1 Tuesday, 5 March 2013
2 (10.00 am)
3 (Delay in proceedings)
4 (10.12 am)
5 THE CHAIRMAN: Mr Stitt, we've got a list of documents from
6 the DLS inquest file, right?
7 MR STITT: Yes.
8 THE CHAIRMAN: We don't have the list of documents which are
9 held by Ms Brown. I asked for two things last week and
10 I asked for them by end of business yesterday: the list
11 of documents in the DLS inquest file and the list of
12 documents held by Ms Brown. I also wanted to know what
13 privilege was claimed for. I have one list of documents
14 from the DLS file. I don't have the second list from
15 Ms Brown. That's the first point.
16 The second point is the list of documents from the
17 DLS inquest file doesn't actually tell me anything other
18 than list 231 documents, some of which the inquiry has,
19 some of which we don't have, but some of which you
20 couldn't possibly be claiming privilege for. And
21 frankly, we are no further on.
22 This issue of privilege is not going to drift on
23 over the next couple of weeks so that we come to the end
24 of the clinical hearing without knowing what the
25 position is. It has to be sorted out. I want a proper

1 list of documents indicating what you're claiming
2 privilege for and the basis on which you're claiming
3 privilege by close of business today. And I want the
4 same from Ms Brown's file.
5 MR STITT: I will undertake to deliver that.
6 THE CHAIRMAN: Thank you.
7 MR STITT: I'll do my best to deliver that.
8 THE CHAIRMAN: I thought we had killed this issue last
9 summer and I was told last summer by Mr McGinnis that
10 you were going to get back to me, and then I find that
11 last week a claim for privilege is resurrected and
12 that's not good enough.
13 MR STITT: I can understand your frustration, sir. I won't
14 say I wasn't involved last summer because I should know
15 exactly what's happened because I'm standing here.
16 THE CHAIRMAN: I realise you weren't, but frankly your
17 solicitors should not have put you in a position where
18 you're fronting a claim for privilege which, if it was
19 to be made, was supposed to be made to me last summer on
20 the advice of the senior counsel who have been in the
21 inquiry before you.
22 MR STITT: I take that point.
23 THE CHAIRMAN: Okay. Mr Wolfe?
24 MRS FIONA BRYCE (continued)
25 Questions from MR WOLFE (continued)

1 MR WOLFE: Good morning, sir. Good morning,
2 Staff Nurse Bryce.
3 First of all, an apology from me, sir. It has been
4 brought to my attention that I haven't been using the
5 professional title of the nurses. And that's something
6 I should take on board and correct. Secondly, on
7 a number of occasions yesterday I apparently used the
8 surname of certain of the nurses without prefacing it
9 without with Mrs or their professional title and
10 I understand that that may have caused some offence,
11 which I apologise for.
12 THE CHAIRMAN: I'm sure it wasn't intended. We'll tighten
13 up on it today.
14 MR WOLFE: Staff Nurse Bryce, yesterday afternoon we had
15 reached a stage in your evidence where you were
16 describing how you had come into contact with Raychel at
17 or about 12.30 on the early morning of 9 June 2001. And
18 before that time, you had been dealing with other
19 children on the ward and hadn't been dealing with
20 Raychel; is that all correct?
21 A. That's correct.
22 Q. Could we have up on the screen, please, just to set the
23 background to this, WS054/1 at page 3? In the second
24 last paragraph you say:
25 "I was dealing with other children on the ward until

1 12.30 on 9 June. When I went into room I, I noticed
2 Raychel was a little unsettled and I noticed a small
3 amount of vomit on her pyjama top and pillow case.
4 I spoke to her and asked her if she was okay, she
5 responded, but I cannot recall what she said. I was not
6 concerned by Raychel's condition. I asked for
7 assistance and we changed her pyjama top and pillow case
8 and she appeared to settle after that and went back so
9 sleep. I checked her intravenous site and marked up her
10 drip to ensure correct amount and rate and recorded this
11 in the fluid balance sheet at 1 am."
12 Before I ask you about the events of 12.30,
13 Staff Nurse Bryce, could I ask you this: in the lead-up
14 to your attendance with Raychel at that time, what
15 information had you received in relation to her
16 condition during the night prior to 12.30?
17 A. Following the handover report?
18 Q. The handover report happened at about 8 o'clock, didn't
19 it?
20 A. Yes.
21 Q. And you have told us that you weren't the nurse to
22 changed her bed clothes with Staff Nurse Gilchrist.
23 A. That's correct.
24 Q. And you have told us that you went about your duties
25 with other children up to 12.30.

1 A. That's correct.
2 Q. In that four or four-and-a-half hour period, were you
3 brought up-to-date at any time with regard to Raychel's
4 condition?
5 A. Not officially, but because there was just three of us
6 on the ward, we are aware of what's going on and I was
7 aware that a doctor had come to see Raychel.
8 Q. Could I ask for WS054/2 at page 6 to be put up on the
9 screen, please? And could I have it alongside --
10 I think that's fine. This is your second witness
11 statement to the inquiry and if I could ask you to look
12 at the answer you've given to (c):
13 "Before seeing Raychel at 12.30 on 9 June, had you
14 received any update on how she had been progressing
15 in the period since you came on duty at 7.45 pm?"
16 To which you have answered "no".
17 A. That's correct.
18 Q. Is your answer to that question now "yes"?
19 A. When I answered that question, I said no as an official
20 type report. But we don't do -- after the handover
21 report, we don't actually meet again and have an
22 official report. That was just general knowledge on the
23 ward, we just passed information from one to the other.
24 Q. Yes, but without getting into semantics, that question
25 didn't ask you about official or formal reports; it

1 asked whether you had been updated. Are you now telling
2 the inquiry that you were updated --
3 A. By the --
4 Q. -- informally?
5 A. Informally, just by being on the ward and knowing what's
6 going on on the ward.
7 Q. So you were updated informally?
8 A. Just by knowing what's going on on the ward, yes.
9 Q. And what did you know from what was going on around the
10 ward in relation to Raychel's condition by 12.30?
11 A. I knew she had been seen by a doctor.
12 Q. Right. So you knew that a doctor had come to see her.
13 What about her condition? Did you know anything further
14 about her condition which you didn't know at 8 o'clock
15 at the time of the handover?
16 A. Not really. Just that -- I knew the doctor had come to
17 see her because she was vomiting.
18 Q. Right. So that's an additional piece of information.
19 You knew that the doctor had come to see her because she
20 had been vomiting.
21 A. Yes.
22 Q. Did anybody give you any information or understanding
23 in relation to the severity of her vomit or the type of
24 her vomit?
25 A. No, not that I can recall.

1 Q. Right. Were you aware that she had been suffering
2 a headache?
3 A. I don't recall --
4 Q. Very well.
5 A. -- that information. I don't recall.
6 Q. Did anyone advise you in terms of what the doctor had
7 done when he came to see her?
8 A. I did know he had given her an anti-emetic.
9 Q. Had you any dealings with the doctor when he came?
10 A. No.
11 Q. In your experience when a doctor comes to see a patient,
12 what should the nature of the interaction be between the
13 nurse and the doctor? For example, should the doctor
14 attempt to seek the nurse out or vice versa, should the
15 nurse attend the bedside?
16 A. Yes. But on night duty there's just three members of
17 staff on the ward and we weren't aware exactly what time
18 the doctor was going to come, so ideally yes, somebody
19 should have seen a doctor or the doctor should have
20 seeked [sic] somebody out.
21 Q. Were you party to the discussion that led to the
22 decision to request a doctor's attendance?
23 A. No.
24 Q. Now --
25 A. Not that I can recall, no.

1 Q. Plainly, by this stage in the evening when the doctor
2 attended, Raychel had been vomiting several times during
3 the day and then, several times in quick succession, she
4 had coffee-ground vomits and then three small vomits,
5 all at or about 10 o'clock. Did you know that detail of
6 information?
7 A. Not that I can recall. I didn't see Raychel until
8 12.30, but I just was aware the doctor had come. But
9 I can't recall that I knew that information.
10 Q. After the doctor left, were you given any information by
11 your colleagues in terms of how Raychel should be cared
12 for now that she'd received an anti-emetic?
13 A. Not officially. We just knew she had received the
14 anti-emetic and we would all ... We would be observing
15 for the effect of it --
16 Q. Yes.
17 A. -- but not officially.
18 Q. When you say you would be observing for the effect of
19 it, was that a task allocated to you?
20 A. No, not a task allocated, no.
21 Q. Do you know who it was allocated to?
22 A. I don't think that would have been allocated to anybody,
23 just as a team we would have known the reason why it was
24 given --
25 Q. Yes.

1 A. -- and to observe then the effect of it.
2 Q. Well, in terms of the effect of it, did you make any
3 observations in that respect?
4 A. No.
5 Q. Were you aware that there was a subsequent vomit
6 observed after Dr Curran's attendance and written into
7 the record by -- I've just lost the detail of that.
8 Without mentioning the name, I'll come back to that.
9 Staff Nurse Patterson was on duty in the infant unit
10 that night.
11 A. Yes.
12 Q. And she observed a vomit at 11 o'clock. Were you aware
13 of that?
14 A. When I went to write up -- when I went to her -- the
15 fluid balance sheet, I was aware of that from what I can
16 recall.
17 Q. In terms of the pathway, the recovery pathway that you
18 would have expected for a child who had emerged from
19 theatre 24 hours earlier with a good recovery,
20 apparently a good recovery, here was a child still
21 vomiting or vomiting, as I say, long after the surgery
22 had finished. Was that unusual in your experience?
23 A. No, children -- not unusual, no. It could happen.
24 Q. And in circumstances where that happens, you would
25 expect a doctor to be involved, would you?

1 A. Well, I would have informed my senior -- the nurse above
2 me, I was working as a staff grade, a D grade, so
3 I would have informed my senior colleague.
4 Q. That's what you would have done?
5 A. Yes.
6 Q. Turning to the vomit that you identified at 12.30,
7 you've described it as "a small vomit, an insignificant
8 amount". If we look at your answer here in front of us
9 at paragraph 6, you are asked whether you noted the
10 vomit and you say:
11 "It had just marked her pillow case and pyjama top
12 and it appeared to be an insignificant amount. There
13 was no large amount of vomit."
14 A. That's right.
15 Q. The vomit was sufficiently significant for you to bring
16 a colleague and to change the child's pyjama top.
17 A. That's true, yes.
18 Q. It wasn't so insignificant that you could have made done
19 with just wiping the pyjama top; is that fair?
20 A. It was just a mark on her pyjama top and her pillow
21 case. It was a dried mark and because Raychel had IV
22 fluids running, I would need help to do that, to change
23 her.
24 Q. Sorry, I don't follow. The connection between changing
25 her and the IV fluids running is what?

1 A. Well, just for assistance because -- I can't exactly
2 remember where it was running, but it was probably her
3 hand or her arm. So therefore to help to change her
4 pyjamas, it was easier with two people.
5 Q. Yes, but why did you need to change the pyjamas?
6 Presumably the child was sleeping or dozing at that
7 point.
8 A. Well, no, she wasn't, she was actually -- she was
9 awakened at that point.
10 THE CHAIRMAN: But there was enough vomit for to you think
11 it was appropriate to change the pyjama top?
12 A. Well, it was just because it was a mark and the type of
13 nurse I am, I felt it was right so it made her
14 comfortable.
15 THE CHAIRMAN: Sorry, Mrs Bryce you have said in your
16 statement there was a small amount of vomit on her top
17 and pillow case. You're now reducing that to a mark.
18 A. I think --
19 THE CHAIRMAN: I don't read a small amount of vomit as being
20 a mark.
21 A. A mark --
22 MR CAMPBELL: Chairman, with respect, the answer at
23 paragraph (h) refers to "an insignificant amount". That
24 surely is in keeping that is now being given.
25 THE CHAIRMAN: I'm not quite sure when small became

1 insignificant, Mr Campbell, but not insignificant enough
2 for Raychel not to need to be changed.
3 MR CAMPBELL: And she's giving her evidence about that and
4 the rationale behind that.
5 THE CHAIRMAN: Okay.
6 MR WOLFE: First of all, should you have written this small
7 amount of vomit into the notes, Staff Nurse Bryce?
8 A. Into her notes?
9 Q. Into her fluid balance note.
10 A. Because it was a mark on her pillow case and her pyjama,
11 it could have been left from a previous vomit, I wasn't
12 sure. I really did not feel that it was of any
13 significance, it was such a small -- it was a small
14 amount.
15 Q. So if you had recorded it in the notes, you would have
16 written "small vomit"; is that fair?
17 A. I don't think I'd have used the word small even, I would
18 have probably put a mark.
19 Q. It had gone on to her pyjamas requiring a change and it
20 had gone on to the pillow case; is that right?
21 A. It was a mark on her pyjamas and a mark on her pillow
22 case, yes.
23 Q. Did you feel that this was a new episode of vomiting,
24 albeit a small amount of vomit?
25 A. I don't think it was a new episode. I don't ...

1 I can't say whether it was small. It came into my head
2 that it may have been maybe a spillage from her previous
3 vomit.
4 Q. This was a child who was supposed to be the subject of
5 observation in circumstances where an anti-emetic had
6 been prescribed. When you think about it now, is this
7 not something you should have reported to Staff Nurse
8 Noble at that time?
9 A. I did pass the message, when I went to speak to the
10 other nurse, Staff Nurse Gilchrist, so we were aware,
11 and I think Staff Nurse Noble then was made aware of it,
12 that she had a mark and we had changed her bed.
13 Q. You are asked at (j) on the document in front of you:
14 "Did you report the fact that Raychel appeared to be
15 a little unsettled when you saw her at 12.30?"
16 And you said "no" to that. As well as having vomit
17 about her, would you accept that you couldn't
18 definitively have said whether that was new or old
19 vomit?
20 A. Sorry?
21 Q. The vomit that was on her pyjamas, you couldn't have
22 worked out definitively whether that was new or old
23 vomit.
24 A. Well, it was dry, it appeared to be dry, have dried into
25 her clothes.

1 Q. Right. This other symptom, she was unsettled at that
2 time, you would have expected a child who had just been
3 through surgery 24 hours earlier and who had been
4 vomiting through part of the day to have been tired and
5 probably asleep at that time of the night, but this was
6 a child who was unsettled; is that right?
7 A. I used the word "unsettled" and then -- by the term
8 unsettled I think I did go on and say that -- I just
9 meant when I went into the room I'd have expected all
10 the children to be sleeping and she was just turning or
11 moving in the bed and I realised she was wakened, and
12 that's why I went to her.
13 Q. But you would have expected her to be sleeping at that
14 time?
15 A. I would have expected her to be sleeping at 12.30 at
16 night, yes.
17 Q. In answer to a question yesterday from the chairman,
18 Staff Nurse Patterson said that if she had found the
19 child unsettled at that time of the night, that would
20 have been a factor to have caused her concern. You were
21 in the chamber yesterday when she said that.
22 A. I can't remember her saying that.
23 Q. The fact that she was unsettled didn't cause you to make
24 a report to Staff Nurse Noble; isn't that right?
25 A. I spoke to Raychel and she answered me and I was happy

1 with how she responded to my question.
2 Q. My question to you, Staff Nurse Bryce is, you didn't
3 make a report to Staff Nurse Noble about her being
4 unsettled?
5 A. I didn't feel the need to.
6 Q. Right. And you didn't feel the need to because you
7 didn't regard this as significant?
8 A. I didn't feel that she gave me any cause for concern.
9 Q. She answered your question; is that right?
10 A. That's correct.
11 Q. And was it on the basis of the answer that she gave you
12 that you weren't concerned?
13 A. Yes. That's correct.
14 Q. Why did that alleviate any concern for you? Why did the
15 answer that she gave you alleviate concern?
16 A. Because I -- I can't recall exactly what she said, but
17 the answer that she gave me was appropriate for that
18 time of night. It was 12.30 and she was drowsy and
19 sleeping, just sleeping or sleepy.
20 Q. You completed the fluid balance chart at or about
21 1 o'clock; is that right?
22 A. I did, yes.
23 Q. By that stage in the morning, Raychel's bag of fluids
24 must have been running close to finishing?
25 A. I can't recall, I just know that I filled up the chamber

1 and completed her fluid balance sheet.
2 Q. We know that a Dr Butler had established a new
3 prescription for Raychel at or about midday on 8 June.
4 A. Mm-hm.
5 Q. And if fluids are running at 80 ml per hour, that bag of
6 one litre of fluids ought to have been expiring in or
7 about 1 or 2 o'clock in the morning. Do you know
8 whether another bag of fluids was prescribed?
9 A. I can't recall. I can't recall that. I don't think so,
10 but I can't recall.
11 Q. Can you offer any explanation as to -- maybe there's
12 a straightforward explanation that I'm missing. But if
13 the maths are right and the bag ought to have been
14 running, done by that time, that would have required
15 a doctor to come along; isn't that right?
16 A. Yes, it would have, yes.
17 Q. But you can't account for --
18 A. I can't recall another bag, no, I can't.
19 THE CHAIRMAN: Can I go back for a moment to the vomit at
20 12.30. Could you give us, please, witness statement
21 053/1 at page 3? The statement of Staff
22 Nurse Gilchrist. The paragraph in the middle of the
23 page which starts with 00.35:
24 "Staff Nurse Bryce came to me and said Raychel was
25 restless and asked me to help her change her pyjama

1 jacket as there was a mouthful of vomit on that."
2 Do you agree that there was a mouthful of vomit on
3 Raychel's pyjama top?
4 A. It depends on how -- on what a mouthful can be. My
5 recollection is that it was a mark, a mark on her pyjama
6 top and on the pillow case.
7 THE CHAIRMAN: Thank you.
8 MR WOLFE: If it was merely a mark, just to finish on this
9 point, why did you use other language to describe it in
10 your witness statement to the inquiry? You used the
11 phrase "small amount of vomit" when you gave a witness
12 statement to the inquiry in 2005.
13 A. Yes. But it was, it was a small amount, a small amount
14 can be a mark.
15 Q. Do you agree, Staff Nurse Bryce, that a mark is
16 a reduction from a small amount? It's an attempt
17 perhaps to degrade or reduce the significance of the
18 vomit.
19 A. No, absolutely not. I don't agree. I know it was
20 a small -- it was a mark.
21 Q. Surely when you think about this now, you must accept
22 that that vomit should have been recorded in the fluid
23 balance chart.
24 A. If I had, I would have put it down as it was a mark on
25 her pyjama top and on her pillow case.

1 Q. Given the context of the number of vomits that preceded
2 this, the fact that an anti-emetic had been prescribed
3 and here was a second piece of evidence of vomiting
4 after the anti-emetic had been prescribed, that ought to
5 have led to a discussion between the nurses as to what
6 action was needed.
7 A. But because it was a dried mark, I was not convinced it
8 was a fresh vomit; it could have been a spillage from
9 the previous vomit.
10 Q. When you changed the pyjama top, was there a need to
11 disconnect the drip?
12 A. I can't recall at the time, but sometimes we do have to
13 do that. But I can't recall.
14 Q. Is the answer to that question not a straightforward
15 yes? If she has both her arms through the pyjama
16 jacket, where's the drip entering?
17 A. It depends if we put the pyjama top fully on -- you
18 know, put her arm into the sleeve again. I can't recall
19 if we did or not.
20 Q. In order to take the pyjama top off, you would need to
21 disconnect the drip; is that right?
22 A. Yes, if she had -- if her sleeve had been in through the
23 pyjama top, yes, but I can't recall if her arm was in
24 through the pyjama top.
25 Q. That seems to be, if I may say so, something of quite

1 a lot of bother if it's merely a dried-in mark on
2 a pyjama top.
3 A. Well, that's the type of nurse I am.
4 Q. Raychel suffered a seizure at about 3 o'clock in the
5 morning. I understand that you were summoned to provide
6 some assistance about an hour after that event; is that
7 right?
8 A. I was there at the time she had the seizure, yes.
9 Q. Right. Just to orientate ourselves in time, at
10 3 o'clock or thereabouts the seizure occurred.
11 A. Yes.
12 Q. Staff Nurse Noble and Nursing Auxiliary Lynch appeared
13 to have been present at or about that time and they
14 brought a Dr Johnston into the room and he provided
15 care. Are you in a position to say how quickly after
16 3 o'clock you made it to room I to assist with Raychel's
17 care?
18 A. I can't recall the exact time, but I think I was on the
19 ward at the time that it happened, yes.
20 Q. Well, let me see if I can assist you with your memory.
21 If we could have your statement up again, WS054/1,
22 page 3. You say in the second last paragraph:
23 "My next involvement in the treatment of Raychel was
24 after she had suffered a fit. Staff Nurse Noble asked
25 me to take her observations. I recorded her pulse and

1 blood pressure at 4.10 am."
2 Then you cite the page reference for that:
3 "I then went and opened the emergency trolley and
4 took the cover off it. Raychel was brought up to the
5 treatment room. I remained in the treatment room to
6 assist other staff."
7 So we know that at 4.10 am -- and we can go to the
8 document, I don't think it's necessary, where you took
9 blood pressure, et cetera, and wrote up a note. Can you
10 recall any other specific hands-on task that you
11 performed at or about that time?
12 A. No, I can't recall anything that I did, no.
13 Q. In terms of the time of your attendance, the 4.10 am
14 observations that you conducted, were you brought along
15 specifically to do those observations or had you been
16 there?
17 A. I can't recall where I did those observations.
18 Q. It seems that it was a case of all hands on deck in the
19 sense that the three nurses -- yourself, Staff
20 Nurse Gilchrist and Staff Nurse Noble -- were all in
21 attendance at various times. Is that right, is that
22 your recollection?
23 A. I can't recall who was all there, I really can't.
24 Q. Right. Can you recall, very shortly after 4.10 am,
25 Dr Trainor arriving?

1 A. I do know she arrived, yes, at some stage, yes.
2 Q. Were you aware at that time that electrolyte results
3 were received or just about to be received via
4 Dr Curran, who was also apparently in attendance?
5 A. I didn't know what exactly -- I didn't know what was
6 going on, really, what everybody was doing. I just was
7 there to assist.
8 Q. Were you aware that a result had come back to the ward
9 showing low serum sodium in Raychel's blood?
10 A. I can't recall that either. I can't recall, sorry.
11 Q. Were you aware that Raychel's pupils had become fixed
12 and dilated by some point between quarter past four and
13 quarter to five?
14 A. I don't know the times because there was a lot going on
15 at that time and I cannot recall the times of when the
16 various things happened.
17 Q. Can I ask you this: Dr McCord was contacted by
18 telephone -- he was a consultant paediatrician -- and it
19 appears that Staff Nurse Noble made the call or placed
20 the call and Dr Trainor conducted the conversation;
21 can you help us with that?
22 A. No, I can't. I can't recall any of that at all, no.
23 Q. At some point Raychel's fluids were changed from
24 Solution No. 18 to normal saline.
25 A. Mm-hm.

1 Q. Can you help us with that in terms of the overall
2 sequence?
3 A. I can't. I'm sorry, I can't.
4 Q. Well, on a less specific and broader theme, did you
5 appreciate that Raychel was gravely ill at that time?
6 A. Absolutely.
7 Q. When you finished work that morning, could you describe
8 the atmosphere among the nurses for us? What was the
9 general feeling in relation to Raychel and her
10 condition?
11 A. We were all absolutely in shock as to what had happened
12 and just did not know, did not know -- we were in shock.
13 Q. This was a Saturday morning that you were coming off
14 duty and Raychel was transferred to the Royal Belfast
15 Hospital for Sick Children.
16 A. Yes.
17 Q. Would you have understood that that was happening?
18 A. My last encounter with Raychel was just when she left
19 the ward to go downstairs for a scan.
20 Q. Yes.
21 A. And I'm not sure what time she was transferred to
22 Belfast.
23 Q. You would have become aware of Raychel's death --
24 A. Yes.
25 Q. -- and can you recall how that sad event was brought to

1 your attention?
2 A. The sister on the ward telephoned me at home. I was at
3 home.
4 Q. That's Sister Millar?
5 A. No, it was another sister.
6 Q. And who was that?
7 A. Sister Lyttle.
8 Q. Was that on the Sunday, the day of the death?
9 A. It could have -- I don't recall the day.
10 Q. Can you recall what you were told in that conversation?
11 A. That Raychel had died of hyponatraemia.
12 Q. When you were told that, did you understand what she
13 meant?
14 A. No.
15 Q. She used the word "hyponatraemia" to you?
16 A. Yes, she did.
17 Q. And not understanding that term at the time, did you ask
18 her to explain?
19 A. I did.
20 Q. And did she take the time to explain it to you?
21 A. Yes, she said it was an electrolyte imbalance and a low
22 sodium.
23 Q. And again, we're still talking quite technical language.
24 Did you understand what that meant?
25 A. An electrolyte imbalance?

1 Q. Yes.
2 A. Absolutely, yes.
3 Q. As I understand your evidence to date, you thought that
4 Raychel's vomiting was not unusual.
5 A. That's correct.
6 Q. And you also thought that Solution No. 18 was a fluid
7 that was good for all seasons, that it was safe --
8 A. It was a safe fluid for use in children, and that was my
9 experience of it.
10 Q. So when Sister Lyttle was telling you that this was
11 a death from hyponatraemia, that there was an
12 electrolyte imbalance, that there was low sodium, did
13 you have questions for her?
14 A. I didn't ask her any questions at the time, no. From
15 what I can recall, I didn't.
16 Q. Did Sister Lyttle you anything else?
17 A. Not -- that was the main gist of the conversation.
18 I can't recall anything else.
19 Q. Well, can you recall whether she asked you about the
20 extent of Raychel's vomiting on the night you were on
21 duty?
22 A. Did she say, sorry?
23 Q. I'm sorry. Did Sister Little ask you any questions
24 about the extent of Raychel's vomiting on the night that
25 you had been on duty?

1 A. No, not that I can recall.
2 Q. Do you know whether you returned to work on the Sunday
3 or the Monday?
4 A. I can't remember because I was doing night duty.
5 I really can't remember when I went to work again after
6 that.
7 Q. You appear to have attended the meeting convened by
8 Dr Fulton on 12 June.
9 A. Yes, I did.
10 Q. Does that imply that you were on duty that day or did
11 you come in especially?
12 A. No, I think I came in especially for that.
13 Q. Before attending that meeting, did you and your nurse
14 colleagues get together to have a discussion about what
15 had happened?
16 A. Not that I can recall, in a formal get together, but
17 because it was a big event, a tragedy that had happened,
18 we would have discussed it. But not -- I can't recall
19 an actual meeting.
20 Q. Can you recall what you might have discussed?
21 A. No, I can't recall.
22 Q. You had been given certain information by Sister Lyttle.
23 A. Yes.
24 Q. And it had been made clear to you that this was a death
25 which had been caused because of an electrolyte

1 imbalance.
2 A. Yes.
3 Q. Would it have been human nature for you and your nurse
4 colleagues to discuss how on earth that could have
5 happened?
6 A. Probably, it's possible.
7 Q. Well, at the meeting itself -- and perhaps we could have
8 up on screen, please, 095-011-049. This is the third
9 page of Dr Fulton's statement to the PSNI in 2005.
10 I know that overnight Dr Fulton has corrected the
11 impression given by this witness statement, but were you
12 definitely at the meeting?
13 A. I was definitely at the meeting, yes.
14 Q. If I can just read through this and I will then ask for
15 your comments. Halfway down the page:
16 "I was immediately struck by how subdued and shocked
17 all the nurses and doctors appeared at the start of the
18 meeting. It was clear to me that they regarded this as
19 a very serious and highly unusual event."
20 Is that right?
21 A. Absolutely.
22 Q. He said that:
23 "The purpose of the meeting was to establish an
24 accurate, detailed picture of all the events leading to
25 Raychel's death."

