
10 Okay. Ms Roulston, unless there's anything you want
11 to add, you are now free to leave. Thank you very much.
12 (The witness withdrew)
13 MR WOLFE: Sir, that's all the evidence for today.
14 THE CHAIRMAN: On schedule.
15 Can I ask, Mr Stitt, there have been some
16 discussions this afternoon with Ms Dillon and Ms Conlon,
17 have there?
18 MR STITT: Yes. Mr Johnson and Ms Dillon are going to speak
19 again. I'm getting a very positive response here.
20 I hope that's an accurate reflection on the talks.
21 THE CHAIRMAN: Good. Unless anyone has anything else to
22 raise this afternoon, that brings us to an end, on
23 schedule for once. I was going to sit at 9.30 tomorrow
24 if we were going to sort out the privilege issue, but
25 there still seems to be documentation issues to sort out

1 and you won't know your position, Mr Stitt, on the
2 general point until lunchtime perhaps.
3 MR STITT: It'll be tomorrow afternoon, but I can assure the
4 tribunal that this matter is being focused on very
5 closely.
6 THE CHAIRMAN: Thank you very much. Then we've got two
7 witnesses tomorrow, Dr Johnston and Dr Curran. Again,
8 we will do everything we can to make sure we hear the
9 full evidence of those two witnesses so neither of them
10 have to be called back. Therefore we will start
11 promptly at 10 o'clock tomorrow. Thank you.
12 (3.42 pm)
13 (The hearing adjourned until 10.00 am the following day)
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