1 Again, is that what you knew to be the purpose of
2 the meeting?
3 A. Yes.
4 Q. He said that:
5 "It was important to do this quickly while everyone
6 had good recall of the details."
7 He expressed the view that:
8 "It would be difficult and distressing, but it was
9 essential to understand what went wrong so that we could
10 reduce or avoid the likelihood of another death or
11 injury."
12 Again, without perhaps necessarily recalling the
13 specifics of that, is that a broad theme of the meeting
14 that you might recall?
15 A. Yes.
16 Q. Towards the bottom of the page he says:
17 "To reassure all staff, I said I would not take
18 detailed minutes of the meeting, but an action plan
19 would be necessary."
20 Over the page, please. He said:
21 "[He] would need statements from key staff, which
22 would contain a detailed description of their
23 involvement in Raychel's treatment."
24 Were you asked to provide a statement?
25 A. No, not at that time, no. I provided my statement in

1 2005, I think, my first statement.
2 Q. To this inquiry?
3 A. Yes.
4 Q. But are you saying that your employing trust, whether
5 Dr Fulton or anybody else in management within it,
6 didn't ask you for a witness statement?
7 A. I wasn't asked for a statement, no. I wasn't asked, no.
8 Q. At that meeting were specific individuals asked for
9 statements by name?
10 A. Not that I can recall, no. Well, not that I can recall.
11 THE CHAIRMAN: I think it's clear that some individuals did
12 provide statements on foot of that meeting. Isn't that
13 correct, Mr Stitt?
14 MR STITT: That is correct, sir.
15 THE CHAIRMAN: Thank you.
16 MR WOLFE: He then goes on in this witness statement to
17 reflect the discussions that took place at the meeting.
18 In terms of your involvement at the meeting, did you say
19 anything at all to the best of your recollection?
20 A. I can't recall anything that I said. I went to the
21 meeting just to hear what had happened to Raychel.
22 Q. Do you think it's likely that you sat through the
23 meeting without saying anything?
24 A. Well, I can't recall what exactly I would -- what
25 I said. No, I can't recall.

1 Q. So just don't know whether you spoke or didn't speak?
2 A. I can't recall.
3 Q. We've heard evidence from Staff Nurse Noble, who was
4 at the meeting --
5 A. Mm-hm.
6 Q. -- and also Sister Millar, who was at the meeting.
7 Staff Nurse Noble recalled at the meeting that there was
8 a frank assertion on the part of Sister Millar that
9 electrolytes ought to have been carried out in relation
10 to Raychel, and she was directing her concerns towards
11 the surgeons who were at the meeting; do you remember
12 that?
13 A. I can't recall anything specific about that meeting.
14 I just know there was a lot of stuff discussed, all what
15 had gone on with Raychel.
16 Q. Okay. Let's remove it from the specifics. I've asked
17 you a specific question about an intervention from
18 Sister Millar, which is based on Staff Nurse Noble's
19 recollection. What are your broad recollections of the
20 meeting?
21 A. Well, I came away from the meeting -- the fluids were
22 going to be looked at and that electrolytes would be
23 checked more regularly on children who were on IV
24 fluids.
25 Q. Yes.

1 A. That was what I came away from that meeting with.
2 Q. So somebody was going to look at the fluids?
3 A. Yes.
4 Q. And we know that that was Dr Nesbitt.
5 A. Yes, I think you're right.
6 Q. Can I push you on that? Was there any indication at
7 that meeting that somebody had heard from a nurse in the
8 Royal that the wrong fluids had been used in Raychel's
9 case?
10 A. I can't recall whether -- I did hear that comment made.
11 I can't recall whether it was at that meeting or whether
12 it was on -- just general conversation.
13 Q. Can you recall who made the comment to you?
14 A. No, I cannot.
15 Q. You've also said that at the meeting the issue of
16 electrolytes was discussed --
17 A. Yes.
18 Q. -- and that there was going to be more regular use of
19 electrolytes --
20 A. Yes.
21 Q. -- with regards to surgical children.
22 A. Yes.
23 Q. Can you recall why that emerged as an issue that was
24 being discussed at a meeting concerning Raychel?
25 A. Because Raychel had died of an electrolyte balance

1 [sic], so they were going to look at how the surgical
2 children were managed.
3 Q. Was it recognised at the meeting that Raychel's
4 electrolytes ought to have been looked at?
5 A. I think that was discussed, from what I can recall.
6 Q. And again, if I can ask you this, was it recognised that
7 electrolytes ought to have been done in Raychel's case
8 because of the severity of her vomiting?
9 A. I'm not sure if it was in relation to her vomiting, but
10 just as children who were on intravenous fluids should
11 need and would need their electrolytes kept an eye on,
12 checked, but I can't recall if it related to her
13 vomiting or not.
14 Q. You think it was related to the --
15 A. Because she was --
16 Q. -- period of time that she was on intravenous fluids?
17 A. I think it was because -- if a child is on intravenous
18 fluids, yes.
19 Q. Right. In terms of the amount of fluid or the rate of
20 fluid administered to Raychel, can I ask you whether you
21 recall that being discussed as an issue at the meeting?
22 A. I can't recall. I can't recall anything significant
23 about that. No, I can't.
24 Q. Let me help you, if I can, on this. If we can go,
25 I think it's over the page, if we start at the bottom,

1 Dr Nesbitt described how he accompanied Raychel in the
2 ambulance. I think it's over to the next page, please.
3 At the top of that page:
4 "Dr Nesbitt reviewed the infusion rate of
5 Solution No. 18 and felt it was too high for Raychel's
6 weight."
7 Does that help you at all, Staff Nurse Bryce?
8 A. No, it doesn't really help me. I really can't recall
9 anything -- an in-depth discussion about it. It may
10 have been mentioned, it may not. I really can't recall
11 that.
12 Q. As we know in Raychel's case, JHOs were the people who
13 arrived in the course of 8 June to administer
14 anti-emetics. Can you recall whether the state of
15 knowledge of JHOs and their ability to help nurses
16 in the kind of situation they found themselves in with
17 Raychel -- do you remember whether that was discussed as
18 a theme?
19 A. No, I can't.
20 Q. Can you help us on this: was there a general perception
21 on the part of nurses that JHOs, not to be rude about
22 it, weren't fully equipped for the task of assisting in
23 cases like this?
24 A. I can't recall that being discussed --
25 Q. Right.

1 A. -- at that meeting.
2 Q. I'm leaving aside whether it was discussed. Is that
3 something you were aware of as a concern among nurses,
4 that JHOs weren't equipped in terms of knowledge or
5 experience for dealing with paediatric surgical cases?
6 A. Well, we would have ... The protocol would have been
7 that you would have contacted the JHO and if they felt
8 that they weren't equipped, they had another line, they
9 would have contacted their senior colleagues.
10 Q. There was a further meeting in September of that year
11 with the family of Raychel Ferguson. You didn't attend
12 that meeting?
13 A. No, I wasn't at that meeting.
14 Q. Were you invited to attend?
15 A. No, I don't think I was.
16 MR WOLFE: Sir, I have no further questions from this side
17 of the house. I'll look round the room.
18 MR QUINN: Could we ask the parents about this?
19 THE CHAIRMAN: We'll break for a few minutes to see if there
20 are any more questions from any of the parties around
21 the floor. So I'll come back out in a few minutes and,
22 subject to any additional questioning, which is likely
23 to be short if there is any, that'll be the end of your
24 evidence.
25 Mr Stitt?

1 MR STITT: I would like to return to the privilege issue.
2 THE CHAIRMAN: Okay.
3 MR STITT: I've taken instructions and the position is this.
4 There are two files that you've directed our attention
5 to. The first is the DLS file and the second is the
6 Trust file. The DLS file, the full index you have, as
7 you've obviously indicated to me earlier. What we're
8 doing is we're doing a two-stage process. We are
9 compiling -- we've just received, and I'll have to have
10 a look at it, but it's a second index, which merely
11 indicates which of the documents have already been
12 provided via the Trust to the inquiry. The third
13 operation which is required is that it is necessary to
14 look at the detail of the remaining documents to see
15 which of those require consideration in relation to
16 a claim of privilege. Rather than a blanket approach,
17 you have indicated, sir, that in your view there are
18 certain documents where that would not be sustainable
19 and there may be an argument about that. But that file
20 is going to be brought from Belfast and I would hope to
21 have that at lunchtime and then I can work on that to
22 meet your deadline.
23 THE CHAIRMAN: What concerns me, Mr Stitt, is that you have
24 advanced a claim for privilege which, at your end, seems
25 to be rather incoherent at the moment because

1 you haven't yet identified the documents for which
2 you're claiming privilege. That concerns me because
3 a claim for privilege emerged last week and then
4 I understand that -- apart from saying there are some
5 documents for which you're claiming privilege, I don't
6 know what those documents are yet. That's not good
7 enough, I'm sorry.
8 MR STITT: We've been adhering to the deadlines you have set
9 down.
10 THE CHAIRMAN: Well, you didn't adhere to the deadlines
11 I set down because the only thing I got yesterday was
12 a list of documents. It didn't tell me what privilege
13 was being claimed for at all. It was just a list of
14 documents.
15 MR STITT: I think there was some misunderstanding and
16 I will take responsibility for that.
17 The second matter relates to the Trust file. The
18 Trust file has already been given to the inquiry, but
19 the inquiry wanted it confirmed by the Trust what
20 precisely was in the Trust file to see if it correlated
21 or how closely it correlated to the documents which had
22 earlier been given to the inquiry. My instructing
23 solicitor, Mr Johnson, had a conversation with Ms Conlon
24 in relation to this on Thursday, and there was an
25 arrangement put forward whereby the file would be

1 brought on Friday by Therese Brown from the Trust and
2 that somebody on behalf of the inquiry would sit down
3 with her and go through that file and see, document for
4 document, what the tally was. And that was the way it
5 was hoped that the matter could be most expeditiously
6 dealt with. We were under the impression that that was
7 going to take place. And I'm not saying this in any
8 form of criticism, but for whatever reason Ms Brown
9 brought down her file, but no one made contact with her
10 in relation to it. I was doing other matters, I was
11 unaware of this arrangement, and unfortunately when we
12 finished, Ms Brown went back to Altnagelvin with her
13 file and the matter wasn't progressed. So I want to
14 make it clear that we were willing -- and of course are
15 still willing -- to provide the list of documents, but
16 that was the way it was anticipated that it would be
17 dealt with. As it is, Ms Brown has this morning been
18 completing -- and I understand has virtually
19 completed -- the complete index to her file and this
20 will be forwarded today.
21 THE CHAIRMAN: Thank you.
22 MS ANYADIKE-DANES: Mr Chairman, there have been some
23 discussions between the solicitors and the admin team of
24 the inquiry and the DLS. It seems that it's not quite
25 the way it's portrayed, but I needn't get into all of

1 that because if it's going to be resolved, it doesn't
2 really matter, except to say that so far as the
3 solicitor to the inquiry is concerned, she understood
4 that Mr Johnson, in conversation with her, had agreed to
5 go through the files and identify, but in any event if
6 that is being done today, perhaps it doesn't really
7 matter.
8 I think there is a level of confusion, Mr Chairman,
9 that you have indicated, and what I'm trying to do to
10 enable the investigation to proceed is to gain access to
11 the documents that we are entitled to have. It goes
12 back as far back as a letter that was sent to you from
13 Therese Brown on 13 December 2004 to say that she was
14 enclosing, as requested, all documents held by
15 Altnagelvin Trust in relation to Raychel Ferguson and
16 Lucy Crawford. Because you had asked all the trusts to
17 do that, and in fact it followed on from a letter from
18 Mr Gowdy that went round to all the trusts where he
19 instructed them to secure all documents -- and in fact
20 Altnagelvin were fairly fast off the mark. They
21 responded saying they had indeed secured all
22 communications.
23 So we are comforted to know that wherever they are,
24 they're all secure. But what we want to know is: what
25 is the complete list of all the documents that they have

1 that relate to Raychel Ferguson, and of that list which
2 are the ones that they say they assert privilege over,
3 and on what basis do they assert that privilege, so that
4 you, sir, can determine whether they are rightly
5 claiming privilege over those matters.
6 It's a very simple thing, it happens day in day out
7 in litigation and it has come as some surprise to us to
8 know that they have asserted privilege over documents,
9 the identity of which we don't know, and so it's
10 impossible therefore for us to be able to assist you,
11 sir, in saying whether that is likely to be a valid
12 claim for privilege.
13 THE CHAIRMAN: Thank you.
14 MR STITT: That sums up the position and it's exactly what
15 I'd said. But just to deal with the first of those
16 points -- and just for clarification, Ms Anyadike-Danes
17 is absolutely correct that there was an initial
18 arrangement whereby the two solicitors would get
19 together and look at the file. That has drawn
20 a response which is not entirely positive from
21 Ms Dillon, but my instructing solicitor --
22 THE CHAIRMAN: Let's cut through this. Is the file here
23 today or is Ms Brown working in Derry?
24 MR STITT: The file is not here today, but I have spoken to
25 her and she will have with us today a complete list,

1 verified by her, of what is in that file. And the file
2 can be brought back another day.
3 THE CHAIRMAN: If the file can be brought tomorrow, can
4 we have the list today?
5 MR STITT: Yes.
6 THE CHAIRMAN: I'll rise now for a few minutes for
7 questioning to be sorted out.
8 MR QUINN: I've identified the two issues. It would save
9 the witness coming back. She should be relieved to get
10 out of the witness box. One issue is for the witness,
11 one issue is in general.
12 The first issue is through you, sir, the parents
13 want to make the point that no one ever told them about
14 recording the passing of urine or the recording of
15 vomiting or reporting to the nurses the passing of urine
16 or the recording of vomiting, and they want that
17 stressed throughout this inquiry, that they never
18 received any specific instructions on that from any of
19 the nursing staff in Altnagelvin.
20 THE CHAIRMAN: This is on the point raised yesterday that
21 the parents had a role to play in compiling the record,
22 but your point is that the parents would have been happy
23 to do that had they known --
24 MR QUINN: Absolutely, sir.
25 THE CHAIRMAN: If it had been indicated to the parents that

1 that was relevant, then they were there or thereabouts
2 every hour or so as the observations were made.
3 MR QUINN: Absolutely, sir, that's the point.
4 THE CHAIRMAN: And they could have said she was at the
5 toilet 20 minutes ago or an hour ago.
6 MR QUINN: It points up the issue raised by Sister Millar
7 that she observed, as she said, Mr Ferguson taking
8 Raychel to the toilet twice. Why did she simply not
9 pull him back and say, "Hold on, Mr Ferguson, are you
10 going to the toilet? Would you not be better telling me
11 and maybe you could tell me what happened in there?".
12 Those are issues they want cleared up and they want this
13 put to each witness and they want an answer from each
14 witness whether or not that witness told them that they
15 should be reporting because they feel that their duties
16 as a parent are being undermined and attacked by this
17 allegation if, in fact, it's correct.
18 THE CHAIRMAN: Do I understand from your evidence,
19 Mrs Bryce, you don't say that you ever said to the
20 parents, "If Raychel goes to the toilet or if she is
21 sick, you come and tell us about it so we can record
22 it"?
23 A. I didn't personally speak to them about it, but I didn't
24 witness Raychel going to the toilet.
25 THE CHAIRMAN: Yes.

1 MR QUINN: The second point really isn't for this witness,
2 but it was a bit of a bombshell this morning when she
3 said that she was telephoned at home by Sister Lyttle
4 who told her that Raychel had died of hyponatraemia. It
5 seems that I should therefore request that the inquiry
6 follow up this line and perhaps ask Sister Lyttle for
7 a statement in relation to how she came by that
8 information. And I make this point because I've checked
9 this morning again, hyponatraemia was never mentioned at
10 the meeting of 3 September 2001 when Mrs Ferguson and
11 her sister and brother attended for an explanation. So
12 it seems that if Sister Lyttle was able to tell this
13 witness that hyponatraemia was the cause, that certainly
14 wasn't relayed to the parents and representatives of the
15 parents themselves at the meeting on 3 September.
16 THE CHAIRMAN: Okay, I'll consider that, thank you.
17 MR QUINN: I'm obliged, sir.
18 THE CHAIRMAN: Before I come to Mr Campbell, are there any
19 other questions from the floor? Mr Campbell, do you
20 want to finish with anything?
21 MR CAMPBELL: No.
22 THE CHAIRMAN: Mrs Bryce, thank you for your time, you're
23 now free to leave.
24 (The witness withdrew)
25 Let's move on. We didn't start until after

1 10 o'clock, so let's get started with Staff Nurse
2 McAuley.
3 MRS MICHAELA MCAULEY (called)
4 Questions from MR WOLFE
5 MR WOLFE: Good morning, Staff Nurse McAuley. Could I ask
6 you this: you have provided the inquiry with two witness
7 statements.
8 A. I have, yes.
9 Q. One dated 30 June 2005 and the second one, more
10 recently, 21 June 2012.
11 A. That's right, yes.
12 Q. We ask witnesses whether they wish to adopt those
13 witness statements as part of their evidence. And that
14 simply means: do you agree that your witness statement
15 is factually accurate and that you're happy for it to go
16 forward as part of your evidence to the inquiry?
17 A. I am.
18 Q. At the time when you cared for Raychel Ferguson in the
19 Altnagelvin Hospital in June 2001, you were known as
20 Staff Nurse Rice; isn't that right?
21 A. That's right, yes.
22 Q. That was your maiden name?
23 A. Yes.
24 Q. And where you have entered signatures on documents and
25 what have you, you signed it off as "MR"; isn't that

1 right?
2 A. That's right, yes.
3 Q. In addition to witness statements that you provided to
4 the inquiry, you also gave a statement to the Trust,
5 your employer, shortly after Raychel's death; isn't that
6 right?
7 A. That's right, yes.
8 Q. And moreover, you also gave a deposition to the coroner
9 as part of the inquest into the events surrounding
10 Raychel's death; isn't that right?
11 A. That's right, yes.
12 Q. At the time when you cared for Raychel, you were
13 employed as a grade D children's nurse in the
14 Altnagelvin Hospital.
15 A. That's right, yes.
16 Q. And you were only recently qualified in that time;
17 is that correct?
18 A. Yes.
19 Q. You had been awarded your diploma in nursing studies
20 in May 2000.
21 A. No. November 1999.
22 Q. November 1999?
23 A. Yes.
24 Q. And you were appointed to Altnagelvin on 26 June 2000;
25 is that right?

1 A. That's right, yes.
2 Q. Before coming to Altnagelvin, you had worked for a short
3 period of time in the Royal Victoria Hospital; is that
4 right?
5 A. That's right, yes.
6 Q. And that was in the area of paediatric neurology and
7 dermatology.
8 A. That's right, yes.
9 Q. So by the time you came to care for Raychel in 2001, you
10 had approximately a year-and-a-half's post qualification
11 experience; is that fair?
12 A. That's right, yes.
13 Q. And all of it was in the area of children's nursing?
14 A. It was, yes.
15 Q. Where are you currently employed?
16 A. In Altnagelvin.
17 Q. As a children's nurse; is that right?
18 A. Asthma and allergy nurse.
19 THE CHAIRMAN: Sorry, specialising in asthma?
20 A. An asthma and allergy nurse specialist.
21 MR WOLFE: I want to ask you some questions about the whole
22 area of hyponatraemia, fluid management and that kind of
23 thing. Could I have up on the screen, please, your
24 deposition to the coroner at 012-042-206? You'll see
25 your signature at the bottom of that page; isn't that

1 right?
2 A. Yes.
3 Q. As I explained to witnesses when showing them this
4 document, your deposition is typed up perhaps in advance
5 and then you come to the inquest and you're asked
6 certain questions, and a note is made of your answers.
7 A. Yes.
8 Q. And then it would appear that if you're agreeable with
9 the answers that you've given, you sign it off.
10 A. Yes.
11 Q. You can see the name "Mr Foster" is on the left hand
12 page, and he was counsel for the Ferguson family at that
13 inquest. And alongside that, you are recorded as having
14 said:
15 "I had not heard of hyponatraemia before Raychel's
16 death."
17 A. That's right.
18 Q. Is that right?
19 A. Yes.
20 Q. What did you mean by that, that you hadn't heard the
21 word?
22 A. I had heard the word of hyponatraemia, but its meaning
23 I wasn't aware of. I didn't fully understand.
24 THE CHAIRMAN: I don't think you were on your own, I'm
25 afraid.

1 MR WOLFE: Could I have up on the screen then your initial
2 witness statement to the inquiry, please, at WS051/1,
3 page 5? You speak here about hyponatraemia. It says:
4 "Hyponatraemia. Mentioned in training in the
5 context of sick children with vomiting and diarrhoea,
6 not mentioned in context of surgical patients. Was not
7 covered as a topic, but mentioned in passing. Prior to
8 this incident, I had no concerns or worries about the
9 use of Solution No. 18 in paediatric patients. Not
10 aware of any other incidents in Altnagelvin or any other
11 hospital involving Solution No. 18."
12 Focusing on hyponatraemia and excluding the
13 reference to Solution No. 18, but just focusing on
14 hyponatraemia, when you say that it was mentioned to you
15 in the training context of sick children with vomiting
16 and diarrhoea, is that a reference to your training
17 towards your professional qualification as a nurse?
18 A. Yes, I remember looking at my old nursing notes, which
19 I had, and there was a topic of hyponatraemia, but it
20 was literally three or four lines of hyponatraemia and
21 it was in relation to children with vomiting and
22 diarrhoea. When I was at the coroner's inquest,
23 I hadn't looked at those notes, so that's why I wasn't
24 aware then of hyponatraemia.
25 Q. Right. So to be fair to you, staff nurse, what you seem

1 to be saying there is that hyponatraemia was covered in
2 your nurse training, but it wasn't by any stretch of the
3 imagination a significant topic?
4 A. It wasn't, no.
5 Q. And it was so insignificant, I think you're telling us,
6 that you had forgotten about it by the time you gave
7 your evidence to the coroner's inquest in 2003, I think
8 I'm right in saying?
9 A. That's correct, yes.
10 THE CHAIRMAN: Just pausing there, in the context of
11 children with vomiting and diarrhoea, what training had
12 you got? Was that if children have vomiting and
13 diarrhoea, then whatever they expel from their body is
14 going to have sodium elements, which is going to lead to
15 an imbalance in the body; do you remember?
16 A. I have no recollection at the moment. I have actually
17 thrown out those notes, so I couldn't even refer back
18 prior to this to find out, but I have no recollection.
19 THE CHAIRMAN: The training you were doing, who was giving
20 that training?
21 A. Queen's.
22 THE CHAIRMAN: Okay, thank you.
23 MR WOLFE: Could I broaden this conversation out a little
24 bit beyond hyponatraemia? The inquiry has obtained
25 expert reports from Professor Hanratty, who's a nursing

1 specialist in the training and education sector, and
2 also from Sally Ramsay, who is a former nurse
3 practitioner and now consultant in relation to these
4 matters. First of all, have you had an opportunity to
5 consider either of their reports?
6 A. I'm aware of Sally Ramsay's, I've read that.
7 Q. Let me start with her then. What she says is that, so
8 far as nurses are concerned, registered nurses are
9 concerned, she would expect:
10 "... a registered nurse to be aware that fluid loss
11 from vomiting, if not replaced intravenously, can result
12 in dehydration and electrolyte imbalance."
13 And she's applying 2001 standards to that opinion.
14 A. Yes.
15 Q. Let me also refer to what Professor Hanratty has said.
16 She says that, when she compares pre and post 1990
17 curriculum documents, it:
18 "... indicates that all students would have had many
19 opportunities to learn about the importance of fluid
20 balance/maintenance, to the health and well-being of an
21 individual."
22 So both experts appear to be saying the same things.
23 One is talking about the educational opportunities
24 available to trainee nurses and the other one is
25 speaking about what she expects of nurses in practice.

1 Can I ask you this: in terms of the education and
2 practical experience that you had before June 2001,
3 would you say that you were aware of fluid balance
4 issues?
5 A. I would been aware of a child vomiting that would
6 develop dehydration, but not of fluid balance.
7 Q. There are two issues potentially, perhaps more, but in
8 terms of my limited knowledge, can I put this to
9 you: when a child vomits, they're at risk of
10 dehydration, particularly if the vomiting is severe;
11 isn't that right?
12 A. That's right, yes.
13 Q. And that would be an indicator, if there was severe
14 vomiting, to try and get fluids into a child.
15 A. Yes.
16 Q. Every mother, if you like, would know that, every parent
17 would know that; would you agree?
18 A. Yes.
19 Q. Secondly, if there's severe vomiting, a child -- as
20 we're dealing with children here -- is at risk of
21 electrolyte imbalance because, with vomiting, a child is
22 losing sodium-rich fluid.
23 A. That's right.
24 Q. In 2001, is that the understanding that you might have
25 had?

1 A. I'm not aware of what I've understood in 2001, but
2 I knew that Raychel had been vomiting and that she was
3 already receiving IV fluids. In 2001, I was unaware of
4 the composition of the Solution No. 18 and how much
5 sodium it would have had.
6 Q. Were you unaware of other fluids that were available to
7 treat patients such as Raychel? There has been
8 discussion of Hartmann's solution in this inquiry to
9 date, which, as a fact, contains higher level of sodium.
10 A. I would have had limited knowledge on Hartmann's
11 solution.
12 Q. Right.
13 THE CHAIRMAN: Had you worked with it when you were in the
14 Royal?
15 A. No, you used Solution No. 18.
16 THE CHAIRMAN: At that time, which was -- okay.
17 A. I left prior to -- prior to leaving, it was
18 Solution No. 18.
19 THE CHAIRMAN: Okay, thank you.
20 MR WOLFE: And in terms of the fluids that were being used
21 at that time, you realised, of course, that Raychel was
22 receiving Solution No. 18.
23 A. Yes.
24 Q. Are you saying to the inquiry that, notwithstanding her
25 vomiting, because she was on an intravenous fluid such

1 as Solution No. 18, that you thought she was perfectly
2 safe?
3 A. That was my understanding at the time.
4 Q. Are we to interpret you as saying that no matter how
5 severe the vomiting, you wouldn't have had any concern
6 because she was on this safe fluid?
7 A. I had limited knowledge at the time and, at the time, my
8 understanding was that she had Solution No. 18 running,
9 therefore she was at less risk of becoming dehydrated,
10 which would have been my concern.
11 Q. Had you ever managed the nursing care of a child with
12 gastroenteritis by that time?
13 A. I had, yes.
14 Q. And presumably you were aware of the process of
15 electrolyte testing, taking bloods, sending them to the
16 lab and having an assessment made of how much sodium,
17 how much potassium is in the blood and whether that was
18 normal or abnormal?
19 A. I would have, yes.
20 Q. And if sodium, for example, was low in the blood of
21 a gastroenteritis patient, there would have been a need
22 to take steps to replace that sodium by the introduction
23 of a fluid.
24 A. I do not remember at the time. I remember we would have
25 had Solution No. 18, which had potassium added to it,

1 but not sodium. So we would have been aware that some
2 children may have been in need of No. 18 Solution with
3 potassium.
4 Q. So at that time you are saying you were never aware of
5 sodium being added in to top up any deficit of sodium?
6 A. I've never been aware that Solution No. 18 didn't have
7 enough sodium in it to replace the loss.
8 THE CHAIRMAN: There seems to have been what seems now to me
9 to be a curious difference in that paediatric children
10 who were on IV fluids were tested every 24 hours, had
11 blood samples taken every 24 hours and they were tested.
12 Was that your memory of what went on in Ward 6?
13 A. That's right, yes.
14 THE CHAIRMAN: But that didn't happen for children who had
15 been through surgery and who were on IV fluids.
16 A. Not as far as I'm aware, no.
17 THE CHAIRMAN: Did you ever understand why there was
18 a distinction drawn between the two? I understand that
19 there was a distinction drawn, I understand that that's
20 probably led by the surgeons on the one hand as against
21 the paediatricians on the other. But did it occur to
22 you that it was a bit curious about why you would treat
23 the two groups differently?
24 A. As a junior nurse at the time, I didn't, I just followed
25 the instructions I was given.

1 THE CHAIRMAN: Okay.
2 MR WOLFE: Were you aware of the concept of a maintenance
3 fluid regime as opposed to a replacement fluid regime?
4 A. I'm not sure if I was aware in 2001 of that.
5 Q. I've used those words just now. Are those concepts
6 familiar language to you today?
7 A. They are, yes.
8 Q. Can you help me on this? What would you understand
9 today by a replacement regime?
10 A. If you had a really ill child who came in, as part of
11 the resuscitation you would be using replacement fluids,
12 and then they were going to maintenance.
13 Q. And you're saying that that was a concept or a learning
14 that you didn't have in 2001?
15 A. Probably learning I didn't have then.
16 Q. But if I can translate that -- and obviously, before
17 I ask the question I will add this caveat: doctors
18 obviously had the responsibility to prescribe the
19 appropriate fluid; isn't that correct?
20 A. That's right, yes.
21 Q. That's still the case?
22 A. Yes.
23 Q. But if I understand the opinion of Mrs Ramsay correctly,
24 it's her view that, in 2001, nurses should have had
25 enough about them to understand the need, if the need

1 arises, for a replacement fluid and to bring that issue
2 to the attention of the doctor if they were concerned.
3 A. I was not aware that that was an issue for Raychel.
4 Q. Yes, but more generally, leaving Raychel to one side if
5 we could, thinking about the case of a gastroenteritis
6 patient, is it not self-evident that if a child is
7 spewing out vomit, perhaps over a lengthy prolonged
8 period of time, that those gastric losses require, back
9 to that word again, replacement? Again, can you help
10 us? Is that not something you would have understood at
11 that time?
12 A. In 2001, no, it wasn't something that I understood.
13 Q. Did you not understand that if a child is spewing out
14 vomit, that they were potentially in difficulty?
15 A. If they were receiving IV fluids, I would have had the
16 belief that they were getting their losses replaced.
17 Q. Can I ask you to look at something you've said in your
18 witness statement, second witness statement, for us,
19 please? It's WS051/2, page 22. At question 15, I set
20 out as a preface what you said and what we've read
21 earlier about your training in relation to
22 hyponatraemia, and you'll remember what you have said
23 this morning, that it was not a significant topic in
24 terms of the training that you received, not a lot of
25 time was spent on it.

1 Then at question 15(e) you're asked:
2 "Was what you learnt at this training in relation to
3 sick children with vomiting applicable to the
4 circumstances of Raychel?"
5 And you say:
6 "During my time spent nursing Raychel, unfortunately
7 I didn't connect my training on hyponatraemia and
8 post-surgical vomiting."
9 Do you see that?
10 A. Mm-hm.
11 Q. The sentence tails off a little, but you seem to be
12 saying that you didn't connect the training that you had
13 received with Raychel's condition; is that the point you
14 were attempting to make?
15 A. My training was limited, maybe it was the word
16 "hyponatraemia" that I didn't connect at the time, that
17 that could have been ... I had very little training on
18 hyponatraemia.
19 Q. The impression which might be taken from that sentence
20 is that if you had only thought about it as you were
21 nursing Raychel, you would have had the information, the
22 wherewithal, to realise that Raychel was getting into
23 dangerous territory by the late afternoon of 8 June and
24 that you could have done something about it.
25 A. I don't think that I would have come to these

1 conclusions with the limited knowledge that I had.
2 Q. Can I ask you this: on the basis of the information that
3 you say you have now, can you tell us how you might have
4 treated or nursed Raychel different?
5 A. From the knowledge I've received from 2001?
6 Q. Yes.
7 A. She would probably have had an EP done, Raychel would
8 have had an EP carried out in the morning time.
9 Q. An EP is an electrolyte profile?
10 A. Sorry, yes.
11 THE CHAIRMAN: Is that because that would be done because
12 that's the new regime that the surgeon would direct
13 that?
14 A. As far as I'm aware, yes.
15 THE CHAIRMAN: And if the surgeon didn't direct it, the
16 nurse would prompt it?
17 A. Yes, as far as I'm aware.
18 MR WOLFE: And I know that it's a rather awkward question,
19 but can I ask you it in this way: applying the knowledge
20 that you have now, what do you think would have been the
21 indicators for an EP, an electrolyte profile, by the
22 morning of your treatment of Raychel?
23 A. If she had been on IV fluids and if the surgical doctors
24 had requested it.
25 THE CHAIRMAN: Let me just get the distinction. Is that

1 something that would happen automatically or would it be
2 triggered if she was vomiting?
3 A. I'm actually not working on the ward at the minute and
4 I really can't answer it in the context of today,
5 I don't know.
6 THE CHAIRMAN: Okay.
7 MR WOLFE: I'm conscious that you're not working in the ward
8 today, but there was clearly some significant learning
9 implemented after Raychel's death, and one of those
10 significant pieces of learning was the implementation of
11 daily urea and electrolyte testing, is that right --
12 A. As far as I'm aware, yes.
13 Q. -- in surgical patients who were in receipt of
14 intravenous fluids.
15 A. That's right, yes.
16 Q. Just before we move off this topic of hyponatraemia and
17 fluid management, in terms of managing a patient who was
18 in receipt of intravenous fluids in 2001, you would have
19 been aware of certain record keeping obligations --
20 A. Yes.
21 Q. -- and in the context of the UKCC standards for records
22 and record keeping?
23 A. Yes.
24 Q. You would have appreciated that, as the nurse caring for
25 Raychel, you ought to have been recording information

1 relating to her fluid management.
2 A. That's right, yes.
3 THE CHAIRMAN: In those days, I understand you didn't record
4 the amount of any urine that passed from Raychel or
5 other children; is that right?
6 A. No, we just said they passed urine.
7 THE CHAIRMAN: And that's why the notes show at one point
8 "PU".
9 A. Yes.
10 THE CHAIRMAN: I understand that the first occasion on which
11 a child passes urine is particularly noted, but that
12 seems to be the only entry in Raychel's record of
13 passing urine.
14 A. That's correct, yes.
15 THE CHAIRMAN: What should have happened?
16 A. All the episodes of urine should have been recorded.
17 THE CHAIRMAN: How do you arrange for that to be done in
18 2001? Is it just by chance that if you happen to see
19 a child going to the toilet you put PU in?
20 A. Usually whenever you'd be checking the drip, if it was
21 alarming on the hour, or if you were checking their
22 observations you would ask if the child had been to the
23 toilet in the last time that you'd been to see them and
24 you'd have asked the parent who was with them.
25 THE CHAIRMAN: And if the parent said "yes", you would put

1 "PU" on to the fluid balance sheet?
2 A. That's correct, yes.
3 THE CHAIRMAN: It didn't happen with Raychel.
4 A. It didn't, no.
5 THE CHAIRMAN: And it obviously should have happened.
6 A. It should have, yes.
7 THE CHAIRMAN: Can you tell me why it didn't happen?
8 A. I don't know.
9 THE CHAIRMAN: That's something that you knew to do
10 in June 2001?
11 A. I did, yes.
12 THE CHAIRMAN: And other nurses would have equally known to
13 do it in June 2001, would they?
14 A. I assume so, yes.
15 THE CHAIRMAN: Thank you.
16 MR WOLFE: Equally, with regard to fluid balance and other
17 output, in other words vomiting, that should have been
18 recorded. Am I right in saying that all episodes of
19 vomiting should have been recorded?
20 A. That's right, yes.
21 Q. And thirdly -- and we can get the care plan up
22 if we need to -- but there was a requirement also to
23 record any fluid input, in other words drinks --
24 A. That's right, yes.
25 Q. -- sips. And again, there appears to have been

1 a failure to record the fact that Raychel was having
2 sips. I do see mention of it in the episodic care plan,
3 but it wasn't recorded in the fluid balance chart.
4 A. No.
5 Q. Again, is that something that ought to have been handled
6 better?
7 A. I remember Raychel taking sips, they weren't huge
8 quantities, but even the word "sips" should have been
9 recorded, yes.
10 Q. Was that part of your thinking at the time? I know the
11 word "sips" appears in the episodic care plan, but when
12 it comes to the fluid balance chart, as we say, nothing
13 is recorded. Was part of your difficulty the fact that
14 the sips were of small measure?
15 A. They were just that, they were just sips, they
16 weren't -- you couldn't have -- they weren't a quantity
17 that you could have wrote down, but I could have wrote
18 the word "sips", yes.
19 Q. And you think you should have done that?
20 A. I probably should have, yes.
21 Q. You came on duty on 8 June and you participated in the
22 nursing handover; isn't that right?
23 THE CHAIRMAN: Before we go to that, we have been going
24 since just after 10, so let's give the stenographer
25 a break. We'll resume at 12.

1 (11.50 am)
2 (A short break)
3 (12.06 pm)
4 MR WOLFE: Staff Nurse McAuley, on the morning of 8 June you
5 came on duty at about 7.45 --
6 A. That's right, yes.
7 Q. -- and you attended a handover.
8 A. That's right, yes.
9 Q. You may not recall this, but the handover was delivered
10 by Staff Nurse Noble.
11 A. I have no recollection of who handed-over.
12 Q. Can you recall what you were told about Raychel's
13 overnight condition?
14 A. I have no recollection, but I assume I'd have been told
15 that she was post appendix and had IV fluids in situ and
16 she was maybe still fasting.
17 Q. At that time of the morning, Sister Millar was in charge
18 of the ward; is that right?
19 A. That's right, yes.
20 Q. And you were one of a number of nurses on duty. Staff
21 Nurse Roulston, can you remember her being on duty?
22 A. I can, yes.
23 Q. And there is a nursing auxiliary?
24 A. That's right, yes.
25 Q. Staff Nurse Roulston recalls that you and her were

1 allocated to rooms A to I -- I think she says A to J,
2 but leaving aside that small difference of view --
3 can you remember that those were the duties you were
4 allocated to?
5 A. That's right, yes.
6 Q. Staff Nurse Roulston recalls that at some point in the
7 day she was asked to cover the infant unit --
8 A. That's right, yes.
9 Q. -- because a staff member had gone off sick.
10 A. Yes.
11 Q. The fact that a staff nurse member had gone off sick,
12 did that lead to a replacement of that nurse or did
13 you have to cope with being one down in terms of your
14 numbers?
15 A. I had to cope with being one down.
16 Q. Did that create extra pressure for you and
17 Nurse Roulston?
18 A. Nurse Roulston was replaced or had been allocated to the
19 infant unit.
20 Q. As I understand the position, and correct me if I'm
21 wrong, initially she was allocated to work on the same
22 number of rooms as you, if you like in tandem, rooms A
23 to I or A to J, whatever it is, but at some point she
24 was allocated to the infants' unit?
25 A. That's correct, and then she was covering my breaks.

1 Q. Yes. So she was primarily focussed on the infant unit,
2 but when you went off on break, Staff Nurse Roulston
3 covered you?
4 A. That's right, yes.
5 Q. Did that leave the infant unit under-resourced?
6 A. I believe there was another nurse in the infant unit as
7 well.
8 Q. Right.
9 THE CHAIRMAN: But in broad terms, the number of nurses on
10 shift is probably not very generous at the best of
11 times, so if you lose one nurse, then everyone is under
12 a bit more pressure and you just have to cope as best
13 you can; is that fair?
14 A. That's right, yes.
15 MR WOLFE: What sacrifices, if any, have to be made if
16 you're a nurse down? Can I put a particular example to
17 you: does it lead to a compromise in terms of the number
18 of visits you're able to make to patients or do you have
19 to do things quicker and more efficiently?
20 A. You are probably doing things quicker and more
21 efficiently. You'd just be -- you wouldn't be
22 compromising patients' care.
23 THE CHAIRMAN: And in Raychel's case, because the alarm was
24 going off approximately every hour or so, you had to be
25 into her bedside every hour; isn't that right?

1 A. That's right, yes.
2 THE CHAIRMAN: So if anybody was going to have a gap in
3 their nursing, it was probably not going to be Raychel;
4 it might be another child who didn't have an alarm going
5 off every hour?
6 A. That's possible.
7 MR WOLFE: Do you agree with that, that the fact that you
8 were a nurse down, if you like, that had no impact on
9 the quality of care that you were able to deliver to
10 Raychel?
11 A. I believed I was able to give her the same quality of
12 care, yes.
13 Q. As she started off that day, you would have recognised
14 that Raychel was a surgical patient.
15 A. That's right, yes.
16 Q. And that, in more extended terms, means she was under
17 the care of the surgical team.
18 A. That's right, yes.
19 Q. What was your understanding at that time in terms of, if
20 you needed a doctor to attend Raychel, who would you
21 contact?
22 A. I believed you'd have bleeped the surgical JHO attached
23 to the consultant whose care she was under.
24 Q. So that would be your first port of call?
25 A. If it was to contact someone from the surgical team?

1 Q. Yes.
2 A. Yes.
3 Q. Obviously, this is a paediatric ward and paediatricians
4 would regularly have been in attendance on the ward,
5 paediatric medical doctors.
6 A. That's right, yes.
7 Q. What were the circumstances in which you could have
8 approached them for assistance?
9 A. Times if you had a child that was critically ill, you
10 could have asked them, and on occasions you'd have asked
11 them to prescribe fluids.
12 Q. Just as you did with Dr Butler later on in the morning?
13 A. That's right, yes.
14 THE CHAIRMAN: So you would turn to them in an emergency?
15 A. Yes.
16 THE CHAIRMAN: And you would turn to them for something
17 which is apparently very basic, but it's not worth
18 getting a surgeon in from another department?
19 A. Sometimes if you had to wait for a surgeon to come, the
20 fluids would have run out and then there would be
21 nothing left and then there would have been a gap in the
22 administration of fluids.
23 THE CHAIRMAN: And because it seems such a basic thing to
24 renew the fluids, there doesn't seem to be any risk
25 involved in getting a paediatrician to do it?

1 A. I didn't believe so, no.
2 MR WOLFE: So we're still at this early morning phase at or
3 about the time of the handover. Obviously, Raychel was
4 going to be one of your patients for the day, and the
5 information that can be conveyed during a short handover
6 is presumably not very detailed, not very extended;
7 is that fair?
8 A. It would give you enough information to approach the
9 child and make your own judgment of how she was to be
10 nursed during your shift.
11 Q. Right. Obviously there's a set of notes that come with
12 every patient.
13 A. There is, yes.
14 Q. And the inquiry heard evidence yesterday about notes, if
15 you like, known as a chart, the chart which stays by the
16 bedside.
17 A. Yes.
18 Q. And then another bundle of notes which are held
19 separately -- somebody referred, I think, to the nursing
20 trolley --
21 A. Yes.
22 Q. -- which might have been kept in the back office behind
23 reception.
24 A. That's right, yes.
25 Q. Does that all make sense?

1 A. Yes.
2 Q. And did you hear that evidence yesterday? I think it
3 was probably Staff Nurse Patterson who gave the
4 evidence.
5 A. I didn't hear.
6 Q. You weren't here?
7 A. No.
8 Q. And can you recall what was held at the bedside and
9 what was held elsewhere in Raychel's case?
10 A. It would have been her meds kardex, fluid chart,
11 observation chart. Then it would have been her
12 admission details and just her evaluations held in the
13 office in a folder.
14 THE CHAIRMAN: The kardex, the fluid chart and the
15 observation chart are at the bedside; everything else is
16 at the office?
17 A. Yes.
18 MR WOLFE: Was that a standard arrangement in your
19 experience?
20 A. Yes, as far as I'm aware, yes.
21 Q. Is that the way documents, notes and records, are
22 arranged to this day?
23 A. As far as I'm aware, yes.
24 Q. Say if a doctor came or was called to see a child and
25 needed to see broader or wider background documents, can

1 they simply ask the nurse for access to them?
2 A. They can, yes.
3 Q. In terms of your familiarisation with Raychel's case,
4 obviously you had received a handover report.
5 A. Yes.
6 Q. Did you go and look at her notes and records to see in
7 a bit more detail what her situation was?
8 A. It wasn't the routine practice at the time to do that.
9 Q. Obviously, as you worked with Raychel during the day,
10 you would be going back and forward to the chart which
11 was held at the bedside.
12 A. That's right, yes.
13 Q. During evidence from some nurses, we have heard of
14 a concept called family-centred care; were you familiar
15 with that concept in 2001?
16 A. Yes.
17 Q. And can you outline for us what your understanding of it
18 was?
19 A. To enable the -- for the families to be involved with
20 the care of their child while they were in hospital.
21 Q. And how was that concept promoted in cases? How would
22 you encourage the involvement of family in the care of
23 their children?
24 A. Whenever you -- in my experience, whenever you'd have
25 been doing an admission, you'd have gone through the

1 details about the ward, the routine and the working of
2 the ward with the family on their admission information.
3 THE CHAIRMAN: So if the world that they're entering with
4 their daughter is strange to them, you have done what
5 you can to make them feel as relaxed as they can be?
6 A. Yes.
7 THE CHAIRMAN: In that they know where things are on the
8 ward and they have a general idea of what to expect?
9 A. Yes.
10 MR WOLFE: A surgeon's ward round or a surgical ward round
11 appears to have occurred shortly after the handover.
12 A. Yes.
13 Q. Did you attend at that ward round?
14 A. I didn't, no.
15 Q. It would appear that a Mr Zafar, who was an SHO on the
16 surgical side, conducted the ward round and was attended
17 by Sister Millar. Did you know that the ward round was
18 happening?
19 A. I didn't know -- I would have been aware if there would
20 have been ward rounds going on and would have been aware
21 of the ward round probably -- I'm not sure at the time
22 if I was aware of the exact time it was going on, but
23 that it had happened and the document was on the
24 treatment book of what occurred during the ward round.
25 Q. The process appears to be that the sister or the nurse

1 in charge of the ward would attend the visiting doctor;
2 is that right?
3 A. That's right, yes.
4 Q. And then it would be the responsibility of the lead
5 nurse to communicate any actions or any plan for the
6 child for the rest of the day?
7 A. That's right, yes.
8 THE CHAIRMAN: Sorry, the lead nurse being the sister?
9 MR WOLFE: In this case it was the sister.
10 A. Yes.
11 THE CHAIRMAN: The sister then communicates with you and
12 Staff Nurse Roulston because you're in charge of Raychel
13 and that's the part of Ward 6 that you and Raychel [sic]
14 are in charge of.
15 A. Yes.
16 THE CHAIRMAN: Okay. Do you remember being told what the
17 outcome of this was?
18 A. I don't know if I remember being told or if I just
19 remembered seeing it wrote on the treatment book.
20 I can't remember exactly how I found out.
21 THE CHAIRMAN: I'm not sure that there is an entry in the
22 treatment book. This is the plan, in effect, which
23 appears to be a fairly standard plan after an
24 appendicectomy that, as the day goes on, the child will
25 be given some fluids orally. And you hope, as the day

1 goes on, to reduce the fluids and then stop them
2 altogether.
3 A. That could have possibly been verbally passed over.
4 THE CHAIRMAN: Yes. First of all, that would be a standard
5 way of treating a child in that situation, wouldn't it?
6 A. Yes.
7 THE CHAIRMAN: And that might be passed over to you
8 verbally?
9 A. Yes.
10 THE CHAIRMAN: Okay, Mr Campbell?
11 MR CAMPBELL: There was an entry in the treatment book by
12 Sister Millar at reference WS056/2, page 29.
13 THE CHAIRMAN: Is that also in file 20 in the hospital
14 notes?
15 MR CAMPBELL: I think it does appear on more than one
16 occasion, but it was appended to Sister Millar's
17 statement.
18 THE CHAIRMAN: Thank you.
19 MR WOLFE: That was one of the curiosities: it doesn't
20 appear in file 20, but it was shown to the police at the
21 time of the 2005 investigation and, as my learned friend
22 says, it's on the screen in front of us as an appendix
23 to Sister Millar's statement.
24 The inquiry has received a description of the
25 purpose of this treatment book from Therese Brown, and

1 it appears to be a book which is completed during the
2 ward round by sister, she has that with her, she
3 completes it contemporaneously so that she doesn't
4 forget as she goes from bed to bed. And then she
5 communicates verbally anything that she's been told and,
6 in any event, the book is available to her nursing staff
7 to consult as and when they require.
8 A. That's right, yes.
9 Q. Does that description accord with your understanding?
10 A. That's right, yes.
11 Q. Could I have up on the screen, please, Staff Nurse
12 McAuley's witness statement? It's WS051/1, page 3. If
13 we could highlight the first paragraph, please, where
14 you record, Staff Nurse McAuley, that:
15 "Raychel was seen by the surgical doctors and was
16 allowed sips of fluid as tolerated and to continue on
17 her intravenous fluids."
18 Is that your understanding of the fluid plan for
19 Raychel that day?
20 A. Yes.
21 Q. So it was your understanding that she was to be allowed
22 sips of water immediately?
23 A. I don't know. I can't recall when she was allowed to
24 have sips of water.
25 Q. Well, do you have any recollection of there being any

1 issue or problem that would have prevented her from
2 having sips immediately?
3 A. I'm not aware. I know it was late morning before she
4 had any sips.
5 Q. Late morning before she had any sips?
6 A. Yes.
7 Q. And if she was tolerating oral fluids, was there a plan
8 for that situation?
9 A. It would have been to reduce the IV fluids if she was
10 tolerating oral fluids.
11 Q. At any stage was she tolerating sips of fluids?
12 A. She took a few sips, but she was vomiting.
13 Q. So she wasn't tolerating them?
14 A. She was taking sips, but I don't know how long after she
15 took the sips that she had vomits. So she could have
16 been tolerating them for a short period.
17 Q. We know that Raychel had been receiving Solution No. 18
18 at a rate of 80 ml per hour preoperatively --
19 A. Yes.
20 Q. -- and that after she came out of her operation, those
21 fluids were simply recommenced.
22 A. Yes.
23 Q. There wasn't a separate or second fluid prescription?
24 A. Not that I'm aware.
25 Q. And leaving aside what may or may not have happened in

1 theatre, the next person to look at Raychel's fluid
2 regime was apparently Dr Zafar, who came as part of the
3 ward round.
4 A. Mm-hm.
5 Q. Can I ask you this --
6 THE CHAIRMAN: I think he's a Mr. He's a surgeon, isn't he?
7 MR WOLFE: He probably is, yes.
8 At that time, what was your understanding of
9 the arrangements for post-operative fluids for children?
10 A. That it was they were able to tolerate oral fluids,
11 their intravenous fluids would be reduced.
12 THE CHAIRMAN: Sorry, go one step back from that before we
13 get to the stage of seeing if the patient can sip
14 fluids. In terms of what IV fluid a child would go on
15 after an operation, did you have any understanding of
16 how that related to the IV fluid she was on before the
17 operation?
18 A. I didn't know.
19 MR WOLFE: I'm not saying you did do this, but clearly
20 consideration of the fluid balance charts that were
21 available to you would have made it obvious, would it
22 not, that she was on the same regime, both pre and
23 post-operatively?
24 A. Yes, I would have been aware of that.
25 Q. And can you help us with this: maintaining a consistent

1 approach pre and post-operatively both in terms of the
2 type of fluid and the rate of fluid, was that the normal
3 arrangement in your experience?
4 A. At the time that was the practice and that's what I was
5 aware of.
6 Q. And can you say whether it was a practice which surgeons
7 carrying out the ward rounds would have been aware of?
8 A. I can't say.
9 Q. Why can't you say?
10 A. I'm not sure if the surgeons were aware of it, I don't
11 know.
12 Q. It is the case that, during the ward round, surgeons
13 were generally interested in looking up what fluids the
14 children were on?
15 A. They would have, yes.
16 THE CHAIRMAN: I think you can take it that since it's the
17 doctor who prescribes fluids, that's something which the
18 doctor should cover on the ward round and it's not
19 primarily your responsibility at all, it's the doctor's,
20 isn't it?
21 A. It's the doctor's responsibility.
22 THE CHAIRMAN: So when the doctor comes on the ward round,
23 he should see what fluid the child is on and decides
24 whether the child stays on that fluid or not.
25 A. He prescribes the fluid.

1 THE CHAIRMAN: And if he doesn't know what fluid the child
2 is on, he enquires and finds out?
3 A. Yes.
4 MR WOLFE: We know in Raychel's case that the fluids weren't
5 reduced in rate, either immediately post-operatively or
6 at all. She continued on the same rate throughout the
7 day; isn't that right?
8 A. That's right, yes.
9 Q. The experts who have looked at this issue for and on
10 behalf of the inquiry, but also Mr Orr, who's provided
11 a report for and on behalf of the Trust, have
12 articulated the opinion that fluids post-operatively
13 should be reduced in their rate. As I say, clearly that
14 didn't happen. But can I ask you this: at that time in
15 2001, were you capable of calculating what fluids for
16 maintenance a child should have based on their weight?
17 A. That was outside my responsibility.
18 THE CHAIRMAN: I'm sorry, the question is a bit different.
19 Forgetting about whether it's part of your
20 responsibility, would you know how to do the calculation
21 of how much fluid a child should be getting?
22 A. No.
23 THE CHAIRMAN: Okay. Well, would you have been able to
24 recognise in June 2001 if a child was obviously getting
25 too much fluid or too little fluid?

1 A. If there was a small child who was getting a huge
2 amount, yes, but I would have felt if it was a toddler
3 age getting 80 ml, that was too much, or if it was an
4 older child getting 20 or 30 ml, I don't know if that
5 was too little, but that was ...
6 THE CHAIRMAN: So you would recognise the extremes, but
7 where there was 50 or 60 or 80, you wouldn't have known
8 that?
9 A. I wouldn't, no.
10 MR WOLFE: Can I ask the question in this way. Raychel was
11 on 80 ml per hour. Some of the experts say that should
12 have been 65 ml per hour for maintenance. But then they
13 say that post-operatively, there's an argument for
14 reducing that still further, reducing it by a further
15 20 per cent, which would bring it down to something
16 in the region of 54 ml per hour. Something in that
17 region. So what she's getting is 80, some of the
18 experts say she should be getting something closer to
19 50. First of all, had you been taught at that time
20 about the need in certain circumstances to reduce fluids
21 post-operatively?
22 A. I wouldn't have had any teaching, I wouldn't have been
23 taught that.
24 Q. The theory is that patients post-operatively have
25 a tendency to retain free fluid within their system and

1 therefore you reduce the amount of fluid going in so
2 that you don't end up with excess fluid. Is that
3 something you were taught?
4 A. I did not have that knowledge at the time, no.
5 Q. So is it fair to say that you didn't give any
6 consideration to whether the fluid that she was
7 receiving was appropriate in terms of its rate?
8 A. I felt that because it was prescribed by the doctor,
9 that that was the appropriate rate for Raychel.
10 I didn't give it any further consideration.
11 THE CHAIRMAN: Because it had been prescribed by the doctor
12 and it wasn't obviously wrong to you?
13 A. That's right, yes.
14 MR WOLFE: Could I have up on the screen, please, the fluid
15 balance chart, 020-018-037? This is the fluid balance
16 chart which was opened for the day of your involvement
17 with Raychel. Could you just help us, now that we have
18 it here in front of us, in terms of what entries you
19 made?
20 A. At 10 o'clock, I recorded the vomit and that she passed
21 urine. At 11 and 12 I had recorded the fluids, again
22 then at 3 and 4 and 7.
23 Q. The vomit at 8 o'clock; was that recorded by you?
24 A. No.
25 Q. There's two further vomits during the day, if you like:

1 one at 1300 hours, and I understand that to have been an
2 entry made by Staff Nurse Roulston --
3 A. Yes.
4 Q. -- and at 3 o'clock, although your name appears in the
5 signature box at 3 o'clock, that's you signing off to
6 the effect that you had checked the fluid in the
7 intravenous system?
8 A. Yes.
9 Q. That's not you signing off as having recorded that
10 vomit; is that right?
11 A. No.
12 Q. I understand that that vomit has been entered by Staff
13 Nurse Roulston again.
14 A. It may have been, yes.
15 Q. In terms of the symbolism that is used here, you've used
16 the language "large vomit"?
17 A. Yes.
18 Q. But another nurse, presumably Nurse Roulston, has
19 written in "vomited plus plus".
20 A. Yes.
21 Q. If you hadn't had any opportunity to speak to
22 Nurse Roulston when you were on duty, what would
23 you have interpreted that to have meant?
24 A. A medium vomit.
25 Q. And how would you have known that that was what was

1 being conveyed by that symbol?
2 A. During nurse training we'd have been taught the symbols
3 of the pluses and how much they equated to.
4 Q. So a small vomit would be one plus; is that right?
5 A. As far as I'm aware, yes.
6 Q. Three pluses would equate to a large vomit?
7 A. Yes.
8 Q. The first vomit of the day at 0800 hours, was that
9 brought to your attention verbally?
10 A. Not that I'm aware.
11 Q. In other words, you didn't have a discussion with
12 anyone?
13 A. No.
14 THE CHAIRMAN: Do you remember that when you recorded the
15 vomit at about 10 am that there was already a vomit
16 recorded at about 8 am?
17 A. I probably would have noted it then, but I can't
18 remember, I can't recall.
19 THE CHAIRMAN: There seems to be a bit of a mystery about
20 who recorded this. Can you help us on that?
21 A. I don't know.
22 MR STITT: May I make the observation that the question was
23 framed as, "Were you aware of the vomit at 8 am?", but
24 my point is it's at 8 am. The box doesn't give the
25 option. That is the nearest appropriate hour to any of

1 these entries.
2 THE CHAIRMAN: So it's 8-ish rather than 8 am exactly.
3 MR STITT: We can obviously refer to the oral testimony and
4 we can refer to the statements, but as regards this
5 form --
6 MR WOLFE: Yes, an entry is made and, in terms of the timing
7 of the vomit, it has been observed, a vomit has been
8 observed sometime within the hour from 7 to 8, is that
9 right, or is it between 8 and 9?
10 A. I'd say 8 and 9.
11 Q. And obviously a nurse could choose to add further
12 information if they wanted by indicating a specific
13 time, but that doesn't appear to have been done.
14 A. It wouldn't have been practice at the time.
15 Q. But my question to you was: in terms of that vomit, you
16 can't recall it being the subject of any great
17 discussion?
18 A. I have no recollection of any discussion.
19 Q. You had received a report of Raychel having a good
20 overnight recovery and this was the first vomit.
21 THE CHAIRMAN: Sorry, which was?
22 MR WOLFE: At 8 o'clock.
23 In a child following surgery, the inquiry has heard
24 that vomiting isn't regarded as being terribly unusual.
25 A. No.

1 Q. Because during surgery, a child will receive opioids and
2 other drugs, which can trigger vomiting.
3 A. That's correct.
4 Q. What is the nursing approach to a patient who is showing
5 signs of vomiting? Is the approach to keep a close eye
6 on the child or what is the -- is there a standard
7 approach?
8 A. Well, you'd be providing the child with some tissues and
9 some sick dishes if they were going to be sick and
10 making sure that their oral care is being carried out
11 and that you record episodes of vomit. And if it's
12 persistent, you contact a doctor so that would be the
13 sort of nursing care that would be provided to all
14 children that are vomiting.
15 THE CHAIRMAN: At what stage do you regard it as persisting
16 to the extent that you call the doctor? When you made
17 your entry, I'm assuming that when you made your entry
18 at about 10 am that it was a large vomit and that you
19 then saw there was a vomit recorded at about 8 am.
20 A. Yes.
21 THE CHAIRMAN: Would two vomits be persistent enough for you
22 to call a doctor?
23 A. You would take the whole picture and you would assess
24 how the child looks at the time. If she hadn't got
25 fluids, I probably would have been thinking maybe more

1 along the line of dehydration, as she would have needed
2 IV fluids, but I would have taken her observations. If
3 they were within normal limits, if she looked okay -- at
4 that stage, she was up and about mobilising, so I didn't
5 feel there would be a need to contact a doctor.
6 THE CHAIRMAN: We'll go on as the day goes on to see the
7 point at which you did think there was a need to call
8 the doctor.
9 A. Yes.
10 MR WOLFE: The vomit that you have entered at or between 10
11 and 11, we actually have a -- could I put on the screen
12 and then we'll come back to the fluid chart,
13 020-015-027? This is described as a "feed chart".
14 A. Yes.
15 Q. Is that your writing?
16 A. No.
17 Q. Do you know whose writing it is?
18 A. I don't.
19 Q. So do you have any understanding whether this relates to
20 the vomit that you recorded in the fluid balance chart?
21 A. I don't know.
22 Q. In terms of the people who might have made the entry, is
23 it fair to say that it was either you, Sister Millar or
24 Staff Nurse Roulston?
25 A. It could be anybody.

1 Q. But who else would have had authority to make an entry?
2 A. Any staff on the ward at the time if they were handed a
3 vomit bowl.
4 THE CHAIRMAN: Like Mrs Bryce, who was passing later on that
5 night and was handed a bowl by Mr Ferguson?
6 A. Yes.
7 THE CHAIRMAN: So she then makes an entry about it. Even
8 though she is not directly involved in Raychel's care,
9 it's drawn to her attention, so she gets rid of the
10 vomit and makes the entry.
11 A. That's right, yes.
12 THE CHAIRMAN: Can you help us on this? If you look at
13 this, which is at 10.25, a recording of large vomit, and
14 we know that on the fluid balance sheet that was up
15 a moment ago at 10 am there's an entry of a large vomit.
16 Do you interpret those as being the same thing? Because
17 it seems to me -- and please correct me if I'm wrong --
18 that since you were making the entry, and since you and
19 Nurse Roulston were in charge of this part of Ward 6,
20 it's unlikely that anyone else would have come along and
21 made the same entry. That makes me think: is this
22 actually a second large vomit at some time at about
23 10.25, separate from the one which you've recorded?
24 A. I don't know.
25 THE CHAIRMAN: We would just be guessing, would we?

1 A. Yes.
2 THE CHAIRMAN: Okay.
3 MR QUINN: Mr Chairman, I just want to bring up the timeline
4 chart, which shows that there was only Sister Millar,
5 Nurse McAuley and Nurse Roulston on duty that day. So
6 there were more nurses and an auxiliary on later on, so
7 someone, as you said, sir, could have come past and
8 picked up on it and entered the record, but it seems
9 that as there were only three on duty, and Sister Millar
10 said it wasn't her, Nurse McAuley who's in the witness
11 box says it wasn't her, that leaves Nurse Roulston,
12 unless the auxiliary staff have an authority to do it,
13 and perhaps that question should be asked.
14 MR WOLFE: In terms of the evidence we've heard, I don't
15 think that is correct, Mr Quinn. I think we've heard
16 from Sister Millar, who described other nurses. In fact
17 you'll recall the sequence, Mr Quinn, where in the
18 afternoon Sister Millar who went to her office recalled
19 -- I think Staff Nurse Wilson may have been one of the
20 names she used -- who were on duty elsewhere in Ward 6.
21 THE CHAIRMAN: I think there's more than three people on
22 Ward 6.
23 MR QUINN: Yes. But they were the ones on duty in this
24 area.
25 THE CHAIRMAN: In the same way that, later on that night,

1 Mrs Bryce happens to be passing and makes the entry;
2 okay?
3 MR QUINN: I see where you're going.
4 MR WOLFE: Mrs Patterson passing.
5 THE CHAIRMAN: Mrs Patterson, sorry.
6 MR CAMPBELL: The same point, sir, to the effect that the
7 personnel in the baby unit could have been the people
8 who made that entry.
9 THE CHAIRMAN: I think the point of the chart, Mr Quinn, is
10 to highlight the names of the people who were most
11 directly involved rather than purporting to be
12 a comprehensive list of who's on duty.
13 MR QUINN: I see that.
14 MR STITT: Back to the fluid balance chart and the point I
15 made earlier about the times being preset. It may be
16 put to the witness, but 10.25 is within that ambit of
17 10 o'clock if you follow me. It's closer to 10 o'clock
18 than 11 o'clock.
19 THE CHAIRMAN: It is. It is just a rather curious thing.
20 We know that as a fact, that other vomits are not
21 recorded in this fluid balance chart. And it would be
22 then rather curious if there was a double-entry for one
23 vomit, a double-entry in the sense that it's on the
24 fluid balance chart at 10 am and then someone opens a
25 separate sheet for it, which is the sheet on the screen

1 at the moment.
2 It's possible.
3 THE CHAIRMAN: But it's curious.
4 MR STITT: Might I put forward the contention that it's
5 actually probable? And put it for this reason. It's
6 the one descriptive vomit as opposed to pluses in the
7 same term -- there may be one later in the day, I beg
8 your pardon.
9 THE CHAIRMAN: I'm not sure we'll ever get an answer to
10 this, but for instance if Nurse Roulston is recording
11 a large vomit as plus plus or plus -- I'm told that
12 that's a medium vomit, plus plus -- that rather suggests
13 this isn't Nurse Roulston who's recording that large
14 vomit.
15 MR STITT: I'm not dealing so much with the identity of the
16 person who is doing it; the term "large vomit", by
17 coincidence, is the same term that this witness used and
18 is the same term that fits in the 10 o'clock box and
19 also fits in at 10.25 on the other form, which is within
20 the 10 o'clock frame rather than the 11 o'clock frame.
21 THE CHAIRMAN: Okay, thank you.
22 MR WOLFE: Can I take you to the descriptor? If we go back
23 to the fluid balance chart, which you did record; do you
24 still have that reference? You've described the vomit
25 as "large".

1 A. That's correct.
2 Q. As I understand from your witness statement, you didn't
3 actually witness the act of vomiting on the part of the
4 child; isn't that right?
5 A. That's right, yes.
6 Q. But you took possession of vomit bowl and disposed of
7 it; is that right?
8 A. That's right.
9 Q. Did anyone else see the vomit bowl apart from the parent
10 presumably giving it to you and yourself?
11 A. I believe it was Sister Millar who gave it to me.
12 Q. And you were asked to dispose of it?
13 A. Yes.
14 Q. Did you have any discussion between yourselves apart
15 from, "Please dispose of this"?
16 A. No.
17 Q. Was there any discussion about, if you like, the volume
18 of the vomit contained within the receptacle?
19 A. Not at the time, no.
20 Q. She didn't tell you, for example, "That's a large vomit,
21 please record it"?
22 A. No.
23 Q. Okay. But you chose the descriptor "large vomit"?
24 A. I made the assumption, yes.
25 Q. Sorry?

1 A. I made the assumption of a large vomit, yes.
2 Q. I don't understand the word "assumption" in this
3 context.
4 THE CHAIRMAN: From what you saw --
5 A. From what I saw at that time, with the knowledge that
6 I had, I recorded it as a large vomit.
7 MR WOLFE: If I could have what you told the coroner up on
8 the screen, please, 012-042-206? The first entry in the
9 handwritten sequence:
10 "I recorded the 10.30 am vomit ..."
11 That might actually help us, sir, in terms of the
12 last document we were having a bit of a debate about.
13 In any event:
14 "I recorded the 10.30 am vomit as 'large' but it was
15 not very large. To me she seemed bright and alert."
16 By the time of the coroner's inquest in 2003, staff
17 nurse, you were already starting to equivocate at that
18 time about whether this was a large vomit or something
19 less than a large vomit.
20 A. Yes.
21 Q. Do you follow?
22 A. Yes.
23 Q. What was causing you by that stage to doubt that this
24 was in fact a large vomit?
25 A. I believe prior to the inquest I'd been -- put fluid

1 into a sick bowl and we'd been discussing whether it was
2 a large vomit or what we would have classified it as,
3 and following that discussion, along with the experience
4 that I would have gained in the two years since the
5 incident, that I would have probably classified it as
6 a medium vomit.
7 THE CHAIRMAN: If you use the pluses as an indicator, plus
8 plus is medium; is that right?
9 A. Yes.
10 THE CHAIRMAN: Plus plus plus is large?
11 A. Yes.
12 THE CHAIRMAN: And four pluses is very large?
13 A. Yes.
14 THE CHAIRMAN: Right. What you told the coroner was it was
15 large but not very large. So it was three pluses, not
16 four?
17 A. Two pluses, not three.
18 THE CHAIRMAN: No, that's medium. Two is medium.
19 A. I think I was ... I said that it was -- whenever I was
20 correcting myself, I said it was a medium vomit.
21 I don't believe it's there.
22 THE CHAIRMAN: No, something quite different is there,
23 Ms McAuley, signed by you, which is not that it's
24 medium, but it was large but not very large. Anyway,
25 this isn't -- you're only one of the people involved in

1 this. I'm afraid there's a rather unhappy inconsistency
2 between how people describe vomits, and I know you can't
3 get it absolutely right, but some people are writing
4 "large", some people are just writing "vomit", and other
5 people are putting two pluses. So somebody coming along
6 afterwards might have some difficulty in recognising the
7 volume of Raychel's vomits as opposed to the number of
8 vomits. Let's move on.
9 MR WOLFE: You explain your evidence to the coroner in terms
10 of your reduction in your definition of the volume.
11 You're saying it's large, but not very large.
12 A. Mm-hm.
13 Q. In terms of the experience that you'd had in the ensuing
14 two years --
15 A. Yes.
16 Q. -- it's almost causing you to try and reclassify this
17 vomit.
18 A. Yes.
19 Q. Could I have up on the screen, please, the statement you
20 made ten days after Raychel's death? 20 June 2001.
21 It's at 022-099-311. You'll recognise this as your
22 statement.
23 A. Yes.
24 Q. Was that a statement you were asked to provide to the
25 Trust?

1 A. I think it was a statement that we had to do at the
2 time, shortly after the event, yes.
3 Q. Yes. Were you asked to set out in the statement as full
4 an account as you can remember of the important events
5 of that day?
6 A. I was given no advice on how to do it. It would have
7 been probably my first statement that I ever wrote, and
8 it was just that, it was something that I wrote and
9 I was given no guidelines of how much detail to put into
10 it.
11 Q. So what purpose was the statement to serve; were you
12 told that?
13 A. No.
14 Q. Well, who asked for it?
15 A. I have no recollection.
16 Q. So you don't know who asked you for it, you don't know
17 what you were doing it for?
18 A. I knew it was because -- if an incident happens, you
19 have to record a statement after an incident.
20 Q. So what were you told to do?
21 A. The events of the day.
22 Q. Write a statement setting out the events of the day?
23 A. I don't know what the exact words of what I was told to
24 do.
25 Q. I'm sure you don't, but broadly speaking, staff nurse,

1 what were you told to do?
2 A. Write a statement.
3 Q. About what?
4 THE CHAIRMAN: Writing up the events of the day.
5 MR WOLFE: Okay.
6 Looking at this statement, you go through the
7 various events and then at the start of the second
8 paragraph, you enter into a discussion about the vomits;
9 okay?
10 A. Mm-hm.
11 Q. "She had a couple of small to medium vomits of
12 undigested food."
13 Do you see that?
14 A. Yes.
15 Q. This is merely ten days after the event; isn't that
16 right?
17 A. Yes.
18 Q. And you would not, in that period of time, have
19 developed any greater experience of observing vomit and
20 classifying vomit --
21 A. No.
22 Q. -- which you say was at the back of how you had to give
23 your evidence to the coroner.
24 A. Yes.
25 Q. Why is it merely ten days after Raychel's death that

1 you're reclassifying vomits, one of which you had
2 clearly recorded as being large at the time?
3 A. I don't know.
4 Q. Could I ask you this: was there an attempt on your part
5 to reclassify the volume of vomit in order to create an
6 impression that the vomiting wasn't particularly
7 significant?
8 A. No.
9 Q. Can you explain why you didn't indicate in your
10 statement that the one vomit that you recorded on the
11 fluid balance chart, which you described as "large"
12 at the time, was not reported as large when you wrote
13 this statement?
14 A. I don't understand the question, sorry. Could you
15 repeat it?
16 Q. You are asked to set out a statement recalling the
17 events of that day.
18 A. Yes.
19 Q. You have set out a description of the vomits that you
20 were aware of.
21 A. Yes.
22 Q. The one that you recorded in the fluid balance chart was
23 "a large vomit".
24 A. Yes.
25 Q. And was that your understanding of a large vomit at that

1 time?
2 A. Yes.
3 Q. It's only after a couple of years of further nursing
4 experience that you would categorise that vomit as not
5 being very large?
6 A. Yes.
7 Q. But here you are, ten days after the event, already
8 reclassifying the vomits, and in particular with regard
9 to the large vomit. It doesn't get a mention.
10 A. I don't believe I was reclassifying. I believe when
11 I wrote that statement I hadn't got any access to any
12 notes and that was just from memory. I hadn't any of
13 the nursing or medical notes when I was making my
14 statement.
15 THE CHAIRMAN: Maybe I've got confused here. Do you see
16 at the start of the second paragraph on that page, the
17 first line is:
18 "She had a couple of small to medium vomits."
19 In the middle of the page.
20 A. Yes.
21 THE CHAIRMAN: Does that include the vomit at about 10 or
22 10.25, which you have put into the notes as a large
23 vomit?
24 A. I assume.
25 THE CHAIRMAN: Right. So what was a large vomit on 8 June

1 is the small to medium vomit on 20 June?
2 A. I believe one was the small, which could have been the
3 8. The medium must have been ...
4 THE CHAIRMAN: Sorry, the one at 8 wasn't small, the one at
5 8 was just described as a vomit. It's not described as
6 small, medium or large. So you wouldn't have -- unless
7 you knew by then who had recorded the 8 o'clock vomit,
8 which is information I don't have, you wouldn't have
9 known whether the 8 o'clock vomit was small, medium or
10 large --
11 A. I wouldn't have known.
12 THE CHAIRMAN: -- according to the fluid balance sheet.
13 A. I wouldn't have known.
14 THE CHAIRMAN: So there is a vomit which is not described at
15 all on the fluid balance sheet in terms of size at
16 8 o'clock and there's a large vomit as described by you
17 at about 10 o'clock and that's on 8 June. When you make
18 a statement on 20 June you refer to "a couple of small
19 to medium vomits" and that's before you get into the
20 afternoon, because a few lines down, you say:
21 "In the afternoon she vomited a couple of times and
22 I bleeped the surgical JHO."
23 And I think that those two later vomits are the ones
24 at about 1 o'clock and about 3 o'clock, aren't they?
25 A. Yes, I believe so.

1 THE CHAIRMAN: In your statement here when you describe the
2 small to medium vomits, that includes one which you had
3 described as "large" in the notes on that morning.
4 A. Yes.
5 THE CHAIRMAN: Can you explain to me how, unless in
6 a fortnight a large vomit became a small to medium
7 vomit?
8 A. I cannot explain.
9 THE CHAIRMAN: Thank you.
10 MR WOLFE: It's the same evidence that you were to give to
11 the coroner in your deposition; isn't that right?
12 A. I believe so.
13 Q. By which stage, presumably, you would have had an
14 opportunity, if you'd wished, to have checked notes for
15 accuracy?
16 A. Yes.
17 Q. Indeed, in the process of providing that statement, that
18 would have been produced first of all for the Trust,
19 is that right, and then sent in to the coroner?
20 A. I believe so, yes.
21 Q. Could we have back up on the screen, please, the
22 previous page? I think it's the fluid balance chart.
23 No, I will just get you the reference. It's
24 020-018-037, please.
25 As we can see from that fluid balance chart, the

1 only vomit that you record is the 10 o'clock vomit;
2 isn't that correct, or the 10.25 vomit if it was that?
3 A. Yes.
4 Q. Although Nurse Roulston was covering your breaks, you
5 were the nurse with primary responsibility for Raychel
6 that day.
7 A. Yes.
8 Q. And yet you've only recorded one vomit, one episode of
9 vomiting.
10 A. Yes.
11 Q. Are you saying that's the only episode of vomiting that
12 you saw?
13 A. That was the only episode of vomit that I was aware of,
14 that I saw, yes.
15 Q. And no other vomits were brought to your attention?
16 A. No.
17 Q. A vomit is recorded at 13.00, at or between 13.00 or
18 14.00, to take Mr Stitt's helpful point. Was that
19 brought to your attention by Nurse Roulston? Who
20 recorded it?
21 A. It probably was, yes.
22 Q. Plainly, by 13.00, there had been three recorded vomits.
23 A. Yes.
24 Q. But at that stage, as I understand the position, no
25 consideration was given to calling a doctor to

1 administer an anti-emetic.
2 A. No.
3 Q. Why was no consideration given to calling a doctor by
4 that time?
5 A. I believe I felt that she had IV fluids going, and she
6 wasn't at risk of dehydration. I don't know why
7 I didn't think of calling a doctor for an anti-emetic at
8 that stage.
9 Q. Clearly dehydration and the discomfort that flows from
10 vomiting are different issues; do you accept that?
11 A. Yes.
12 Q. You would accept that if a child is vomiting, it might
13 be distressing.
14 A. Yes.
15 Q. If a child is vomiting large amounts, she might well be
16 uncomfortable.
17 A. Yes.
18 THE CHAIRMAN: Well then, what changes at 3 o'clock when the
19 decision is taken to call the doctor? At that point,
20 she's still not at risk of dehydration because she's on
21 the IV fluid. So why call a doctor at 3 o'clock and not
22 at 1 o'clock?
23 A. I believe because it continued and just for comfort
24 reasons: she was feeling nauseated, so just to make her
25 feel comfortable.

1 THE CHAIRMAN: I'm not suggesting there's necessarily an
2 absolute right and wrong on this, but in effect the
3 balance is tipped because the vomits have gone on from 1
4 to 2, from 2 to 3, and now from a third to a fourth, and
5 at that point you say, "We had better do something about
6 this, we had better get the doctor to look at her"?
7 A. Yes.
8 MR WOLFE: You indicated you have seen the report of
9 Sally Ramsay.
10 A. Yes.
11 Q. And you'll be aware of her opinion that at or by the
12 time of the 10 o'clock vomit, which you observed,
13 disposed of and recorded, that a doctor should have been
14 summoned for the purposes of reviewing and administering
15 an anti-emetic. You've seen that opinion expressed.
16 A. Yes.
17 Q. There are other opinions who put the time frame a bit
18 broader than that. Mr Orr says that by the time of the
19 third vomit at 1 o'clock, a doctor who have been
20 summoned.
21 A. Mm-hm.
22 Q. When you think about this now, staff nurse, would you
23 agree that a doctor should have been summoned for this
24 purpose?
25 A. Yes.

1 THE CHAIRMAN: Sorry, you need to pin the question down
2 a bit more. A doctor should have been summoned at
3 1 o'clock.
4 MR WOLFE: I thought it was in the preface, but let's narrow
5 it down to the times.
6 When you think about it now, should a doctor have
7 been brought to see Raychel to examine her and prescribe
8 an anti-emetic perhaps by 10 o'clock?
9 A. From what I know now?
10 Q. Yes.
11 A. From what I know now, yes.
12 Q. If you'd thought about it at the time --
13 A. I didn't feel it, no.
14 Q. Did you think about it at the time?
15 A. No, I didn't.
16 Q. And you now recognise that you should have been thinking
17 about that as an action to solve the vomiting issue at
18 that time?
19 A. I believe so, yes.
20 Q. And certainly by --
21 MR CAMPBELL: Mr Chairman, it seems, in the sequence of that
22 re-putting of the question, that the witness has agreed
23 to more on the second occasion than she did on the first
24 occasion. My understanding of the transcript from the
25 first time the question was posed was that she was

1 accepting that the 1 o'clock vomit --
2 THE CHAIRMAN: What line are on you?
3 MR CAMPBELL: It's above the page now shown.
4 THE CHAIRMAN: Page 99 [draft], is it? The page number is
5 beside the number 1 --
6 MR CAMPBELL: At about line 11 [draft]. The question
7 begins:
8 "... in which the Orr report is referred to."
9 And 1 o'clock is part of the preface to that
10 question. It's my understanding it was at that point
11 that Staff Nurse McAuley was accepting that action
12 should have been taken by way of contacting a doctor.
13 THE CHAIRMAN: At 1 o'clock?
14 MR CAMPBELL: At 1 o'clock. When the question is then
15 re-put by Mr Wolfe, he brings it back to 10 o'clock.
16 THE CHAIRMAN: That's on the basis of Ms Ramsay's report,
17 I think.
18 MR WOLFE: There appears to be a range of times available.
19 THE CHAIRMAN: The fact that the experts aren't identical on
20 the point at which a doctor should have been called
21 suggests to me that there's no absolute rigid rule here
22 about whether it should have been 10 o'clock or
23 1 o'clock. But the gist of the experts' reports, as
24 I read them -- and subject to anything that anybody has
25 to say -- is that the nurses should not have waited

1 until 3 o'clock.
2 MR CAMPBELL: In the analysis or the description of vomits,
3 there is always inevitably going to be a subjectivity to
4 different people's descriptions of any given vomit,
5 whether by means of language or by means of the plus
6 plus system.
7 THE CHAIRMAN: Yes, okay.
8 MR WOLFE: In terms of the work that you were doing on that
9 morning, we note that you carried out observations in
10 terms of the intravenous administration at 11 o'clock
11 and 12 o'clock; is that correct?
12 A. Yes.
13 Q. But you tell us in your witness statement that you've no
14 recollection of what Raychel was doing between 10 am and
15 1 pm.
16 A. That's correct.
17 Q. So when you were visiting Raychel's room for the
18 purposes of making these entries on the fluid balance
19 chart, they weren't prolonged visits, were they?
20 A. No.
21 Q. How long would it take to observe what's said on the
22 pump, restart the pump and make the note?
23 A. It's hard to say. If you'd been asking the parents any
24 questions, five or ten minutes.
25 Q. Do you have any recollection of Raychel's condition

1 in that mid-morning period leading up to lunchtime?
2 A. At the times I checked the infusion?
3 Q. Yes.
4 A. I have no recollection.
5 THE CHAIRMAN: I suppose on one view, Ms McAuley, that might
6 suggest that she seemed to be okay.
7 A. Yes.
8 THE CHAIRMAN: Because if she was in difficulties, then
9 that is something that you might have been expecting to
10 record or that you might be more likely to have
11 remembered?
12 A. Yes.
13 THE CHAIRMAN: So without her being in great form that
14 morning, there must at least be the possibility that
15 your absence of memory is an indication that she wasn't
16 doing too badly?
17 A. I believed that she wasn't doing too badly.
18 MR WOLFE: Could I test your recollection again in this way?
19 Can I ask you whether during that mid-morning period
20 leading up to lunchtime which of her parents were
21 present?
22 A. I believe it was her father.
23 Q. The parents' recollection is that the father left the
24 hospital at or about 11 am and returned somewhere
25 in that window between 1 o'clock and 1.30 and that the

1 mother had arrived at the hospital, that is
2 Mrs Ferguson, at or about 9.30 and stayed through to
3 3 o'clock, went away and came back later. Just to
4 simplify that a little, in the period between
5 approximately 11 am and 1.00/1.30, their recollection
6 is that the father wasn't there but the mother was
7 there. Can you assist us with that?
8 A. I can't, no.
9 Q. You can't say whether that's right or wrong?
10 A. No, I can't say.
11 Q. Because you have no recollection?
12 A. No.
13 Q. In terms of Raychel's condition in that period -- and
14 let me now look at the period between 11 am and
15 lunchtime -- Raychel's mother recalls that when she
16 arrived at the hospital at or about 9.30, Raychel was
17 doing well, and everybody seems to be at one on that.
18 A. Yes.
19 Q. That would be your recollection as well?
20 A. Yes.
21 Q. She recalls that by mid-morning, by 11 o'clock, Raychel
22 was becoming increasingly nauseous. In one place she
23 tells us that she's not vomiting at that time and in
24 another place she talks about a slime vomit, which is
25 perhaps an indication of nausea but not a full vomit.

1 That's a matter that the chairman will look at. Have
2 you any recollection of Raychel having been, if you
3 like, happy and in good form at or about 9 o'clock, at
4 or about breakfast time?
5 A. Yes.
6 Q. Seeming less well getting closer to lunchtime?
7 A. I haven't specific timescales. I do remember in the
8 morning time seeing Raychel up, mobilising, a couple of
9 times during the morning/pre-lunchtime period --
10 specific times I'm not sure, I can't remember -- but at
11 no time had she come across to me ... any concerns that
12 I should have about her. There was nothing that came
13 across that I was worried about.
14 Q. A Mrs Duffy was a visitor to the ward and she had
15 a child who was in a bed nearby to Raychel. She recalls
16 in an inquiry statement that, from midday onwards,
17 Raychel started to be very sick and that appears to be
18 coincident in time with Mrs Ferguson's account to the
19 inquiry, which is that she brought Raychel to the toilet
20 at or about midday and Raychel produced a large vomit of
21 undigested food. Can I ask you this: were you aware of
22 Raychel being brought to the toilet by her mother at any
23 time in the morning?
24 A. I have no clear memory. I do have memories of Raychel
25 going to the toilet, of exactly who took her -- I do

1 remember the father at one stage taking her. The mother
2 possibly could have took her too. I'm not sure of the
3 timescales.
4 Q. Have you a picture of the mother being there in the
5 morning?
6 A. Late morning, yes.
7 Q. And Raychel's mother recalls that after that midday
8 vomit, she reported that episode to someone she
9 describes as "a small nurse with dark hair"; was your
10 hair darker at that time?
11 A. No.
12 Q. It wasn't?
13 A. No.
14 Q. Do you know, if you think about that description, who
15 that could have been?
16 A. I'm not sure.
17 Q. Nurse Roulston?
18 A. No.
19 Q. No?
20 A. No.
21 Q. Because she's not small or because she doesn't have dark
22 hair?
23 A. She's tall.
24 MR WOLFE: Sir, that might be a suitable point.
25 MR QUINN: Mr Chairman, could we refer again to the

1 handwritten statement, which is 020-099-311?
2 THE CHAIRMAN: That's the statement of 20 June.
3 MR QUINN: That's correct. May I ask through you,
4 Mr Chairman, just how many vomits did this nurse
5 witness? Because if we have a recollection of the fluid
6 chart and the vomits that are recorded, the first point
7 is this nurse seems to have witnessed a couple of small
8 to medium vomits of undigested food and she had no
9 concerns at that stage. That's point 1.
10 THE CHAIRMAN: She's recording that Raychel had a couple of
11 small to medium vomits, not that she --
12 MR QUINN: Yes, she had.
13 THE CHAIRMAN: -- personally witnessed them.
14 MR QUINN: Could we clarify that? Is it her memory or is it
15 that she's looked at the records? Because she said that
16 she didn't have a chance to look back at the records.
17 That's the point I'm making here.
18 The second point I'm making is there's clearly
19 a break in this because, in the next four lines down, it
20 begins then:
21 "In the afternoon, she vomited a couple of times."
22 Again, could we ask the same questions about her
23 recollection or is it from the records? And I make
24 these points because if one then puts up the fluid
25 balance sheet and follows that along, you can see that

1 the vomits that are mentioned, plus plus, one of them
2 was signed "AR" and the other one is signed "MR". I'd
3 like some clarification on these three issues.
4 THE CHAIRMAN: Just be careful because I think what
5 Ms McAuley has already told us is that she's responsible
6 for the entry of the 10 am vomit and the 3 o'clock
7 signature of MR, the witness's maiden name, is
8 in relation only to the fluids; the vomit is recorded by
9 Ms Roulston.
10 MR QUINN: That's what I thought because the writing is
11 exactly the same as AR recorded it at 1300. The writing
12 is exactly the same, so I took that as read.
13 MR WOLFE: That's confirmed in the witness statements.
14 MR QUINN: I just wanted to confirm that to make sure there
15 was no doubling of vomits. The point I'm making is: if
16 there were vomits as recorded in her handwritten
17 statement of 20 June, there may well have been six
18 vomits before 1500 as recorded in the fluid balance
19 sheet.
20 THE CHAIRMAN: Is that depending on how you interpret the
21 reference to "two small to medium vomits"?
22 MR QUINN: It does. I'd like the witness to be asked that
23 question about precisely how many vomits there were
24 before 1300 or 1500, as the case may be.
25 THE CHAIRMAN: Could you bring us back to the previous page

1 on the screen, please? Thank you.
2 MR WOLFE: 022-099-311.
3 MR QUINN: If you can put them both up together, if
4 possible.
5 THE CHAIRMAN: We're not going to be able to swing round the
6 fluid balance sheet.
7 Focus on the second paragraph starting:
8 "She had a couple of small to medium vomits."
9 And then a few lines down it says:
10 "She vomited a couple of times."
11 Are those -- particularly the small to medium
12 vomits -- different to the vomits which are registered
13 on the fluid balance sheet at about 8 o'clock and about
14 10 o'clock, or are they the same vomits?
15 A. I believe they're the same vomits.
16 THE CHAIRMAN: So in answer to the query about whether this
17 is actually referring to six vomits rather than four,
18 do you say it's referring only to four?
19 A. To four vomits.
20 THE CHAIRMAN: Two which are small to medium and two in the
21 afternoon?
22 A. Yes.
23 THE CHAIRMAN: Thank you very much. We'll break for lunch.
24 It's 1.20. We'll do everything we can to get your
25 evidence finished this afternoon, Ms McAuley, so we'll

1 start in 45 minutes at 2.05. We'll do everything we can
2 to finish your evidence this afternoon.
3 A. Thank you.
4 (1.20 pm)
5 (The Short Adjournment)
6 (2.05 pm)
7 (Delay in proceedings)
8 (2.20 pm)
9 THE CHAIRMAN: Just before Mr Wolfe starts, Mr Stitt, I just
10 want to raise one thing with you, which is this.
11 I don't dispute that the Western Trust is entitled to
12 claim privilege; it clearly is under the statutory
13 powers which I have. But before we get into a debate
14 about what you're claiming privilege for, the basis for
15 that privilege and the extent to which I uphold any
16 claim for privilege, I would like your client to
17 consider whether it will assert its legal entitlement
18 and I would like your client to reflect on this.
19 The Belfast Trust did not do that in relation to the
20 inquest file in Adam's case. This claim for privilege
21 is being made exceptionally late. It will inevitably
22 cause alarm to the family because a previous claim for
23 privilege ended up with them seeing the reports from
24 Dr Warde which, in their eyes, I'm sure, the Trust had
25 for the inquest and then buried.

1 You may have seen the Francis report or you may
2 heard about the Francis report on Mid-Staffs Health
3 Trust in the last couple of weeks. If I refer you to
4 paragraph 2.195 of that report, there's an element in it
5 where Mr Francis called, as witnesses to that inquiry,
6 the legal advisers to the Trust. He was exploring the
7 issue of whether there is a distinction to be drawn
8 between the strict legal position which a trust has in
9 law and what the proper approach is for the trust to
10 take. In other words, the fact that a trust can do
11 something legally doesn't mean that the trust as
12 a public body should do something.
13 The other point to throw into this is that, from the
14 start, we have been promised full and unequivocal
15 co-operation from Altnagelvin Trust. I know that when
16 statement was made by Mrs Burnside at the start of the
17 inquiry -- that I do not interpret that as Mrs Burnside
18 saying she's going to waive any claim for privilege the
19 Trust has.
20 I'm not asking for a response now, I'm not saying
21 you're not entitled to claim privilege because
22 I recognise that you are entitled to claim privilege,
23 but what I'm flagging up is the issue for the Trust
24 about whether it really is in the Trust's interests or
25 everybody else's interests for that claim for privilege

1 to be asserted.
2 MR STITT: I understand. May I very briefly respond to that
3 by saying that I don't agree, with respect, necessarily
4 that there is a conflict, to use that term, between
5 a Trust claiming litigation or legal advice privilege in
6 relation to a document or a file and giving as much
7 reasonable assistance as it can to a public inquiry?
8 I'm concerned, as counsel, as to the ramifications, if
9 it's going to be taken as read that -- because this the
10 effect of what you're saying, Mr Chairman -- any trust
11 in any inquiry really, effectively, all its documents
12 and all its papers should be exposed to everybody in the
13 inquiry.
14 That would be tantamount to saying to any further
15 lawyer advising a trust or counsel in consultation or
16 counsel writing to solicitors: by the way, the
17 old-fashioned notion of legal professional privilege has
18 now gone. The whole point of that is that frank and
19 honest advice can be given by counsel doing their
20 absolute best to give fair and proper advice to their
21 client. And it seems to me a very, very dangerous step
22 indeed for a trust to go down the road of throwing open
23 its doors and saying, "We're not going to claim
24 privilege".
25 I understand and respect the suggestion which you

1 put forward, and I can understand how persons in the
2 inquiry, particularly the Ferguson family, may feel that
3 there is obviously something to hide here. It is not as
4 straightforward as that and I'm respectfully saying that
5 legal professional privilege is one of the cornerstones
6 of our system and I'd be very loath to advise our
7 clients to give it up.
8 THE CHAIRMAN: I understand that, and that's why I'm
9 specifically saying that I recognise the Trust's right
10 to assert it. What I am inviting the Trust to do --
11 with your input, obviously -- is to consider the extent,
12 if any, to which it asserts its claim for privilege.
13 The Francis report is raising what is now becoming an
14 increasing issue in the Health Service about whether
15 there is a conflict or a tension between the legal
16 rights which a public body like a Trust has on the one
17 hand and the duty of candour, which public bodies have.
18 And what Mr Francis has specifically investigated is the
19 extent to which there is a tension between the two.
20 I don't understand him, from a quick reading of that
21 section of the report, to be saying legal professional
22 privilege doesn't exist anymore. What he's
23 highlighting is the effect that it has, and it has
24 a whole series of effects. We know from the general
25 debate that's going on publicly at the moment, for

1 instance, about the appropriateness or otherwise of
2 confidentiality clauses in settlements and the effects
3 which they have, which is from one perspective keeping
4 quiet about things which have gone terribly wrong.
5 I can tell you now that when we get to the
6 governance end, particularly with the department, this
7 will be a feature of those hearings, and I know directly
8 that that is an issue which the department is concerned
9 about, about how it reconciles the various legal
10 entitlements which people and trusts have with the
11 responsibility to run an open Health Service and facing
12 up to mistakes when those mistakes are made. That's the
13 point I'm making.
14 MR STITT: Absolutely. I haven't read the Francis report,
15 but we're all aware of --
16 THE CHAIRMAN: It's 1,750 pages, so it'll take you quite a
17 while to read it.
18 MR STITT: It is a huge volume, I appreciate that.
19 THE CHAIRMAN: That reference again --
20 MR STITT: It'll be on the transcript.
21 I have to say that I will be advising the Trust it's
22 up to them. I shall, of course, convey clearly what
23 you have said and it's my duty to do so. But by the
24 same token, I'm not going to consider lightly the
25 abandonment of legal professional privilege.

1 THE CHAIRMAN: Okay.
2 MR STITT: I say that although I have looked at the file --
3 and I have done so within the last two weeks -- and it
4 seems to me, generally speaking, it is subject to legal
5 professional privilege, but there is an important
6 principle here and I really do have to underscore that.
7 THE CHAIRMAN: Thank you. Mr Wolfe?
8 MR WOLFE: Good afternoon, Staff Nurse McAuley.
9 Could I bring you to the events that were occurring
10 at or about midday on 8 June 2001? You'll recall from
11 the witness statement that you had provided to the
12 inquiry that, at or about that time, Raychel's
13 intravenous fluids were running low in the bag and that
14 you had to take steps to address that issue.
15 A. Yes.
16 Q. And you addressed that issue by approaching a Dr Butler.
17 A. That's right, yes.
18 Q. Dr Butler, at that time, was an SHO on the paediatric
19 side; isn't that right?
20 A. Yes.
21 Q. Your request to her was, would she write up another bag
22 of intravenous fluids for Raychel?
23 A. I believe so.
24 Q. In order to get hold of Dr Butler, did you have to page
25 her or did you telephone?

1 A. No, she happened to be on the ward near the nurses'
2 station and that's why it was her that I approached.
3 Q. And clearly, Raychel was a surgical patient.
4 A. Yes.
5 Q. Yet you approached somebody on the paediatric side.
6 A. Yes.
7 Q. Why did you not go, for example, back to Mr Zafar, who
8 dealt with the ward round earlier in the morning and
9 might be expected to have had an overview of Raychel's
10 fluid needs?
11 A. At that stage, the fluids were running out and I just
12 believed I needed to get a new bag of fluids prescribed
13 to keep the continuation of fluids going.
14 THE CHAIRMAN: Mr Wolfe, I think it's important to remember
15 that while there is a point to be made here, it was the
16 staff nurse's understanding at that time that
17 Solution No. 18 was safe. We have heard that there were
18 issues from time to time or problems about actually
19 contacting surgeons to come on to the ward. There were
20 paediatricians around. And I think to an extent you
21 flagged up this evidence this mornings, Ms McAuley, that
22 in those circumstances where it seemed to be a fairly
23 safe, routine task to be done, which you didn't have any
24 apprehensions about, you would ask a paediatrician if
25 there was a paediatrician handy.

1 A. Yes.
2 MR WOLFE: Was it your understanding that fluids of that
3 type at that rate were to continue into another bag?
4 A. Yes, because Raychel's fluids weren't reduced at that
5 stage, so it was to continue on her fluids, just.
6 Q. Right. So it was your understanding that the fluids
7 were to continue until you were able to reduce them?
8 A. Yes.
9 Q. And the litmus test for reducing them -- maybe I've
10 confused you by using that word -- the test, if you
11 like, for being able to reduce them was whether she was
12 able to tolerate oral fluids; is that right?
13 A. That's right, yes.
14 Q. Can you recall what you said to Dr Butler?
15 A. I don't recall the exact words, but I'm sure I would
16 have said that it was for a surgical patient who had her
17 appendix removed and that she was vomiting and it was
18 a continuation of the same fluids that was needing to be
19 prescribed.
20 Q. Can I put to you, for your comment, Dr Butler's
21 perspective?
22 A. Yes.
23 Q. She has given a witness statement to the inquiry. In
24 fact, she has given two witness statements to the
25 inquiry, the first of which is WS026/1. At page 2 of

1 that statement -- we don't need it up on the screen,
2 thank you -- one of the enquiries she said she probably
3 would have made was to ascertain how long it was after
4 surgery as she would have been concerned if the child
5 had been on fluids for more than 24 hours. Again,
6 do you have any specific memory of her raising that kind
7 of issue with you?
8 A. No, I have no memory.
9 THE CHAIRMAN: But if she had raised that issue with you,
10 the answer would have been, "Well, she hasn't been on
11 fluids for more than 24 hours"; isn't that right?
12 A. Possibly.
13 THE CHAIRMAN: Because Raychel had gone on to fluids a bit
14 after 10 o'clock the night before, so at that point,
15 Raychel was about 14 hours on fluids.
16 A. That would be right, yes.
17 THE CHAIRMAN: So if Dr Butler had raised that issue then,
18 she would have got an answer which --
19 MR WOLFE: That's right. What I'm investigating here is
20 whether and to what extent Dr Butler engaged in any kind
21 of process leading to the prescription.
22 So you can't remember her asking that kind of
23 question. Can you recall whether she gave any
24 consideration to the notes that were available at the
25 bedside?

1 A. I don't recall.
2 THE CHAIRMAN: Do you recall being there when Dr Butler came
3 and put up the new bag? Sorry, did Dr Butler put up the
4 new bag or did she just write the prescription?
5 A. She wrote the prescription.
6 THE CHAIRMAN: So did she see Raychel at all that you
7 remember?
8 A. I don't think so.
9 THE CHAIRMAN: Does this mean literally you got her in the
10 corridor or at the nurses' station?
11 A. Yes.
12 THE CHAIRMAN: So she didn't actually see Raychel?
13 A. As far as I am aware, no.
14 THE CHAIRMAN: Sorry, there were some notes at the nurses'
15 station, some of the medical records that you have
16 described this morning. Do you know if she looked at
17 them at all?
18 A. I don't think so.
19 THE CHAIRMAN: Thank you.
20 MR WOLFE: Dr Butler suggests that it would only have been
21 in circumstances where you were raising a concern about
22 Raychel that she would have gone on to consider
23 examining the child. And indeed, if you had raised
24 concerns about her, her advice would have been to
25 contact the surgical team. Can I ask you, given your

1 view of Raychel's condition at that time -- and you gave
2 us some evidence about that this morning -- is it fair
3 to say that you didn't raise any concerns about
4 Raychel's condition with her?
5 A. I didn't have any concerns at that time about Raychel's
6 condition.
7 THE CHAIRMAN: Which leads back to the reason why you asked
8 her to do it because you didn't think you needed to wait
9 for a surgeon because you weren't worried about Raychel.
10 A. That's correct.
11 MR WOLFE: In terms of advising about --
12 THE CHAIRMAN: Sorry. Mr Campbell?
13 MR CAMPBELL: I'm told that the prescription sheet that
14 Dr Butler would have completed would have been on the
15 reverse side of the fluid balance sheet, which of course
16 won't show up on the photocopies that we have available
17 to us.
18 THE CHAIRMAN: We'll check that during the afternoon,
19 Mr Campbell. I think we hold the original file.
20 MR CAMPBELL: The point being that the fluid balance sheet
21 would have been with Raychel's bed --
22 THE CHAIRMAN: So all she had to do was turn it over?
23 MR CAMPBELL: -- and that the doctor would have been in
24 close proximity to that in order to complete the
25 prescription.

1 THE CHAIRMAN: Okay.
2 MR WOLFE: The prescription, if we could put it up, is
3 020-019-038. It's first entry on this sheet, sir. The
4 second entry relates to the normal saline that was given
5 post seizure. We can see on this that Dr Butler signed
6 off as the prescriber and Staff Nurse Rice, you, erected
7 the fluids at 12.10; is that right?
8 A. That's correct, yes.
9 Q. And there's the signature of another nurse there. Tell
10 us who that is.
11 A. Staff Nurse Hall(?).
12 Q. She was another nurse on duty in Ward 6, was she?
13 A. Yes.
14 Q. She had responsibility for other patients and not
15 Raychel?
16 A. That's correct.
17 Q. But she was somebody who was handy and available and who
18 could carry out the administrative task of checking off
19 the fluid with you?
20 A. Yes. Fluids require two nurses to check the fluid type
21 and the bag and then make sure that it was an
22 appropriate expiry date and batch number and record
23 those and then erect the fluids.
24 THE CHAIRMAN: Can I ask you, what Mr Campbell said from the
25 floor a moment ago, is that your recollection, that the

1 prescription is on the other side of the page from the
2 fluid balance sheet?
3 A. That's correct, yes.
4 THE CHAIRMAN: Right. So if the fluid balance sheet was at
5 Raychel's bed, for Dr Butler to have signed that, does
6 that mean either she went in to Raychel's bed or else
7 you brought the sheet out to her?
8 A. It's possible that I could have brought the clipboard
9 out.
10 THE CHAIRMAN: Right. But that at least gave her an
11 opportunity to look at what was written on it, and at
12 that time -- can you give us page 37, please? Go back
13 one page. 020-018-037. If you almost put your hand on
14 the screen in front of you, by the time Dr Butler -- if
15 she'd seen this, she would have seen the vomit at 8, the
16 large vomit at 10, and she wouldn't have seen any
17 further vomits recorded on the sheet at midday, would
18 she?
19 A. No.
20 THE CHAIRMAN: Okay. Thank you.
21 MR WOLFE: Just looking at that chart, the weight ought to
22 have been recorded on that chart; isn't that right?
23 A. It should have been, yes.
24 Q. It's a key determinant of the appropriate rate of fluids
25 for a child.

1 A. It would be, yes.
2 Q. Clearly, as you've demonstrated, if this is the reverse
3 side of the fluid prescription sheet, it wouldn't have
4 been difficult for Dr Butler to observe the fact that
5 there had been vomiting. Notwithstanding the ease by
6 which she could have referred to that, can you remember
7 any particular discussion about the vomiting?
8 A. No.
9 Q. It appears on the evidence you've given so far that you
10 had no concern about it in terms of it causing
11 difficulties for Raychel.
12 A. At the time, Raychel's observations and her mannerisms
13 appeared appropriate and I had no concerns.
14 Q. Of course, here was an opportunity with a doctor here in
15 front of you to have made a request for an anti-emetic
16 to be prescribed; isn't that right?
17 A. It would be, but I hadn't concerns at that time that she
18 needed an anti-emetic.
19 Q. Yes.
20 THE CHAIRMAN: Where would Dr Butler have got the rate from,
21 80 ml an hour?
22 A. The rate that it was running at previous.
23 THE CHAIRMAN: Sorry, well, in other words, does that mean
24 she must have seen the fluid balance sheet?
25 A. Yes.

1 THE CHAIRMAN: Just for the record, Mr Campbell, that's your
2 point, is it? It is the reverse side of the same page,
3 that's it, the yellow (indicating)?
4 A. That's right.
5 THE CHAIRMAN: If anybody wants to see that, it's here.
6 MR WOLFE: If we move into the afternoon of 8 June, we can
7 see from the fluid balance chart in front of us that, at
8 or about 1 o'clock, it is Nurse Roulston who is
9 recording that the intravenous fluids are all in order;
10 isn't that right?
11 A. Yes.
12 Q. And indeed, she observes a further vomit at that time.
13 A. Yes.
14 Q. In the hours leading up to 3 o'clock then, the
15 signatures are yours, aren't they, at 2 o'clock and
16 3 o'clock?
17 A. The signature at 2 o'clock is not mine.
18 Q. Whose signature is that?
19 A. Staff Nurse Boyle.
20 Q. Boyle?
21 A. Yes.
22 Q. Again, what was her role?
23 A. She was a staff nurse on the ward at the time.
24 Q. Right. In terms of why she was dealing with Raychel at
25 that time, can you explain to us why?

1 A. It's possibly that the pump was alarming and she went in
2 to correct it, as we would do if we were walking about
3 the ward and ...
4 Q. Right. In terms of the 1 o'clock coverage,
5 Nurse Roulston was doing that because you were on
6 a break; is that right?
7 A. That's correct, yes.
8 Q. So it appears that the last time you see Raychel before
9 3 o'clock is the 12 o'clock --
10 A. That's correct, yes.
11 Q. -- signing off and perhaps when you were dealing with
12 Dr Butler as well at or about that time?
13 A. Yes.
14 Q. Have you any particular recollection of Raychel's
15 condition in the hours before 3 o'clock or can we take
16 this record as indicating that you didn't have any
17 dealings with Raychel during those three hours?
18 A. I would have had no dealings. When I would have come
19 back from lunch it would have been practice for Staff
20 Nurse Roulston to have informed me of what happened with
21 the patients she was covering while I was on my break
22 and if she had any concerns, to pass them on to me.
23 THE CHAIRMAN: Sorry, what sort of time would your lunch
24 have been at?
25 A. Possibly 12.30-ish. I'm not sure.

1 THE CHAIRMAN: And do you get 45 minutes?
2 A. 45 minutes.
3 THE CHAIRMAN: Thank you.
4 MR WOLFE: We have asked Staff Nurse Roulston about this
5 whole issue of communications and she's told us in her
6 second witness statement that so far as the 1 o'clock
7 record of vomiting is concerned, she doesn't recall
8 reporting that vomit to anyone. And similarly, with
9 regard to the second vomit that she picks up on at
10 3 o'clock, again she says she doesn't recall discussing
11 that vomit with anyone.
12 Plainly, in order to have good communications
13 between this team of nurses, she should have been
14 communicating to you, shouldn't she?
15 A. It would have been the practice at the time.
16 Q. If she's not communicating verbally to you, the fallback
17 position is presumably this record that we have in front
18 of us.
19 A. Yes.
20 Q. Can you say at this remove whether she did communicate
21 with you the fact of these two further vomits?
22 A. I can't say for definite. I can just say it would have
23 been practice, if one nurse was away on break, for the
24 other nurse to pass on to them what happened to them
25 during the time, but I can't recall any conversations.

1 Q. When you came back into the area, if you like, of caring
2 for Raychel or attending to Raychel at 3 o'clock, after
3 three hours of not having any dealings with her --
4 THE CHAIRMAN: Sorry, the last questioning was on the basis
5 that Nurse Roulston hadn't told anybody about the
6 vomiting at 3 o'clock.
7 MR WOLFE: And 1 o'clock.
8 THE CHAIRMAN: I thought she had spoken to Sister Millar,
9 who agreed that she should get a doctor for the
10 3 o'clock vomit; is that not right?
11 MR CAMPBELL: You're getting their names mixed up,
12 Mr Chairman. This is Mrs McAuley --
13 THE CHAIRMAN: I know, I know, that's right. But
14 Mrs McAuley --
15 MR CAMPBELL: It was Mrs McAuley who spoke with
16 Sister Millar --
17 THE CHAIRMAN: After the 3 o'clock?
18 MR CAMPBELL: After 3 o'clock.
19 THE CHAIRMAN: But how then -- for Mrs McAuley to have known
20 that, surely since -- and the 3 o'clock vomit is
21 recorded by ... That's Staff Nurse Roulston, isn't it?
22 MR WOLFE: We'll develop this now, but what appears to have
23 happened at 3 o'clock is that you were told, Staff
24 Nurse McAuley, by Mrs Ferguson that Raychel was still
25 vomiting -- those were the words you used in your

1 witness statement -- and that prompted you to speak to
2 Sister Millar; isn't that right?
3 A. I believe that's right, yes.
4 Q. We'll come back to that in a moment, but what I wanted
5 to ask you is this: given that you appear to have been
6 absent from the care of Raychel for about three hours --
7 is that fair?
8 A. I wouldn't say I was absent from the care.
9 Q. Well, you were on break for one hour.
10 A. Mm-hm.
11 Q. And then what were you doing in the other two hours?
12 A. I would have been still allocated to Raychel's care.
13 Q. Yes. But as I understand it, the observations were
14 carried out at 1 o'clock.
15 A. Yes.
16 Q. And they were carried out by Staff Nurse Roulston.
17 A. That's right, I believe.
18 Q. Let's get the record up on the screen, please.
19 020-015-029.
20 THE CHAIRMAN: I think the witness isn't accepting that if
21 she doesn't do the hourly observations, that that
22 doesn't mean she's absent from Raychel's care. I think
23 that's the point.
24 A. Yes.
25 THE CHAIRMAN: You say you're still on the ward, but if the

1 alarm goes off at 1 o'clock or 2 o'clock and at
2 1 o'clock you might have been at lunch and at 2 o'clock
3 if the alarm goes off and you're with another patient,
4 then another nurse will step in.
5 A. That's correct.
6 THE CHAIRMAN: You weren't accepting Mr Wolfe's suggestion
7 that that means that you were absent from looking after
8 Raychel?
9 A. That's correct.
10 THE CHAIRMAN: Okay.
11 MR WOLFE: So during that period from 12 o'clock to
12 3 o'clock, it's Nurse Roulston who identifies two
13 vomits; isn't that right?
14 A. Yes.
15 Q. And it's Nurse Roulston who carries out the four-hourly
16 observations at 1 o'clock?
17 A. That's correct, yes.
18 Q. And you say she should have been communicating with you
19 any developments in Raychel's care, but you had no
20 specific recollection of a conversation having taken
21 place?
22 A. That's correct, yes.
23 Q. Clearly, apart from times when you're on your break, you
24 should be at or about the ward; isn't that right?
25 A. That's right, yes.

1 Q. In terms of seeing Raychel, examining her, keeping in
2 contact with her parents, those kinds of outward
3 appearances of nursing care, do you think you took any
4 of those steps during that period of time?
5 A. Raychel was nursed in a four-bedded area and I would
6 have been in and out of that room at various times
7 through the -- at those specific times that you're
8 stating, but may not have had any hands-on care with
9 Raychel, but would have been able to observe Raychel.
10 Q. What I want to ask you about is your recollection of
11 Raychel's condition during that early to mid-afternoon
12 period. Can I put a number of perspectives to you for
13 your comment? Mr Ferguson returned to the hospital at
14 or about 1 or 1.30 pm, and between 1/1.30 and 3 o'clock,
15 he recalls that Raychel vomited on three occasions and
16 he took three kidney trays out to the nurses.
17 Do you have any recollection of him doing that?
18 A. I was not made aware of any vomits in those times.
19 Q. He would say that he was told by a nurse or nurses that
20 her stomach was empty now and that she would not throw
21 up again and that Raychel was -- he was encouraged to
22 give Raychel capfuls of 7 Up. Had you any dealings with
23 him in that respect?
24 A. I have no recollection, no.
25 Q. But he says, generally speaking, it was his impression

1 that over that period Raychel was going downhill.
2 What was your impression of Raychel? Have you any
3 recollection of an impression of her during that early
4 afternoon period?
5 A. I have no recollection.
6 Q. Again, her mother, Mrs Ferguson, makes similar comments
7 in her witness statement to the inquiry, and moreover
8 a Mrs Harrison, who was Raychel's godmother, visited her
9 between 3.00 and 3.45 pm and described Raychel as
10 entirely non-communicative during that period.
11 Can I now ask you this: you've given us
12 a description or a recollection of Raychel as she was
13 at the start of the day at or about 8 o'clock or
14 9 o'clock.
15 A. Yes.
16 Q. Is it reasonable for these witnesses to tell the inquiry
17 that by this stage in the afternoon Raychel gave all the
18 appearances of going downhill?
19 A. I have no memories of what Raychel was like at those
20 times.
21 THE CHAIRMAN: Well, can I ask you this: when you saw
22 Mrs Ferguson at about 3 o'clock, and she told you that
23 Raychel had been vomiting again, you contacted
24 Sister Millar and called for the doctor; okay?
25 A. Yes.

1 THE CHAIRMAN: Do you recall whether you saw Mrs Ferguson at
2 Raychel's bedside?
3 A. I believe it was at the bedside, yes.
4 THE CHAIRMAN: So in other words, you were there at
5 3 o'clock, actively involved with Raychel; right?
6 A. Yes.
7 THE CHAIRMAN: Do you have any recollection of how she
8 appeared? I presume if she had been vomiting that
9 at the very least she was washed out and miserable, but
10 do you remember? Can you help us with any detail?
11 A. I just remember her lying down at that stage and at that
12 stage she had vomited. She had been in surgery late at
13 night and she was resting, but nothing to indicate there
14 was any worries about her appearance to me.
15 THE CHAIRMAN: So the concern which got you to get on to the
16 doctor was the vomiting rather than her specific
17 appearance?
18 A. I believe so, yes.
19 MR WOLFE: Let me just bring us to 3 o'clock or thereabouts.
20 We know from the fluid balance chart that Nurse Roulston
21 had recorded an entry at or about 3 o'clock --
22 A. Yes.
23 Q. -- somewhere in that time frame. But that wasn't how
24 you became aware that Raychel had been vomiting; isn't
25 that right? It came through the mother.

1 A. It possibly come came via both.
2 Q. I'm sure anything's possible, but in terms of your
3 recollection and what you have told us, Staff Nurse
4 McAuley, you say in your first witness statement to us:
5 "In the afternoon Raychel vomited a couple of times,
6 during which time I spoke to the mother, who told me she
7 was still vomiting and I said I would get the doctor."
8 That's in WS051/1, page 3. So that, according to
9 you, in 2005, was the source of your knowledge.
10 A. Yes.
11 Q. It wasn't that Nurse Roulston had told you and it wasn't
12 that you had spotted the vomiting yourself; do you
13 understand?
14 A. Mm-hm.
15 Q. It was the mother that told you.
16 A. Yes.
17 Q. When she said to you that Raychel was continuing to
18 vomit, did you go and check the child?
19 A. I believe I was at the bedside at the time.
20 Q. Right. And was Raychel nauseous and vomiting at that
21 time?
22 A. I believe she was nauseated, but wasn't actively
23 vomiting when I seen her.
24 Q. It's a matter for the chairman to assess how relevant
25 the timing of all of this is and I need to put this

1 other perspective to you. I think what you're saying
2 is that, at or about 3 o'clock, you got this report from
3 the mother. Mrs Ferguson tells the inquiry that herself
4 and her husband left the hospital at or about 3 o'clock
5 to go and attend to, I think, her other children, who
6 were getting out of school. At the time she left, at or
7 about 3 o'clock, Raychel had stopped vomiting, albeit
8 she had been vomiting a Lyttle earlier, and she returned
9 then to the hospital at 3.45. During her absence,
10 Raychel's godmother had attended and visited the child.
11 Again, on this matter of detail, can you help us?
12 Can you remember the parents leaving for a period
13 mid-afternoon?
14 A. I have no recollection.
15 Q. Just then in terms of what triggered your decision to go
16 to Sister Millar to talk about whether a doctor should
17 become involved, can I put this other piece of timing to
18 you? Mrs Ferguson says she returns to the hospital at
19 or about 3.45/4 o'clock, and Raychel is looking
20 listless -- she uses the phrase "looking like a zombie".
21 She gets into bed with Raychel and Raychel is retching
22 and nauseous, but isn't initially vomiting, but does
23 vomit at 5 o'clock, and the vomit has blood in it. She
24 says she reports that to a nurse and that is the trigger
25 at that time for getting a doctor involved. Again,

1 can you comment on that?
2 A. I wasn't aware of the vomit at 5 o'clock. I'd been
3 trying, in the afternoon, to get a doctor and I'd had
4 several attempts of trying to contact the surgical
5 doctors.
6 Q. Let me get the sequence then. We'll work on your
7 version of events and that'll take the complexity out of
8 it. You contact Sister Millar; is that correct?
9 A. Yes.
10 Q. And you have a discussion in terms of whether the child
11 would benefit from the attendance of a doctor; is that
12 right?
13 A. I believe it was something like that, yes.
14 Q. What were your concerns at that point?
15 A. That Raychel had vomited and was feeling nauseated and
16 I thought maybe if she had an anti-emetic she would feel
17 a wee bit more comfortable.
18 Q. Were you given any instructions in terms of who you
19 should contact?
20 A. Someone on the surgical team. At that stage, it would
21 have been the surgical SHO.
22 THE CHAIRMAN: And the reason why you wouldn't got to
23 a paediatrician at this point is because there is
24 something to be concerned about, whereas when you went
25 to Dr Butler at midday you didn't feel there was

1 anything to be concerned about?
2 A. No.
3 THE CHAIRMAN: So this is an example of why you do go to a
4 surgeon if you think there is a cause for concern, as
5 opposed to Dr Butler just replacing what appeared to you
6 to be a standard IV fluid?
7 A. I believe that's correct, yes.
8 THE CHAIRMAN: Okay.
9 MR WOLFE: At one point or another, Sister Millar assumed
10 that you would be making contact with the senior house
11 officers, that's either Mr Zafar or Mr Makar. For the
12 avoidance of doubt, you didn't attempt to make contact
13 with the senior house officers; is that right?
14 A. No, as far as I'm aware it was the JHO.
15 Q. Why did you elect to contact the JHOs as opposed to the
16 SHOs?
17 A. At the time, that was my knowledge of the process, of
18 trying to get in contact with the surgical doctors.
19 Q. Did you think you were disallowed from contacting
20 anybody more senior?
21 A. I didn't think -- it was my position as a nurse, I had
22 to contact the junior doctor and, if he felt need be, he
23 could contact his seniors. If the child was really
24 sick, I was really concerned, or there was other
25 reasons, you know, there would have been nothing to stop

1 me contacting the senior doctor.
2 Q. And again, there does appear to be a vagueness about the
3 time at which you initially commenced your attempts to
4 contact the junior doctors. Can you help us on that?
5 A. I'm unclear of when I first attempted to contact the
6 JHO. I know it was some time in the afternoon and
7 I know it was several attempts and between the first and
8 the second or the second and the third, I'd have been
9 going about other nursing duties and time would have
10 elapsed. I wouldn't have been waiting at the phone for
11 the doctor to ring back.
12 Q. I think you've told us that you first brought the issue
13 to the attention of Sister Millar at or between 3.30 and
14 4, that is you reported the further vomiting to her at
15 that time.
16 A. Yes.
17 Q. And she was in her office on the same floor, but in
18 another part --
19 A. Yes.
20 Q. -- of the building.
21 THE CHAIRMAN: Sorry, when you say you wouldn't be waiting
22 at the phone for the doctor to ring back, do I take it
23 from that the way you try to contact a doctor is by
24 a bleeper?
25 A. Yes.

1 THE CHAIRMAN: Does the doctor typically respond first of
2 all by ringing the ward to see why you're bleeping him?
3 A. That would be the process, yes.
4 THE CHAIRMAN: And then, over the phone, you give some
5 information, which might lead then to the doctor coming
6 to the ward.
7 A. That's correct.
8 THE CHAIRMAN: And when the doctor does come to the ward,
9 do you then typically have a fuller discussion with the
10 doctor about what's wrong?
11 A. Yes.
12 MR WOLFE: When you bleep, is that something that's done
13 through switchboard? You phone the hospital switchboard
14 and they then send out a signal to the bleeping device?
15 A. Yes.
16 Q. And then the doctor phones switchboard, finds out who's
17 looking for him and then is put through to the ward?
18 A. I think that's how it works, yes.
19 Q. Did you simply get no response?
20 A. I got no response, no.
21 Q. Did you get any explanation for the no response?
22 A. No.
23 Q. Was that a common or a not unusual thing that you would
24 get no response?
25 A. It wasn't unusual.

1 Q. Clearly, the intended recipient of the bleep wouldn't
2 know what your problem was until he or she spoke to you;
3 isn't that right?
4 A. That's correct, yes.
5 Q. It could be either a very serious matter or a minor
6 matter.
7 A. Yes.
8 Q. If it was a very serious matter, is there another system
9 or another device that you could have used?
10 A. I'm not sure if I would have been aware at the time, but
11 for me I would probably have, if it was a serious matter
12 and I couldn't get first response, I would have informed
13 the nurse in charge or Sister Millar.
14 Q. Apart from using the bleeping facility via switchboard,
15 was there any method by which you could attempt to get
16 hold of the doctor directly yourself, such as by phoning
17 the surgical day room or the library or wherever else
18 the JHOs congregate?
19 A. Not that I was aware, no.
20 Q. How long do you think passed by before eventually
21 Dr Devlin was spoken to between you first deciding that
22 it was in order to make contact with a doctor and
23 getting to speak to him?
24 A. It's hard to tell. I really can't say a time because
25 I'm not sure.

1 Q. It appears to be something in the area of two hours,
2 perhaps two and a half hours; is that fair?
3 A. Possibly two hours.
4 THE CHAIRMAN: I've been told that there was a problem which
5 Sister Millar raised at the meeting on 12 June about her
6 unhappiness with the responses from the surgeons. But
7 was two to two-and-a-half hours an unusually long time
8 to wait for a response from a doctor?
9 A. That timescale would have been long, yes.
10 THE CHAIRMAN: Yes. I'm trying to get a picture. Was that
11 an exceptionally long time to have waited or was that
12 the sort of time that you might have had to wait on
13 a regular basis?
14 A. I don't recall.
15 THE CHAIRMAN: Okay.
16 MR WOLFE: During that period of, you think, two hours or
17 whatever time it precisely was, was Raychel's condition
18 being observed and monitored?
19 A. Her condition would have been -- we would have been
20 observing Raychel from going in and out to the room.
21 There would have been observations carried out at
22 5 o'clock and her drip site would have been checked
23 hourly.
24 THE CHAIRMAN: And you saw her at 4 o'clock, did you?
25 A. That's correct, yes.

1 MR WOLFE: Staff Nurse Roulston saw her at 5 o'clock for the
2 purposes of observations.
3 A. Yes.
4 Q. And perhaps if we could have that up on the screen
5 again. At 5 o'clock, she observed that the child was
6 asleep.
7 A. Yes.
8 Q. That's perhaps consistent with Mrs Ferguson's account,
9 who has said, as I've told you already, that having
10 returned to the hospital at 3.45 or 4.00, she got into
11 bed with the child and while the child was uncomfortable
12 with retching, and eventually was vomiting at or about
13 5 o'clock, she did have some sleep during that period.
14 Again, why was Staff Nurse Roulston coming to the ward
15 at this time? Were you on break?
16 A. It must have been around the start of break.
17 Q. Would that be another time in the nursing day for
18 a break to occur?
19 A. Yes.
20 THE CHAIRMAN: This witness would have seen Raychel at
21 4 o'clock because the IV fluid was checked at 4 o'clock.
22 MR WOLFE: That's right.
23 THE CHAIRMAN: Then Nurse Roulston would have seen her at
24 5 o'clock for the IV fluid and also for the purpose of
25 this observation.

1 MR WOLFE: That's right. And apart from the records
2 contained here, the notes contained here and the fluid
3 balance chart, they're the only records for that period
4 of time.
5 A. Yes.
6 Q. During the afternoon, was Raychel receiving sips of
7 fluid that you can recall?
8 A. I can't recall specific times, but I know Raychel was
9 tolerating some sips of fluid late morning. It could
10 have been early afternoon, I just can't be sure.
11 THE CHAIRMAN: I had got the impression it was late morning
12 only. Am I wrong? Mr Quinn, can you help?
13 MR QUINN: I can't help you.
14 THE CHAIRMAN: Okay, thank you.
15 MR WOLFE: The problem is that, apart from the episodic care
16 plan to which we will turn presently, there's no other
17 record of that.
18 Leaving a child who needs an anti-emetic, needs to
19 be seen by a doctor who might prescribe an anti-emetic,
20 for two hours or perhaps more, do you regard that as
21 acceptable?
22 A. During that period, I would have been in and about other
23 duties. I was the only nurse in the area at the time
24 and the time could have elapsed and if I had realised
25 the doctor wasn't there and that's why another attempt

1 at bleeping had happened ...
2 Q. Yes. Clearly, in a busy ward you are looking after
3 other patients who have needs. It might be easy to
4 become distracted, but Sister Millar was clearly aware
5 of the fact that you were looking to get a doctor as
6 well. Did you eventually speak to her about your
7 inability to get a doctor?
8 A. I believe it was in evening, prior to Dr Devlin coming
9 on duty -- or coming on to the ward, sorry.
10 Q. It was in the evening?
11 A. Prior to Dr -- just as Dr Devlin was coming on.
12 Q. Right. During the period while you were waiting for the
13 doctor, is it fair to say that Raychel was uncomfortable
14 and nauseated?
15 A. I was unaware of what she was during that time.
16 Q. Why were you unaware?
17 A. The specific times -- I wasn't with her at those times.
18 Q. But did you continue to think that it was appropriate
19 for a doctor to come to give an anti-emetic?
20 A. Yes.
21 Q. And presumably, it was appropriate for the doctor to
22 come to deliver an anti-emetic because the child
23 required one.
24 A. Yes, because she was feeling nauseated, not vomiting but
25 feeling sick.

1 Q. That's why I'm curious as to why you said you were
2 unaware of how she was at that time.
3 A. Sorry, I misunderstood the question.
4 Q. You continued to feel that there was a need for an
5 anti-emetic during that time.
6 A. Yes.
7 Q. And that was because Raychel continued to be nauseated?
8 A. Yes.
9 Q. Albeit you say that you weren't aware of any further
10 vomiting?
11 A. That's correct, yes.
12 Q. And while, no doubt, you were busy with other things,
13 staff nurse, would you accept the opinion expressed by
14 Sally Ramsay for the inquiry that to leave a child who
15 clearly needs an anti-emetic in this condition for
16 two-and-a-half hours isn't acceptable? Regardless of
17 whose fault it is, whether it's the system's fault or
18 whether it's individual fault, that is unacceptable.
19 A. Yes.
20 Q. After a period of time of being unable to contact a JHO,
21 presumably there were other options that you could have
22 considered. There were paediatricians on the ward; yes?
23 A. There was, yes.
24 Q. Why would you approach a paediatrician for the
25 straightforward task of renewing the fluid prescription

1 and not contact a paediatrician when there's
2 a significant delay in getting a JHO to come for an
3 anti-emetic?
4 A. At that time, I was unaware paediatric doctors would see
5 a surgical patient that wasn't critically ill.
6 Q. But you knew they would prescribe fluids?
7 A. Yes.
8 Q. I have difficulty, maybe you can help us. What is the
9 difference between asking a paediatrician to prescribe
10 fluids and asking him or her to prescribe an
11 anti-emetic?
12 A. They probably would have wanted to assess the child if
13 she was needing an anti-emetic to find out about the
14 vomiting and feel it was more for the surgical doctors
15 as she was under the care of the surgical team.
16 THE CHAIRMAN: I have the picture, which I have to decide
17 on, that Staff Nurse McAuley thought: if needs be, I'll
18 get the paediatrician to do the basic, non-controversial
19 task, apparently, of prescribing more IV fluid, and
20 at the other end, I'll ask the paediatrician if there's
21 an emergency. But you didn't think that this was an
22 emergency?
23 A. No.
24 THE CHAIRMAN: So you were waiting, perhaps frustrated about
25 the length of time it took, but you were waiting for the

1 surgeon to arrive?
2 A. That's right, yes.
3 THE CHAIRMAN: And had you thought it was more serious, then
4 you would have asked for a paediatrician?
5 A. I would, yes.
6 THE CHAIRMAN: Or had you thought it was more serious, you
7 would asked for an SHO on the surgical side. In other
8 words, you would have skipped the JHO who wasn't
9 responding.
10 A. Yes.
11 THE CHAIRMAN: But the fact that you waited that length of
12 time confirms that, although you had a degree of concern
13 about Raychel's condition, your concern was limited;
14 is that fair?
15 A. Yes.
16 THE CHAIRMAN: Okay.
17 MR WOLFE: Moving on then to the arrival of Dr Devlin.
18 Dr Devlin, let's be clear, wasn't the JHO who you'd been
19 trying to bleep; isn't that right?
20 A. That's right, yes.
21 Q. When you bleep or through switchboard bleep, do you know
22 that you're bleeping for a particular doctor?
23 A. At that stage, I just asked for Mr Gilliland's JHO to be
24 bleeped. When Dr Devlin came on, I believe he was just
25 starting his duty, coming on at the start of his shift.

1 I don't think -- he wasn't Dr Gilliland's JHO.
2 Q. That's actually one point I want to ask you about. When
3 you say you were contacting a JHO for Mr Gilliland, as
4 you do in your witness statement, what you were looking
5 for was a JHO under the command of Mr Gilliland, not
6 Mr Gilliland himself?
7 A. That's correct, yes.
8 Q. When Dr Devlin arrived, did you approach him?
9 A. I believe now that it was me that approached him, yes.
10 Q. Was Sister Millar present at that time?
11 A. I believe she was, yes.
12 Q. Did you have any discussion with Sister Millar before
13 you approached the JHO?
14 A. Not that I can remember, but I think she maybe said,
15 "There's Dr Devlin, why don't you ask him?"
16 Q. So did you approach him?
17 A. Yes.
18 Q. Can you remember what you told him?
19 A. I can't, no.
20 Q. Can you remember having a conversation with him?
21 A. I don't remember having a conversation with him, but
22 I would believed I would have informed him that Raychel
23 was post appendix and that she had episodes of vomiting
24 and nausea.
25 Q. You tell us in your witness statement that you didn't

1 attend Dr Devlin at Raychel's bedside; is that correct?
2 A. I didn't attend with him, no.
3 Q. So what you said to him -- and I appreciate that your
4 recollection appears to be vague -- but you think you
5 would probably have said to him, "This is a post
6 appendix patient who's had episodes of vomiting"?
7 Is that fair?
8 A. That's fair, yes.
9 Q. And did you ask him to do anything in particular, to
10 prescribe anything in particular, or did you leave him
11 to his own devices?
12 A. I don't recall. I may have suggested an anti-emetic,
13 but I don't recall.
14 Q. Can I put to you Dr Devlin's perspective? Just before
15 I do so, can I ask you this: did Staff Nurse Roulston
16 know that you were attempting to contact a doctor?
17 A. I'm not sure.
18 Q. In terms then of Dr Devlin and his perspective, can
19 I ask you this? Would you have gone and got the
20 anti-emetic for him or how would he have obtained same?
21 A. I wouldn't have got it. He probably would have got the
22 nurse that was on the medicine duties to either give him
23 the keys or to take it out of the cupboard for him.
24 Q. Okay. So it wasn't you?
25 A. No.

1 Q. What Dr Devlin says to the inquiry in his first witness
2 statement is that he was told that Raychel was less than
3 24-hours post-appendicectomy and she had vomited on
4 a few occasions that afternoon, but had been drinking
5 fluids earlier in the day. That's his recollection of
6 what he was told. Again, would you care to comment on
7 that?
8 A. I don't believe that's what I told him.
9 Q. What do you think would have been wrong with that
10 account?
11 A. I don't believe I told him that she was tolerating
12 fluids in the early part of the day.
13 Q. Right. Because that isn't factually accurate, is that
14 why you wouldn't have told him?
15 A. I would have been aware that she had sips, but was not
16 tolerating volumes of fluid.
17 Q. So it'd be wrong to tell him that she was tolerating
18 volumes of fluid?
19 A. Yes.
20 Q. That would have given out the wrong impression?
21 A. Yes.
22 Q. When he saw Raychel, she was vomiting. Presumably when
23 you saw Dr Devlin, he wasn't that far from Raychel's
24 bed, the area where she was being managed.
25 A. No.

1 Q. And you haven't accounted for any vomiting at that time.
2 A. I wasn't aware. I wasn't informed of any vomiting at
3 that time.
4 Q. Why didn't you attend Dr Devlin at the bedside?
5 A. It was possibly that I was carrying out other duties on
6 the ward. By the time that he came in the evening time,
7 it could have been tea breaks, I'm not sure, and I knew
8 there was a parent with her as well.
9 Q. In terms of the account that you gave Dr Devlin, do you
10 think you should have been providing him with a fuller
11 history of Raychel's case? In other words, can I ask
12 you this: Raychel had had a good overnight recovery;
13 isn't that right?
14 A. Yes.
15 Q. And she appeared to be fine, and then she had a series
16 of vomits during the morning in reasonably quick
17 succession --
18 A. Yes.
19 Q. -- and by this stage in the afternoon -- which is
20 getting on for 5.30/6 o'clock, isn't it --
21 A. Yes.
22 Q. -- she had been on intravenous fluids for the best part
23 of 18 hours --
24 A. Yes.
25 Q. -- and it is the case that her fluids hadn't been

1 reduced during that period at all?
2 A. No.
3 Q. Moreover, she had had very Lyttle oral fluid; isn't that
4 right?
5 A. That's correct, yes.
6 Q. Should you have told him all of those things?
7 A. I have no recollection of what I told him. There was
8 things that I could have told him, but he also would
9 have had the notes and charts to reflect back on if
10 he was going to make a judgment.
11 Q. But the impression that might be taken from your
12 evidence is that you simply asked him for an anti-emetic
13 for the child, albeit you told him that she had been
14 vomiting and was post-appendicectomy, and just asked him
15 to get on with it; is that a fair impression?
16 A. At the time I would have informed him of the vomits that
17 Raychel had, that her observations were within normal
18 limits, that I had no unduly [sic] concerns about her
19 condition at the time and then Dr Devlin, him being
20 a medic, would have made a diagnosis of what he felt was
21 required at that time when he saw her.
22 Q. You would appreciate the difference between a nursing
23 role and a medical role. Would you agree with me that
24 a nursing role involves advising a doctor of all of the
25 background and communicating clearly any departures from

1 the expected recovery pathway?
2 A. Yes.
3 Q. And by this stage, Raychel was not getting any better,
4 was she?
5 A. No, she was still vomiting.
6 Q. That's right. She was still vomiting albeit you didn't
7 appear to have seen that; isn't that right?
8 A. When I say "still vomiting", she still had episodes of
9 vomiting in the afternoon.
10 Q. Yes. Whereas, would you agree with me by that stage
11 in the afternoon, as some of the experts have observed,
12 Raychel might have been expected to be up and about,
13 quite mobile, drinking, off her IV fluids, and perhaps
14 eating something light? Isn't that what you would have
15 expected from a mild appendicectomy?
16 A. Some children go down that line and some children don't,
17 so at that time it would have been normal that there
18 would have been children that didn't follow that and
19 that were eating and drinking by the evening.
20 Q. Well, looking at this, Dr Foster, who is one of the
21 surgeons who's examined the facts of this case, he said
22 that neither the nursing staff nor Dr Devlin seemed to
23 have asked themselves an important question. That
24 important question, as he terms it, is: why was Raychel,
25 with a mild appendicectomy or a mild appendicitis at

1 worst, still vomiting? You appear to have no
2 significant concerns at that point. Is that the
3 position?
4 A. Yes. I was aware that children -- I wasn't aware how
5 long that anaesthetic drugs or surgery would have
6 children vomiting, and at that time I was aware that,
7 yes, she was vomiting, but I didn't know that that was
8 an excessive time back in 2001.
9 THE CHAIRMAN: I'm sorry, Mrs McAuley, but surely -- I know
10 that you were reasonably recently qualified
11 in June 2001, but surely even at that stage you would
12 have known that it wasn't normal for a girl who'd had
13 a fairly straightforward appendicectomy to be vomiting
14 all the next day.
15 A. Some children still -- my knowledge at the time was some
16 children still would have vomited the next day after
17 their appendix.
18 THE CHAIRMAN: But you want to find out why. That's not
19 a standard reaction.
20 A. My knowledge was it was just post surgery, the
21 anaesthetic drugs, and that's my limited knowledge at
22 that time, that was the reason why --
23 THE CHAIRMAN: I can that and I can understand a vomit or
24 a couple of vomits or maybe three vomits are maybe not
25 that unusual, but vomiting through the morning and then

1 into the afternoon, is that not something that's
2 unusual?
3 A. No.
4 MR QUINN: Mr Chairman, can I ask at this point, while we
5 are on the issue, rather than cover it later, as to
6 precisely what this nurse told Dr Devlin about the
7 vomiting?
8 THE CHAIRMAN: I think Mr Wolfe has tried to ask that and
9 I'm not sure she's very clear about that.
10 MR WOLFE: Yes. I think -- I will certainly ask the
11 question again.
12 MR CAMPBELL: That point has been covered, Mr Chairman, and
13 her evidence was that she had no recollection of the
14 specifics of that conversation.
15 MR QUINN: Well, can I ask then if she recalled anything
16 about vomiting at all or informed him about vomiting?
17 THE CHAIRMAN: At the bottom of page 146 of the [draft]
18 transcript, if you go to the bottom of page 146 [draft]
19 and the top of 147 [draft], this is Mr Wolfe:
20 "Question: So what you said to him -- and
21 I appreciate that your recollection appears to be
22 vague -- but do you think you would have probably have
23 said to him, 'This is a post appendix patient who's had
24 episodes of vomiting'; is that fair?
25 "Answer: That's fair, yes."

1 And I'm not sure it ever really got much beyond
2 that.
3 MR QUINN: It's important because if one brings up her
4 witness statement, which is WS051/2, page 17, you can
5 see there's a slightly different picture painted
6 in relation to that.
7 THE CHAIRMAN: Sorry, that continues. Mr Wolfe then asked
8 Mrs McAuley what Dr Devlin had said and that's at the
9 bottom of page 147 going into 148 [draft], but let's go
10 on to the witness statement we have. Which paragraph
11 are you at?
12 MR QUINN: It's (k). We have this issue about whether it
13 was Dr Devlin that was bleeped. It seems not. Then at
14 (i) you have:
15 "In relation to Dr Devlin's attendance, what exactly
16 did you tell Dr Devlin about Raychel's history of
17 vomiting? I am not sure if it was Sister Millar or I
18 who spoke to Dr Devlin. If it was me, then I don't
19 recall the conversation."
20 It seems to me, on behalf of the family, that maybe
21 there was no information whatsoever given to Dr Devlin
22 about the vomiting. And I just want that clarified at
23 this stage -- in black and white if we can -- whether or
24 not there was any evidence or any information given to
25 Dr Devlin about the vomiting. Why I lead into this is

1 that if one then puts up beside that the handwritten
2 statement of 022-099-311, which is the statement of
3 20 June.
4 The point I'm making here is it seems as though when
5 you read through those passages and look at the
6 transcript and filter through the evidence that this
7 witness wasn't giving the doctor any information. What
8 this witness was doing was bleeping the doctor and then,
9 as she said, the second paragraph, bottom three lines:
10 "The surgical JHO had arrived on the ward and
11 I asked him to give Raychel ..."
12 So it's a request made by her, not that she gave
13 Dr Devlin any information, that she asked her to do
14 a clinical assessment. It seems she had made up her
15 mind about this, that she needed an anti-emetic and she
16 was going to get it, and she confirms that in her typed
17 statement, which is her second statement to the inquiry,
18 when she's asked about the request for this. That
19 appears actually in WS051/1, page 3, if that could be
20 exchanged for the document on the left of the screen.
21 It's the penultimate paragraph halfway through:
22 "I bleeped the surgical JHO a couple of times, but
23 did not get any response. Then some time after
24 1700 hours, Dr Devlin, a surgical JHO, came into the
25 ward and it was explained to him that Raychel was a post

1 appendix child on IV fluids and was vomiting and could
2 she have an anti-emetic."
3 Well, none of that has been given in evidence now.
4 It seems that that isn't correct because she has no real
5 recollection of what happened and then this was
6 administered.
7 So it seems, in my respectful submission, that the
8 nurse has made up her mind, or perhaps the sister had
9 made up her mind -- because she offers up
10 Sister Millar's evidence earlier on -- that there was
11 going to be a drug, an anti-sickness drug, given and
12 they did not feed the doctor any information and I would
13 like some clarification on that.
14 THE CHAIRMAN: Didn't Sister Millar say something along
15 these lines last week? That when she came out and she
16 was worried -- she found out that a doctor hadn't
17 arrived to see Raychel, she came out, she saw Dr Devlin
18 and, in effect, she grabbed Dr Devlin.
19 MR QUINN: Yes, because Dr Devlin just happened to be to the
20 ward.
21 THE CHAIRMAN: For the purpose of him giving Raychel an
22 anti-emetic.
23 MR QUINN: Yes, that's correct. The thrust of this
24 interruption, if I may say so, is that all of the nurses
25 seem to be taking a common line. That is they are

1 saying: well, we gave the doctors information, the
2 doctors acted upon it. I'm saying, on behalf of the
3 family, that's not what the family are taking out of
4 these days of evidence. They see this as the nurses
5 taking a common line and that is they are saying: we
6 didn't do anything wrong, we simply give the fluid, we
7 don't prescribe it, we give the doctors information, we
8 don't describe the drugs, they administer them.
9 With respect, I say that's not the case. When one
10 reads through the statements one can see that it's the
11 nurses who are recommending the anti-sickness medication
12 and not the doctor who has been given information and
13 who then goes and prescribes it. And that's why
14 Nurse Noble said, "We left it out for the doctor ".
15 THE CHAIRMAN: That's the second anti-emetic.
16 MR QUINN: It was, yes, but that seems to be the practice on
17 the ward.
18 THE CHAIRMAN: Do you understand the point that's -- sorry,
19 Mr Campbell?
20 MR CAMPBELL: The point that I had referred to earlier
21 in the transcript, in fact, appears at page 150 [draft].
22 Mr Wolfe had set out a number of points leading up to
23 the question. He put to the witness at line 3 on
24 page 150 [draft]:
25 "should you have told him all of those things?"

1 And the answer was:
2 "I have no recollection of what I told him."
3 I knew that she had specifically said that with
4 regard to that conversation:
5 "There was things that I could have told him, but he
6 also would have had the notes and charts to reflect back
7 on if he was going to make a judgment."
8 THE CHAIRMAN: Right. There's two levels to this. One is
9 what the doctor should have done and the other,
10 Mr Campbell, I think, is what information the nurses are
11 supposed to give to the doctor and what information the
12 nurses did give to the doctor. It's at least possible
13 that the picture which is emerging is of a failure on
14 both sides of that argument because it's not at all
15 clear that the nurses are giving the information that
16 they should have given and rather that certainly the
17 evidence -- the very strong suggestion last week by
18 Mrs Noble and Sister Millar was that they were in effect
19 saying to the doctors, "Here's the anti-emetic", rather
20 than saying, "These are our concerns". I can understand
21 them prompting a young doctor to give an anti-emetic,
22 but my concern last week on hearing the evidence was
23 that they had gone further than that.
24 MR CAMPBELL: That certainly could be an analysis that could
25 be arrived at in respect of the second anti-emetic,

1 Mr Chairman. However I don't think that that can
2 reasonably be laid as an accusation in respect of this
3 prescription of anti-emetic. The point is that the
4 witness is being asked a series of searching questions
5 and some further questions at Mr Quinn's suggestion.
6 The point of the matter is that she simply can't recall
7 the details of the conversation that she's being asked
8 to give such detailed, specific answers about.
9 THE CHAIRMAN: So you're suggesting the reason why it's not
10 worth pursuing this point any further with Mrs McAuley
11 is that she simply doesn't remember?
12 MR CAMPBELL: Yes. And doing her best, she will attempt to
13 answer as best she can and might enter into the realms
14 of speculation.
15 THE CHAIRMAN: I think Mr Quinn might say, in response to
16 that, in her first statement to the inquiry on page 3,
17 she did give some level of detail which was that it was
18 explained to Dr Devlin and so on. So unless she
19 remembered more clearly in 2005 when this statement was
20 written and doesn't remember now, I have to accept that
21 that's a possibility, that over eight years her memory
22 has faded. But her oral evidence today doesn't sit with
23 that and I have to decide if that's because --
24 MR CAMPBELL: That is a determination for you to make,
25 certainly. I would caution that when witnesses are

1 asked -- and some witnesses will try harder than others
2 to give an answer and it may not always be a useful
3 answer for the purposes of finding the facts if the
4 witness is, in effect, backed into a corner and tries to
5 come up with an answer when there is no obvious answer
6 from the basis of their recollection.
7 THE CHAIRMAN: Yes. And I will also take into account that
8 Mrs McAuley, to be fair to her, that she made --
9 particularly this morning -- a number of concessions
10 without a fuss about them. She made a series of
11 concessions about things that hadn't been done in the
12 way that they might been done, which is to her credit
13 that she made the concession without being pushed into
14 them.
15 MR WOLFE: Yes, sir, and of course another perspective on
16 this is what Dr Devlin has to say about the exchange,
17 and I've already put his account and we'll, of course,
18 hear from him tomorrow. It appears to be a fuller
19 account than the nurse in front of us, the witness in
20 front of us, with the best will in the world, can't
21 provide. There's a number of sources for the
22 evidence --
23 THE CHAIRMAN: I understand why Mr Quinn made the
24 intervention that he did, but I'm not sure that we can
25 take this point much further with Mrs McAuley.

1 MR WOLFE: Just to complete this sequence then, staff
2 nurse -- and I think I can almost pre-empt what you're
3 going to say, but let me put the criticism in this
4 way: the point is made by a number of the experts who
5 have looked at this that by any time in the late
6 afternoon, given the period that Raychel had been in
7 receipt of intravenous fluids, added to the fact that
8 there had been frequent vomiting, her electrolytes ought
9 to have been assessed; okay? So by 6 o'clock, by the
10 time of the attendance of Dr Devlin, that's the kind of
11 thing that should have been done.
12 Is it the case that you simply had no concern that
13 there was going to be a fluid imbalance here?
14 A. It was outside my responsibility.
15 Q. Well, it would have been your responsibility to report
16 a concern to the doctor; would you agree about me?
17 A. If I had concerns, I would have reported them to the
18 doctor, yes.
19 Q. Can I suggest to you it's not good enough to say, "It's
20 outside of my responsibility." It's clearly the
21 doctor's responsibility to decide whether electrolyte
22 profiling is necessary, but it's your responsibility to
23 give him all the information and perhaps to prompt him
24 into that kind of decision.
25 A. In 2001, I didn't have the knowledge to know that

1 Solution No. 18 didn't have the sufficed amount of
2 sodium that was required.
3 THE CHAIRMAN: That goes back to a knowledge point. I don't
4 think it's worth taking that further, Mr Wolfe. I think
5 I've got that.
6 MR WOLFE: I'm going finally to the issue of record keeping
7 in this sequence of the evidence. You had made efforts
8 on your account to get a doctor to come.
9 A. Yes.
10 Q. A doctor failed to come in a timely fashion; isn't that
11 right?
12 A. Yes.
13 Q. You didn't get an explanation for that and none was
14 provided to you.
15 A. No.
16 Q. Raychel, as I think you've accepted, would have been in
17 need of an anti-emetic throughout that period.
18 A. Yes.
19 Q. And then a doctor came and administered IV Zofran; isn't
20 that right?
21 A. That's correct, yes.
22 Q. And none of that was noted?
23 A. There was a handwritten note at the end of the
24 evaluation to say that she had received IV Zofran.
25 Q. We'll come to that now. That was the only note that you

1 made.
2 A. That's right, yes.
3 Q. That didn't go into the formal notes attaching to the
4 child's record; isn't that right?
5 A. It would have been in her nursing notes that was in the
6 office.
7 Q. Right. In terms of the effect that the anti-emetic had,
8 did anybody take the responsibility of assessing,
9 monitoring whether it was effective?
10 A. Whenever I would have been checking the infusion site
11 again. At that stage I was not aware of any further
12 vomiting. I believe Raychel still felt nauseated and
13 that is why I wrote "IV Zofran given with fair effect".
14 Q. Before Dr Devlin left the ward, did you or any of your
15 nursing colleagues speak to him?
16 A. I didn't.
17 Q. Should he have sought out a nurse or should a nurse have
18 sought out him before he left?
19 A. I'm not sure.
20 THE CHAIRMAN: There should have been some conversation
21 between Dr Devlin and one of the nurses before he left
22 again, shouldn't there?
23 A. It's possible he could have said, "I've given that child
24 the anti-emetic now", or something to that effect, but
25 I'm not sure if occurred or -- but it wasn't to me. I

1 never had a conversation with him.
2 THE CHAIRMAN: That's really the point. The point is that
3 I think we've discussed this with previous nurses --
4 I can't remember whether we discussed it with you
5 earlier on -- but when a doctor's coming to the ward,
6 you've described earlier on there's the bleep, then
7 a doctor rings, the doctor then comes to the ward, and
8 there should be then some conversation on the ward.
9 A. Yes.
10 THE CHAIRMAN: And as the doctor leaves, the nurses need to
11 know what the doctor's view has been or the extent to
12 which the doctor says, "Everything is under control",
13 or, "You need to look out for this, contact me if things
14 don't improve in the next hour or two". But you need
15 some sort of conversation as the doctor's leaving, don't
16 you?
17 A. You would, yes.
18 MR WOLFE: The fact that no conversation took place, Staff
19 Nurse McAuley, might be consistent with the view that
20 was taken that this child simply needed an anti-emetic
21 and that there was no need to follow-up with the doctor
22 to find out what he thought or what his plan was, going
23 forward.
24 A. I can't say.
25 Q. Well, did you have any understanding of what you should

1 have been doing if the anti-emetic didn't settle the
2 problem?
3 A. I probably would have got in contact with the doctor
4 again.
5 Q. You were working with an episodic care plan at that
6 time.
7 A. Yes.
8 Q. We've been told by various nurses that that document was
9 to be regarded as, if you like, a living document, so if
10 new issues, new problems arose in the care of a child,
11 you would expect the plan to be re-evaluated, amended,
12 and other actions put in. Did you understand that that
13 was how the care plan was supposed to be used?
14 A. Yes.
15 Q. At this stage in the day -- perhaps if the care plan
16 could be pulled up or the relevant entry from it.
17 063-032-076.
18 THE CHAIRMAN: Do you want to highlight the bottom section?
19 MR WOLFE: Go to the top section, actually, to start with.
20 THE CHAIRMAN: The top half of the page?
21 MR WOLFE: The very top of the page, I think.
22 This is the extract from the episodic care plan that
23 was made available, as we understand it, at the handover
24 to the night shift of nurses.
25 A. Yes.

1 Q. You can see at the top of the page something which
2 I would ask you to comment on if you can. As we move
3 down the page, we'll see that you made entries at
4 1700 hours on 8 June. Whereas it says here on the top
5 of the page:
6 "Printed on 8 June 2001 at 4.39 pm."
7 A. Yes.
8 Q. Do you see that?
9 A. Yes.
10 Q. Can you explain that apparent inconsistency for us?
11 A. I believe, from memory, that when you went on to write
12 under each problem, if it was after the hour, it rounded
13 up to the nearest hour, would be the time correlated to
14 the entry that you made. So that's why each entry would
15 be timed 1700 hours.
16 Q. Right. So if you're making an entry at 4.39 or some
17 time after 4.30, it would become date stamped 1700?
18 A. As far as my knowledge is of it, yes.
19 Q. Right. And this was printed off at 4.39, that bit's
20 correct?
21 A. I believe so, yes.
22 Q. If we can go down to the bottom of the page. Can I ask
23 you about this? So sometime after 4.30, you've made an
24 entry which becomes timed at 17.00; is that right?
25 A. The typed entry comes up at 17.00, yes.

1 Q. And if I understand your explanation of this Lyttle
2 inconsistency, it's because you have made this entry at
3 some point after 4.30 pm?
4 A. I believe so, yes.
5 Q. Then the handwritten bit?
6 A. That was in the evening time.
7 Q. Is that your handwriting?
8 A. It is, yes.
9 Q. And clearly, that was written in after Dr Devlin had
10 been.
11 A. Yes.
12 Q. So with regards to the 1700 entry, you've written:
13 "Observations appear satisfactory."
14 Is that based on the observations in the afternoon?
15 A. It would be the observations that are carried out at 9,
16 1 and 5.
17 Q. So that's based on the daily cycle?
18 A. Yes.
19 Q. And then you say:
20 "Continues on PR Flagyl."
21 Which is the antibiotic, isn't that right?
22 A. Yes.
23 Q. And then you have said, "Vomit x3 this AM."
24 Is that this morning?
25 A. Yes.

1 Q. "But tolerating small amounts of water this evening."
2 A. Yes.
3 Q. That was intended to be, if you like, a description of
4 Raychel's condition throughout the day up until about
5 4.30 pm.
6 A. Yes.
7 Q. Leaving aside the note you've added to the bottom, would
8 the person reading that be reasonable in interpreting
9 that as saying there was no vomiting in the afternoon
10 and indeed she was now much more settled because she was
11 tolerating sips of water?
12 A. At the time that that was wrote, that was probably
13 accurate, but there would also have been verbal
14 communications going on as well.
15 Q. Was the purpose of this entry to assist with the
16 handover when the nurses came on shift at or about
17 8 o'clock?
18 A. That's correct, yes.
19 Q. But would you agree with me it's not factually accurate
20 in terms of what you knew at or about 5 o'clock?
21 A. There's probably one ... Probably "tolerating small
22 amounts of water this evening" wasn't a good timescale;
23 it probably was more afternoon than evening.
24 Vomiting -- there was no ... At that stage there was
25 nothing recorded to say that she had vomited at

1 3 o'clock.
2 Q. There's nothing in this note?
3 A. No.
4 Q. So the note is inaccurate because it fails to reflect
5 the 1 o'clock vomit and the 3 o'clock vomit.
6 A. I believe the 1 o'clock vomit is under the "three vomits
7 this AM".
8 Q. So that's counted as the morning vomit for these
9 purposes?
10 A. Yes.
11 Q. Why did you fail to record the 3 o'clock vomit?
12 A. "Vomiting this PM" is -- in the handwritten version --
13 Q. I'm conscious of that.
14 THE CHAIRMAN: Surely it's on the typed version -- I mean,
15 the handwritten addition improves it, but surely when
16 you were typing it up at 4.39, what you wanted to be
17 saying was:
18 "Vomited three times this morning [that includes up
19 to 1 o'clock]. Vomited again this afternoon and
20 nauseous"? Because your description of why Raychel
21 needed the anti-emetic, even when Dr Devlin arrived at
22 sometime around 5 o'clock, was that she had vomited
23 again and she was still nauseous; isn't that right?
24 A. Yes.
25 THE CHAIRMAN: Maybe I'll let you answer by saying this. At

1 what point did you add on the handwritten bit? Because
2 the typed bit does not give an accurate picture either.
3 A. No.
4 THE CHAIRMAN: So at what point did you add on the
5 handwritten bit?
6 A. I can't give an exact time, but probably nearer 7, prior
7 for the nurse in charge to get ready for handing over.
8 You'd have been -- the computers would have had
9 a downtime and it would have been difficult to access
10 computers at that time. So it was practice that if
11 there was any changes made, there was a handwritten
12 document put on to the printed-out copy from the
13 computer.
14 THE CHAIRMAN: I understand that. I don't want to be
15 unfair, Mrs McAuley, I don't want to be too harsh, but
16 if you were typing this up at 4.39, why does it not
17 refer to the 3 o'clock vomit or the fact that she is
18 nauseous? Because the way it reads is that she was sick
19 this morning, but things are on the mend this afternoon.
20 And that's not right.
21 A. I agree it's not right, no.
22 THE CHAIRMAN: And it's easy for me to come along here years
23 later and say this, but surely it should have said,
24 "Vomited again at 3 o'clock", or however you describe
25 it, whatever the words are, "Feeling nauseous, IV Zofran

1 given". Sorry, at that stage it would have been,
2 "Another vomit, nauseous, and doctor called". That was
3 the position at 4.39, wasn't it?
4 A. I believe that it was, yes.
5 THE CHAIRMAN: I don't want to prolong this, but is there
6 any reason why it doesn't say that?
7 A. I'm not sure. I'm aware that my documentation was poor
8 on that day. I had a limited period to update all the
9 children that I was looking after.
10 THE CHAIRMAN: Okay.
11 MR WOLFE: How many records would you have been completing
12 on -- this is DM Nurse, is that what it's called?
13 A. Yes.
14 Q. How many similar records would you have had to complete
15 before going off duty?
16 A. Whichever patients was in areas A to I. I don't know
17 the numbers off that day.
18 THE CHAIRMAN: Would you have been doing some and
19 Nurse Roulston doing others, or would you have been
20 doing them all?
21 A. I'd have been doing them all.
22 THE CHAIRMAN: So this is a point at which you were under
23 pressure?
24 A. Yes.
25 MR WOLFE: It's 3.55, now, sir. I would hope to get through

1 the remainder by 5 o'clock.
2 THE CHAIRMAN: Right. Are we finished on this point?
3 MR WOLFE: We're finished on this point.
4 MR QUINN: Can I ask a point of clarification on this?
5 We have discussed this among ourselves with my learned
6 friend. The records that we hold in relation to this
7 record that's on the screen is headed that it's printed
8 out --
9 THE CHAIRMAN: Some days later.
10 MR QUINN: It's on the day of the meeting, which is 12 June
11 2001 at 3.18 pm. I just want some clarification as
12 to -- if it is -- I assumed -- maybe I'm wrong, there
13 could be absolutely nothing in this. I assumed this was
14 a computer-generated record that had been printed out on
15 the 8th and that this nurse had handwritten on it.
16 THE CHAIRMAN: As we understand it, the one that's on screen
17 at the moment, we've got that from the Royal's records
18 because that's what went down with Raychel to the Royal.
19 MR QUINN: That explains that.
20 THE CHAIRMAN: Does that make sense?
21 MR QUINN: Yes, it does.
22 THE CHAIRMAN: That's why there's a different file number on
23 it, Mr Quinn. It's file 63, the Raychel clinical
24 records we got from the Royal.
25 Let's just pause there because that doesn't explain

1 why that handwritten bit isn't also on the records which
2 were still in Altnagelvin.
3 MR QUINN: I know that. That's the point I'm making.
4 THE CHAIRMAN: Can you help us with this? The document
5 that's on the screen in front of you, Ms McAuley, that's
6 your handwriting at the bottom of it, isn't it?
7 A. Yes.
8 THE CHAIRMAN: As we understand it, we've got this from
9 Royal's records because when Raychel was sent down to
10 the Royal, her records went with her.
11 A. Yes.
12 THE CHAIRMAN: So the Royal would have this. The version
13 we have, if we could bring it up, please, it's
14 020-027-060. If you cut off the bottom third maybe and
15 highlight the top two thirds. We've lost a Lyttle bit
16 at the top, the Lyttle bit at the top says that this
17 page we're looking at now was printed on 12 June at
18 3.18. So that was the day of the critical incident
19 meeting within Altnagelvin. Okay?
20 A. Yes.
21 THE CHAIRMAN: But the part that's retained by Altnagelvin
22 doesn't include your handwritten addition just at the
23 bottom of the screen.
24 A. I'm aware of that because I had asked for that several
25 years back to confirm that I had written it.

1 THE CHAIRMAN: Right. And it wasn't in Altnagelvin?
2 A. No.
3 THE CHAIRMAN: Then when you got confirmation of the bit
4 that you had handwritten in, was that only when you got
5 access to the additional records from the inquiry of
6 what had gone to the Royal?
7 A. I became aware of that entry on the transcript of the
8 first day and it was in one of the paragraphs,
9 documentation, and nobody knew who wrote it, and at that
10 stage I contacted Therese Brown's office to say that was
11 my writing.
12 THE CHAIRMAN: Okay. Then the handwritten note never made
13 it into the print. Okay.
14 Mrs McAuley, we'll take a break for ten minutes.
15 We'll come back and your evidence will be finished by
16 5 o'clock and that'll be you finished.
17 (4.00 pm)
18 (A short break)
19 (4.10 pm)
20 (Delay in proceedings)
21 (4.22 pm)
22 MR CAMPBELL: Before Mr Wolfe resumes, there's a point I'd
23 like to clarify regarding the consolidated care plan and
24 the handwritten annotation on that document.
25 THE CHAIRMAN: Just give us one second and we'll wait for

1 the others to come in. I take it the DLS are still
2 here.
3 MR CAMPBELL: I believe so. (Pause).
4 During the break I was speaking with
5 Ms Anne Witherow, who is currently the deputy director
6 of nursing within Altnagelvin. She wanted me to
7 emphasise to the inquiry that there really is no mystery
8 regarding the care plan and its annotated handwritten
9 version going up to Belfast. The reason is that all of
10 Raychel's clinical notes when went her at the time of
11 transfer.
12 THE CHAIRMAN: I understand that. I'm absolutely fine with
13 it because, in fact, it's something that didn't happen
14 in one of the other cases, so I'm more than happy --
15 MR CAMPBELL: Then when the care plan is printed out for the
16 purpose of the meeting on the 12th. Of course it does
17 not have the handwritten addition --
18 THE CHAIRMAN: Because the handwritten addition --
19 MR CAMPBELL: That explains why two versions --
20 THE CHAIRMAN: -- was never typed into the note.
21 MR CAMPBELL: That's why the two versions can then co-exist
22 and the handwritten copy then comes back from Belfast
23 some years later.
24 THE CHAIRMAN: I understand that. That's fine. Thank you
25 very much.

1 MR STITT: Might I come back, if it's convenient,
2 in relation to this question of the legal privilege?
3 THE CHAIRMAN: No. Sorry. Yes, you can, but not now.
4 I would really like to let Mrs McAuley finish. We're
5 going to have her finished by 5 o'clock and rather than
6 us have a legal debate now, I'd like Mrs McAuley to
7 finish --
8 MR STITT: I fully understand. In case you were wondering,
9 that's where I'd been for the last two hours, dealing
10 with that issue.
11 MR WOLFE: Finishing with the Dr Devlin sequence, a number
12 of further quick questions. Dr Devlin seems to recall
13 that after he had finished administering the
14 anti-emetic, he advised a nurse, who he believes might
15 have been you, to contact the surgical team if Raychel
16 experienced further problems. Can you recall him saying
17 that to you?
18 A. I have no recollection of that. As far as I was aware,
19 I was on lunch or my tea break when Dr Devlin seen
20 Raychel. So I wasn't aware of any conversation after.
21 THE CHAIRMAN: Sorry. Does that mean that you don't --
22 do you not remember D Devlin being there at all?
23 A. I do remember him being there. He was on the ward and
24 he seen one of his patients that he came up to see
25 first, then he went to Raychel. I don't remember when

1 he left or I didn't see him going to Raychel or any of
2 the event that happened after that.
3 THE CHAIRMAN: And that might have been because you were on
4 a tea break or it might also have been that,
5 unfortunately, there wasn't the discussion that there
6 should have been after he saw Raychel, for whatever
7 reason, whether it's his fault or somebody else's fault.
8 Okay.
9 MR WOLFE: Can I ask a further question arising out of the
10 attendance of Dr Devlin? Just so that we can have it
11 straight, it arises out of what Mr Quinn said earlier.
12 It's this: when Dr Devlin was approached, was he simply
13 asked to prescribe an anti-emetic and get on with it,
14 or, alternatively, did you simply ask him to review
15 Raychel, examine her and work it out for himself?
16 Do you see the two options there?
17 A. I believe I would have informed him that Raychel was
18 post appendix, that she was on IV fluids, and that she
19 had vomited.
20 Q. Right. Do you think you mentioned an anti-emetic?
21 A. I possibly could have said she may require an
22 anti-emetic.
23 THE CHAIRMAN: From your perspective, it's entirely
24 legitimate for you to suggest that as one of the options
25 provided that Dr Devlin goes on to make his own decision

1 about what Raychel needs. You're giving him an idea --
2 A. Yes.
3 THE CHAIRMAN: -- rather than telling him what to do?
4 A. Yes.
5 THE CHAIRMAN: And I can understand how a nurse will
6 sometimes prompt a doctor to think along certain lines.
7 There's a query of how far it goes in this case.
8 MR QUINN: I think it's a Lyttle unfair for the nurse to
9 say, "I possibly could have said she may require an
10 anti-emetic". When you look at her handwritten
11 statement and her two typed witness statements, one
12 says, "I asked him to give", and the other one says, "I
13 suggested that he give". It's a Lyttle unfair to say,
14 "I possibly could have said". I would accept that "she
15 probably said" might have been a better answer, but I'll
16 leave that to you, Mr Chairman, to place that question.
17 THE CHAIRMAN: There's a complete lack of clarity on this
18 point.
19 MR QUINN: Not in the statements there's not.
20 THE CHAIRMAN: Not in the statements. In a sense, the
21 clearest evidence might have been given on this last
22 week by Sister Millar.
23 MR QUINN: It might well have, but I think it's a Lyttle
24 unfair leaving it in the air for the family because it's
25 quite clear from the statements that this nurse says she

1 asked Dr Devlin to give Raychel an anti-emetic and she
2 says in her typed statements that she suggested that he
3 should consider giving her one. So --
4 THE CHAIRMAN: The first inquiry statement was "and could
5 she have an anti-emetic".
6 MR QUINN: So it's not really fair not to test the evidence
7 by putting those points to her.
8 THE CHAIRMAN: I think the different possibilities have been
9 put to her in her statements and I'll just have to reach
10 a conclusion now.
11 MR WOLFE: Of course, it won't need to be said to you, Staff
12 Nurse McAuley, that had you made a note of your
13 interaction with Dr Devlin, much of this confusion would
14 have been avoided.
15 A. It would have been depended what I've wrote in my note,
16 yes.
17 Q. And do you agree with me that you ought to have made
18 a note in relation to the attendance of Dr Devlin and
19 what was said to him, quite apart from the short note
20 that you entered on to the episodic care plan?
21 A. Sometimes it's difficult to write so much detail.
22 Whenever you're trying to care for so many patients and
23 document various things on other patients as well, you
24 may not always have the time to write detailed notes.
25 Q. I appreciate that. In an ideal world, would you accept

1 that a note should have been written in respect of his
2 attendance?
3 A. If it was an ideal world, yes.
4 Q. You have explained that your note, your typed note in
5 the episodic care plan, was written under a degree of
6 pressure --
7 A. Yes.
8 Q. -- because you had other notes to make before the end of
9 your shift and you were doing them alone.
10 A. Yes.
11 Q. Other note keeping for which you had some
12 responsibility, for example on the fluid balance chart,
13 there is, as we highlighted earlier, an absence of
14 recording of sips of water, an absence of recording in
15 respect of urination. You appear to have missed a vomit
16 that Dr Devlin was certainly aware of.
17 A. I was not aware of that vomit that Dr Devlin had seen.
18 He never informed me or no other member of staff
19 informed me.
20 Q. Do you agree, certainly to the extent that you were
21 aware of sips, that that should have been recorded?
22 A. Sips should have been recorded in the fluid balance
23 chart, they weren't. They were recorded in the
24 evaluation.
25 Q. The fact that you were aware that her father, I think

1 you told us, brought her to the toilet, should that have
2 been recorded?
3 A. It should have, yes.
4 Q. And if the doctor was aware of vomiting or if any of
5 your nursing colleagues were aware of the vomiting, that
6 should have been recorded?
7 A. They should have recorded it or informed me, yes.
8 Q. Would you agree with Sally Ramsay's criticism that the
9 failure to record these matters means that fluid
10 balance, in essence, wasn't recorded properly?
11 A. The fluid balance was incomplete, yes.
12 Q. In terms of your assessment that, really, there was no
13 particular concern for Raychel other than the need to
14 get her an anti-emetic, is it possibly the case that,
15 because several nurses were dealing with Raychel, no one
16 had a complete overview and therefore the vomiting was
17 seen as a, if you like, common problem simply to be
18 controlled by an anti-emetic rather than looking at her
19 underlying problem?
20 A. At the time, my knowledge of the vomit was just related
21 to post surgery.
22 Q. Yes. But do you think part of the problem here was
23 there wasn't this continuity of care because you were
24 looking at Raychel, you only saw one vomit for yourself,
25 according to your account, Nurse Roulston noted some

1 vomits and recorded them, but on her account she didn't
2 report them. Do you think there was a problem here in
3 communications between nurses, which led to a failure to
4 appreciate just how unwell Raychel actually was?
5 A. There would have been two ways of finding out the amount
6 of vomiting and Raychel's state: looking at the
7 observation chart and the fluid balance chart, and
8 seeing Raychel for ourselves and generally nurses
9 talking among themselves and passing over verbal
10 reports. We would have been able to get a full picture
11 of Raychel.
12 Q. It does appear that the full picture was missed.
13 A. Looking back now, yes.
14 Q. Is that because communications were not adequate in
15 part?
16 A. No.
17 Q. Why do you think the full picture was missed?
18 A. The full picture was missed because we weren't aware --
19 or I wasn't aware -- of hyponatraemia at the time or the
20 potential for electrolyte imbalance in relation to
21 having Solution No. 18 in progress.
22 Q. In terms of the effectiveness of the anti-emetic, you've
23 described it as having a "fair effect".
24 A. Yes.
25 THE CHAIRMAN: Sorry, just before you go to that, just one

1 final point about what was or was not said to Dr Devlin.
2 I have just turned up my note of what Sister Millar said
3 last Thursday. She said that she had spoken to you
4 about 3 o'clock. She agreed that you should get
5 a doctor. She contacted you an hour later and a doctor
6 hadn't arrived yet. She said that she went out into the
7 ward, she saw Dr Devlin, and then what she said was:
8 "I asked Staff Nurse McAuley to ask Dr Devlin to
9 give Raychel an anti-emetic."
10 That's what Sister Millar said last week. Do you
11 disagree with that or do you remember that?
12 A. I don't agree with what Sister Millar's saying; I'm just
13 saying I don't remember the conversation that I had with
14 Dr Devlin.
15 THE CHAIRMAN: If Sister Millar was right and she asked you
16 to ask Dr Devlin to give Raychel an anti-emetic, is it
17 likely that you would have asked Dr Devlin to give
18 Raychel an anti-emetic?
19 A. It is likely that I would have, yes.
20 THE CHAIRMAN: Because Sister Millar had asked you to do
21 that?
22 A. Yes.
23 MR WOLFE: Just on the transcript there, the answer to one
24 of the questions that you received there, sir, is "I
25 don't agree with what Sister Millar's saying". I'm

1 wondering is that -- Mr Campbell might want to say
2 something on this.
3 MR CAMPBELL: I thought that's what the witness said.
4 MR WOLFE: I wasn't sure if that's what she meant.
5 THE CHAIRMAN: Can we clarify it? Let me go back over this
6 again. Last week, Sister Millar said, "I asked Staff
7 Nurse McAuley to ask Dr Devlin to give Raychel an
8 anti-emetic". Do you agree that Sister Millar asked you
9 to do that or do you remember Sister Millar asking you
10 to do that? Sorry, let me simplify it. Do you agree
11 Sister Millar asked you to do that?
12 A. It's possible that she did, yes; I just don't remember
13 the conversation that I had with Dr Devlin.
14 THE CHAIRMAN: But then what that led on to was that if
15 Sister Millar's right and that is what she asked you to
16 ask Dr Devlin, it's likely that that is what you asked
17 Dr Devlin to do?
18 A. Yes.
19 MR WOLFE: Let's move to deal with the situation of how
20 effective the anti-emetic was. You've written that it
21 had "fair effect".
22 A. Yes.
23 Q. We'll not put that document back up on to the screen,
24 but you said the anti-emetic had "fair effect".
25 A. Yes.

1 Q. Does that mean that Raychel was vomiting again at some
2 point after an initial effective response to the drug?
3 A. I don't believe that Raychel was -- I wasn't aware of
4 any further vomiting that Raychel had, but I believe she
5 was still feeling nauseated, and that's why I said,
6 "with fair effect".
7 Q. Mrs Ferguson gives a perspective on this and she says
8 that after receiving the medication from the doctor,
9 Raychel vomited again within the hour, and she was
10 zombie-like and lifeless. So the picture she's
11 presenting is of a child who, shortly after 6 o'clock --
12 perhaps by 7 o'clock -- was vomiting again and lifeless.
13 You were still on duty at that time; isn't that right?
14 A. I was, yes.
15 Q. Would you care to comment on her recollection?
16 A. At that time, I would have checked -- at 7 o'clock I'd
17 have been checking the IV infusion rate and that's not
18 how I would have remembered Raychel.
19 Q. How would you have remembered her?
20 A. I think she was in bed at that stage. I don't think she
21 was sleeping, I'm not 100 per cent sure. There was no
22 episodes of vomiting reported to me then, nor did I see
23 her vomiting at that stage.
24 Q. Her father returned to the hospital -- that is
25 Mr Ferguson -- at about 6.45, and Raychel was lying down

1 in the bed, didn't acknowledge him, and later visitors
2 arrived and these were the visitors known as the
3 McCullaghs. They found Raychel to be unresponsive to
4 them as well. Mrs McCullagh recalls that Raychel simply
5 lay on the bed, on top of the bed clothes, was very
6 restless, fidgety, unsettled and didn't communicate with
7 her friend that was visiting. Again, is that your
8 recollection?
9 A. No.
10 Q. You have told us that, before going off duty at 7.30,
11 you remember seeing Raychel up and about walking in the
12 corridor with her drip stand.
13 A. That's correct, yes.
14 Q. Outside room I?
15 A. Yes.
16 Q. She was showing two small boys, who you took to be her
17 brothers, some pictures on the wall?
18 A. That's right, that's what it appeared, yes.
19 Q. Before asking you about that, are you absolutely certain
20 that we're talking about the same child?
21 A. I am absolutely certain, yes.
22 Q. Is there any possibility at all that you could be
23 mistaken?
24 A. No.
25 Q. How long did you observe this scene of Raychel with two

1 small boys, showing them some pictures on the wall?
2 A. It wasn't very long, it was just a passing observation
3 that I observed. It wasn't any -- you couldn't call
4 it(?) any length of time. I just seen her with two boys
5 in the corridor and that's all I remember.
6 Q. Would there have been other children on the ward on that
7 evening connected up to a drip?
8 A. Possibly, but I don't have any recollection. It was
9 Raychel that I seen in the corridor.
10 Q. Did you see her face?
11 A. Yes.
12 Q. Or did you see her from behind?
13 A. The side.
14 Q. And that indicated to you that Raychel was fit and well
15 and there were no concerns?
16 A. That's correct, yes.
17 Q. At what time did you reach the view that the anti-emetic
18 merely had fair effect so that she was still nauseous?
19 A. Half six, 7 o'clock, I'm not sure.
20 Q. So are you saying that you saw her up and about after
21 the nausea had ceased?
22 A. At the time that I recorded the nausea, possibly yes.
23 Q. No, you say that the anti-emetic was given, it had only
24 fair effect in the sense of she was continuing to be
25 nauseous.

1 A. Yes.
2 Q. At what point was she up and about and was she nauseous
3 at that time; can you say?
4 A. I can't say. She may have been going to the toilet, she
5 was outside room I in the corridor with a drip stand.
6 It might have been she was only there for a minute,
7 I don't know. But I know that it was Raychel that
8 I seen in the corridor with a drip stand.
9 Q. The account that you gave to the inquiry, which I've
10 just rehearsed, was part of your statement to the
11 inquiry in 2005; isn't that right?
12 A. That's correct, yes.
13 Q. And you gave that in a statement on 30 June 2005. For
14 your record, sir, it's page 3 of 051/1. Can I have up
15 on the screen, please, the statement that you gave to
16 the Trust in 2001? That's 021-067-158. There was the
17 earlier handwritten statement and I think they're
18 identical. Maybe Mr Reid could check that.
19 THE CHAIRMAN: Wait one moment. It's probably better
20 working with the original. 029-099-311.
21 MR WOLFE: This is the statement that you provided on
22 20 June 2001.
23 A. That's right, yes.
24 Q. Can I suggest to you that your memory 12 days after
25 8 June would be much fresher about the events of that

1 day than it was in 2005 when you provided the inquiry
2 with a statement?
3 A. Yes.
4 Q. We went over this statement earlier for different
5 purposes and you were somewhat vague in what you were
6 instructed to do in preparing this statement. But
7 I think we reached the point where you were agreeing
8 that you were asked to set out an account of that day
9 and the main events of that day; is that fair?
10 A. That's fair, yes.
11 Q. Dealing with the events after the anti-emetic was given
12 in the last paragraph, you say:
13 "From 6 pm to 8 pm, when I went off duty, I was not
14 aware of any further vomiting. She was sitting up in
15 bed with her family. I had no concerns as her
16 observations remained within normal limits and she had
17 no complaints."
18 Do you see what you've done there? You have
19 accounted for exactly where Raychel was and that appears
20 to have been one of your last recollections of Raychel;
21 is that fair?
22 A. It's one of the last things I wrote, yes.
23 Q. In that paragraph you are attempting to illustrate why
24 you had no concerns for Raychel; isn't that right?
25 A. Yes.

1 Q. If Raychel had been up on her feet, chatting with her
2 brothers as if she didn't have a care in the world,
3 that's something you would have included in that
4 statement, isn't it?
5 A. As I said, it possibly was as Raychel coming back from
6 the toilet, I don't know what her reason in the corridor
7 was. I haven't mentioned other times that she was out
8 in the corridor in that statement neither, but that's
9 not saying that's not what I remember.
10 Q. As an example of how you might illustrate that you had
11 no concerns about the child's health, you couldn't think
12 of a better example, could you, that the child was up
13 and about with her brothers? And yet you didn't include
14 it.
15 A. When I wrote this statement, I didn't realise the
16 concerns that were had by the family prior to writing
17 this first statement. If I had known that, yes, I would
18 have put that I seen Raychel on the corridor prior to
19 leaving. I was not aware of those. If I had felt
20 it would have caused as big an impact, I would have
21 recorded that in that initial statement, but I seen
22 Raychel in the corridor.
23 THE CHAIRMAN: Mrs McAuley, what you appear to be doing in
24 the last paragraph of the statement is explaining how,
25 after the doctor had been out, in reality things seemed

1 to improve, there was no further vomiting, she's sitting
2 up in bed with her family and you had no concerns;
3 right?
4 A. Yes.
5 THE CHAIRMAN: The statement to the inquiry, which is made
6 about four years later, goes beyond saying she was
7 sitting up in bed and beyond explaining that, it goes up
8 to saying that she's actually up and walking.
9 A. Yes.
10 THE CHAIRMAN: Children can be sitting up in bed and really
11 not very well, but doing their best by sitting up in
12 bed, can't they?
13 A. Yes.
14 THE CHAIRMAN: But for a child to be out of bed and walking
15 -- and not just walking to the toilet, but walking along
16 in a corridor and pointing out pictures on the wall to
17 their brothers, that really suggests a child who you
18 wouldn't be worried about because she's on the road to
19 recovery.
20 A. Yes.
21 THE CHAIRMAN: But you knew that when you were being asked
22 to make the statement that Raychel had died. You knew
23 things had gone terribly wrong just a few hours later
24 on. The point that you made to illustrate how well she
25 was was limited to her sitting up in bed. And I think

1 the Ferguson family say you're simply wrong to say that
2 she was walking around, pointing out pictures in the
3 corridor, because she say -- and visitors say -- she was
4 really was not very well at all as she had been sick
5 again. You say you don't know about that, but she was
6 sick again, she was lifeless and she had not improved as
7 a result of the anti-emetic. If you wanted to
8 illustrate how well she was when you made that statement
9 in June 2001, wouldn't you have more naturally done it
10 by referring to her being up and about, walking, out of
11 bed?
12 A. So it's just a memory that I have. I remember when it
13 first came in to be added on to my statement is when
14 we were discussing the events of the day and it was only
15 then, with discussing it, that I've realised the
16 relevance of it.
17 THE CHAIRMAN: That's when you're discussing it four years
18 later when you are preparing a statement for the
19 inquiry?
20 A. For the coroner's inquest.
21 MR WOLFE: Let me turn up the reference to the coroner's
22 inquest, 012-042-206. Maybe if we have the two pages,
23 please, together. 012-042-205 and 206 up together,
24 please.
25 The typed part of this deposition, Staff Nurse

1 McAuley, ends in the same way. In fact, it may well be
2 a verbatim statement. You end by saying:
3 "From 6 o'clock to 8 o'clock, when I went off duty,
4 I was not aware of any further vomiting. She was
5 sitting up in bed with her family."
6 And then there's some further questions. And then
7 at the end Mr McAlinden, who was counsel for the
8 Trust -- and I can't work out those first two --
9 THE CHAIRMAN: "I last saw".
10 MR WOLFE: "I last saw Raychel at between 7 and 8 pm prior
11 to going off duty."
12 Do you see that?
13 A. Yes.
14 Q. Just to get all of these pieces out on the table, sir,
15 we have the note that was made by counsel or solicitor
16 at the inquest. Let's see if this might assist us in
17 any way. 098-022-061. If we could pick up in the
18 middle paragraph:
19 "Mr McAlinden asked Staff Nurse Rice when it was she
20 last saw Raychel, to which she replied that it had been
21 about 7 to 8 pm, when she was going off duty."
22 Then the note-maker records:
23 "At this point, both parents -- who had been
24 muttering throughout both nurses' evidence -- shouted,
25 "That's a lie". Mrs Ferguson, crying [et cetera]."

1 I needn't read the rest.
2 That does seem to suggest, sir -- and maybe through
3 the witness -- that something was said that prompted
4 that outburst by the parents. Can I ask you, Staff
5 Nurse McAuley, before giving your witness statement to
6 the inquiry in 2005, had you ever previously given an
7 account to anybody which raised this issue of seeing
8 Raychel standing with her two brothers?
9 A. Prior to the coroner's inquest?
10 THE CHAIRMAN: No, no. It's not in the statement that you
11 made about 10 or 12 days after Raychel died. That's the
12 20 June statement.
13 A. No.
14 THE CHAIRMAN: It's not in your statement to the coroner in
15 2003 because your statement to the coroner in 2003 is
16 the same as your statement internally, or it certainly
17 ends with you saying that you saw her sitting up in bed
18 with her family.
19 A. Yes, it was discussion prior to that with the legal
20 team. I said, you know, we were just talking and
21 I says, "You know, I seen Raychel in the corridor", and
22 he said, "Why did you not put that in?", and I said, "I
23 don't know why I didn't put it in". He said it would
24 have been an important thing to put in. So he was then
25 going to question me on it, I believe, during the

1 inquest.
2 MR WOLFE: And were you questioned on it during the inquest?
3 A. I believe my response is the handwritten version, that
4 I seen her.
5 THE CHAIRMAN: No, the handwritten version says you last saw
6 her between 7 and 8 or 7.30 and 8, but it doesn't say
7 that you saw her up and about walking.
8 Did Staff Nurse McAuley say that at the inquest and
9 is that what prompted the outburst from the family?
10 MR WOLFE: I see nods from the public gallery.
11 THE CHAIRMAN: What seems to have happened is that you put
12 the same written statement to the coroner as you'd made
13 internally and then you say you spoke to the Trust
14 barrister before the inquest and, during your evidence
15 at the inquest, you having mentioned beforehand to the
16 barrister that you'd seen Raychel up walking about, you
17 then added that detail to your evidence, which hadn't
18 been said before, and that's what prompted the family to
19 become upset. Is that the sequence? And that's the
20 sequence that the Fergusons agree? Okay.
21 MR WOLFE: It would appear to be unfortunate, therefore,
22 sir, that the scribes at the inquest didn't pick up the
23 fullness of the evidence.
24 THE CHAIRMAN: Yes. I'm going to take it, because of the
25 Fergusons' reaction in the chamber and from what Staff

1 Nurse McAuley has said, that that is what happened.
2 MR WOLFE: Could I put this further point into the mix?
3 MR CAMPBELL: Before we leave that point, Mr Chairman,
4 I think that exchange that has just taken place
5 highlights the need for caution with regard to this very
6 note.
7 THE CHAIRMAN: Absolutely, yes.
8 MR WOLFE: In fairness, it probably says more than
9 the coroner's note.
10 THE CHAIRMAN: In this respect, it's incomplete rather than
11 wrong.
12 MR CAMPBELL: Yes. It lacks an important detail --
13 THE CHAIRMAN: Absolutely.
14 MR CAMPBELL: -- which the Fergusons have confirmed.
15 MR WOLFE: If I could have up on the screen 022-002-007.
16 This is a document that can be found in file 22,
17 self-evidently, and it's been indexed on file 22 under
18 the heading, "Therese Brown's handwritten notes on
19 inquest", albeit that if one considers the preceding
20 several pages, this note looks slightly different in
21 character to the preceding several pages in that the
22 preceding several pages do look as if they are a record
23 of what was said by the coroner at the inquest, whereas
24 this seems to be, on my understanding, a stand-alone
25 note, documenting both the point about this witness

1 seeing Raychel walking around, and it goes on to deal
2 with other separate matters:
3 "Benchmarking, change of fluid balance sheet [and
4 then at the bottom], passing of urine, PU, [and then]
5 blood pressure."
6 THE CHAIRMAN: Yes.
7 MR WOLFE: The point nevertheless, comes to this, and I'll
8 ask it again, Staff Nurse McAuley. The family members
9 who were with Raychel at that time between 7 and 8 pm
10 suggest that Raychel was so unwell that she simply
11 wouldn't have been up and walking about and that you
12 must be at least mistaken about this. Is there anything
13 further you want to say on it?
14 A. I'm not mistaken. It was Raychel that I seen in the
15 corridor.
16 Q. You went home that night at about 8 o'clock.
17 A. Yes.
18 Q. Were you working the next day, 9 June?
19 A. I was, yes.
20 Q. And did you receive any information 9 June about how
21 Raychel had fared overnight?
22 A. Whenever I came on to the ward on 9 June, I had noticed
23 that the emergency trolley had been opened and I can't
24 remember if I noticed it in the corridor, but I noticed
25 that it was opened and I was wondering who had taken

1 unwell during the night, and it was only shortly after,
2 when report had started, that I realised that it was
3 Raychel that had took unwell.
4 Q. And did you receive any information about what had
5 become of her?
6 A. I don't remember the exact details of what I had
7 received at that time, but that she had had a seizure
8 and was downstairs, I believed -- I wasn't sure if she
9 was in ICU or having a scan.
10 Q. Who were you speaking to at that point?
11 A. I wasn't speaking, it was just information that was
12 being relayed to the day staff coming on.
13 Q. And apart from learning that she'd had a seizure, were
14 you given any understanding about the suspected causes
15 of this seizure?
16 A. No.
17 Q. Raychel, as we know, was transferred to Belfast,
18 seriously ill. Were you aware of that?
19 A. I think I became aware of that later on that day, yes.
20 Q. And in what circumstances did you discover that Raychel
21 had died?
22 A. I received a phone call on the Monday.
23 Q. And who placed that phone call with you?
24 A. It was Sister Lyttle.
25 Q. What did she tell you?

1 A. She told me that, unfortunately, Raychel had passed away
2 and that there was a meeting scheduled for the Tuesday.
3 I think that's all I remember that she said.
4 Q. Did you hear the evidence this morning of
5 Staff Nurse Bryce?
6 A. Yes.
7 Q. And she recollects that she was told during that
8 telephone conversation that she had with Sister Lyttle
9 that Raychel had died of hyponatraemia, that there was
10 an electrolyte imbalance involving sodium; did you hear
11 that evidence?
12 A. I heard the evidence, yes.
13 Q. What were you told about the cause of Raychel's death by
14 Sister Lyttle?
15 A. I'm not sure if I was told anything of the cause of
16 death.
17 THE CHAIRMAN: But you would have asked, wouldn't you,
18 because this was such a shocking event? I mean, a girl
19 who comes in for a standard appendicectomy, goes home
20 the next day or two alive and well. Something awful had
21 happened to Raychel. You must have asked what happened.
22 A. I just remember being in a state of shock. I wasn't in
23 my own house -- the phone call I received in my parents'
24 house. I really didn't like to discuss a conversation
25 -- work-related matters when I was in view of other

1 people, so I didn't discuss it in detail.
2 THE CHAIRMAN: Okay.
3 MR WOLFE: You were unable to attend the meeting on 12 June,
4 which was convened by Dr Fulton.
5 A. That's correct, yes.
6 Q. That's because you had annual leave coming up.
7 A. That's right, yes.
8 Q. However, you presumably had conversations with nurse
9 colleagues about what had befell Raychel so as to cause
10 her death.
11 A. Before the meeting or after the meeting?
12 Q. Well, let's start with before the meeting.
13 A. I had no conversations prior to the meeting.
14 Q. Right. Okay. You had a conversation after of the
15 meeting then?
16 A. Conversations after the meeting probably would have
17 occurred when I came back from annual leave.
18 Q. Yes. Did you go off on a long period of annual leave?
19 A. A week.
20 Q. And did you seek out information at that point about
21 what might have caused her death?
22 A. I don't think I did. I'm not sure. I was quite
23 a junior member of staff. It wasn't something that
24 I would have felt comfortable ...
25 Q. Looking back on it now, what's your memories of what you

1 were told about what had led to her death?
2 A. There's been that much discussed, I couldn't tell you
3 what was originally said. There's just been -- the past
4 number of years, there's been various theories discussed
5 and various points made. The particular time frame of
6 what I heard, I have no recollection, I'm sorry.
7 THE CHAIRMAN: When you came back on the ward a week later,
8 what did you find different on it?
9 A. I realised at that stage that the fluid -- that the
10 surgical patients were receiving electrolyte profiles.
11 I know that there was a lot of work being done on IV
12 fluid for surgical patients and there was a lot of
13 changes going about and developing new protocols for IV
14 fluids for surgical patients.
15 THE CHAIRMAN: Had Solution No. 18 disappeared?
16 A. A week later? I can't remember.
17 THE CHAIRMAN: Okay.
18 MR WOLFE: Upon returning to work, you were clearly asked to
19 place a statement in to the Trust.
20 A. Yes.
21 Q. You can't remember who asked you to do that?
22 A. No.
23 Q. The use of electrolyte profiling was a new development
24 in surgical practice on Ward 6.
25 A. As far as I was aware, yes.

1 Q. And were you given an understanding as to why it was
2 being instituted so shortly after Raychel's death?
3 A. I can't remember. I'm sure I was, but I just can't
4 remember.
5 Q. Well, thinking back on it now, were electrolytes viewed
6 as an issue that was problematic in the course of
7 treating Raychel?
8 A. I believe so, yes, now.
9 Q. Looking back on it, was it appreciated that Raychel's
10 electrolytes should have been profiled at some point
11 during 8 June?
12 A. If we had known then what we know now, yes.
13 Q. No, no. What I'm asking you is: when you came back from
14 your vacation in June, was it recognised at that time
15 that electrolyte profiling ought to have been done
16 in Raychel's case?
17 A. I'm not sure, I don't know.
18 MR WOLFE: Sir, I have no further questions from this side,
19 save one. There was a meeting with the family conducted
20 by the Trust in September 2001; were you aware of that?
21 A. I believe -- I don't know. I know there was a meeting,
22 but I don't know when I became aware. I wasn't invited
23 to that meeting.
24 MR WOLFE: Very well. As I said, sir, I have no further
25 questions. Mr Coyle?

1 MR COYLE: There's a matter that perhaps I could raise
2 through you or through Mr Wolfe. It's document
3 021-067-158. As you'll see, sir, it's a typewritten
4 account. It seems to us to resemble entirely the
5 document that Mr Wolfe had been putting to the staff
6 nurse of 20 June.
7 THE CHAIRMAN: Except that it's dated the 26th.
8 MR COYLE: It's dated the 26th. The text to our eyes seems
9 identical, but there's two points perhaps yourself or
10 Mr Wolfe might invite comment upon. That is: what were
11 the circumstances of the typewritten document coming
12 into existence? It may well be the nurse can't advance
13 matters beyond that which she already has.
14 THE CHAIRMAN: Let's pause at that. Do you see that
15 document, Mrs McAuley? That looks like a typed version
16 of the handwritten page that you prepared on 20 June.
17 That appears to have been typed up and you've signed it
18 at the bottom.
19 A. Yes.
20 THE CHAIRMAN: Do you remember how that came about?
21 A. I'm not sure.
22 THE CHAIRMAN: Okay.
23 MR COYLE: The second ancillary point is there was an
24 opportunity or further opportunity for the staff nurse
25 to reflect upon her account another week later and to

1 amplify it or correct it, and if she can't recall much
2 about it, perhaps it is a Lyttle redundant, but
3 certainly it did allow for recollection after the heat
4 of the event had passed a Lyttle.
5 THE CHAIRMAN: I'll take that as a comment, Mr Coyle,
6 because I think really, on her evidence, what appears to
7 have happened was that this point only emerged as they
8 prepared for the inquest and there was some discussion,
9 which is entirely understandable, about how Raychel was
10 in the late afternoon/early evening.
11 MR COYLE: Yes.
12 THE CHAIRMAN: I'll then have to form a view about the
13 additional point which has emerged at that time.
14 MR COYLE: It's just there was another opportunity, sir, and
15 we thought we'd draw it to your attention.
16 THE CHAIRMAN: Before I come to Mr Campbell, does anyone
17 else have anything? Mr Campbell?
18 Mrs McAuley, thank you very much for your evidence.
19 Unless there's anything you want to add, you're now
20 finished. Thank you. You can leave the witness box.
21 (The witness withdrew)
22 THE CHAIRMAN: I think Mr Stitt has something to say to me.
23 MR STITT: Yes, the privilege issue. There are really four
24 points I want to make. The first is -- it's some good
25 news and some not so good news. We'll start with the

1 good news. That is that the Western Trust file, which
2 had been in the possession and custody of Ms Brown -- it
3 has been described by the inquiry as individual file 1
4 and individual file 2, we've adopted that method of
5 description -- and a full index to the current
6 up-to-date file has been e-mailed to the inquiry.
7 THE CHAIRMAN: Thank you.
8 MR STITT: It is identical to the original file which was
9 received by the inquiry, with two exceptions. The first
10 is the original Jamison draft, which was the subject of
11 earlier correspondence and discussion. That was the
12 short report which was then extended. So that draft ...
13 THE CHAIRMAN: That was not on the original index and is now
14 in the revised index; is that right? The original
15 statement of Dr Jamison was not in the original index
16 and is now in the revised index?
17 MR STITT: Yes. The index which has been forwarded is in
18 fact the original index and it's confirmed and I have
19 authority to confirm that the documents in that are the
20 same documents as are currently in that file, files 1
21 and 2, individual files 1 and 2, with the exception that
22 in the file, not in the index, is the Jamison draft
23 statement and also a Gilchrist statement, which is in
24 the domain of the inquiry in any event.
25 THE CHAIRMAN: So that means those are two documents which

1 were on the file but which were not referred to in the
2 index originally provided to us?
3 MR STITT: Yes, that's correct.
4 THE CHAIRMAN: Are they referred to in the index which is
5 now provided to us?
6 MR STITT: The index which is now provided to you is the --
7 THE CHAIRMAN: The original index?
8 MR STITT: The original index, so they are not on that
9 index, but they are two additional documents which are
10 not in the index and I can have more particularly
11 described -- presumably they are described in the
12 e-mail.
13 THE CHAIRMAN: Thank you.
14 MR STITT: I'm told they've been described in the e-mail as
15 to the dates of the two statements. I'm instructed that
16 there are no other discrepancies between the original
17 file which was forwarded and the file which is being
18 currently inspected.
19 THE CHAIRMAN: Thank you.
20 MR STITT: The second point relates to the injunction issued
21 earlier that the Trust should be made aware of the
22 importance attached to the claim for privilege as
23 articulated earlier. I regard this as particularly
24 important and, for that reason, I have asked that the
25 transcript, that section of the transcript, which won't

1 be on the website for another 24 hours, be e-mailed now,
2 as soon as possible, to my instructing solicitor, who
3 will e-mail it to our senior solicitor, who will e-mail
4 it to the Trust.
5 I'm going to ask your leave to come back on this
6 tomorrow. I'd like to have full and proper instructions
7 in relation to it. I think the best way, rather than
8 a mobile phone in a consultation room, is for my clients
9 not only to receive my advices, which I've given to my
10 senior instructing solicitor, but I think they should
11 also see the transcript.
12 THE CHAIRMAN: Well, the transcript is usually available
13 much quicker than 24 hours. I think this was the point
14 raised first thing after lunch.
15 MR STITT: Yes, immediately after lunch at 2.15.
16 THE CHAIRMAN: We'll able to provide that.
17 MR STITT: 109 to page 114 [draft].
18 THE CHAIRMAN: We'll be able to do that immediately we rise.
19 We'll e-mail that to Mr Johnson.
20 MR STITT: The third thing is in relation to the indication
21 given to me that this approach was inconsistent with
22 other trusts in relation to their claim for privilege.
23 I have sought instructions from that specifically as to
24 whether there was a blanket dropping of any claim for
25 privilege or precisely what --

1 THE CHAIRMAN: No, sorry, I never said there was a blanket
2 dropping of claims for privilege. I specifically said
3 it was inconsistent with what the Belfast Trust had done
4 on the Adam inquest file.
5 MR STITT: That's my mistake.
6 THE CHAIRMAN: There have been claims for privilege, but
7 there was -- a document emerged from a Brangam Bagnall
8 file in June last year and that led to the whole file
9 being produced without any claim for privilege and there
10 was no claim for privilege over the Brangam Bagnall
11 consultation note. I'm sorry if I didn't express myself
12 clearly enough.
13 MR STITT: I think the fault was mine.
14 THE CHAIRMAN: There has not been a blanket abandonment by
15 other trusts of claims for privilege.
16 MR STITT: I misunderstood that. I can recollect that you
17 specifically referred to a consultation note in the
18 Adam Strain case and I am seeking specific instructions
19 in relation to that because only when I've got that can
20 I -- because I wasn't involved at that time. But I've
21 asked for and I will receive full instructions by
22 tomorrow morning in relation to that.
23 THE CHAIRMAN: What I'll also do, Mr Stitt, is I'll get
24 referred to you the correspondence which I had with
25 Mr McGinnis on the back of that issue arising at the end

1 of June. Mr Johnson might be able to help you with
2 this, but there were exchanges from late June
3 through July, in the course of which, among other
4 things, I was told in writing that the trusts were
5 considering their position in relation to privilege, but
6 they wanted advice from senior counsel and they would
7 revert to me. That flowed from the discovery of the
8 Brangam Bagnall inquest file, but broadened out, and
9 those exchanges are from mid to late June until at
10 least July. What I will do is I will try and get
11 e-mailed to you a list of the exchanges so that you can
12 have access to them.
13 MR STITT: That would be helpful. Could I also ask, sir, if
14 it's not too much trouble, would you copy Mr Johnson
15 into that e-mail?
16 THE CHAIRMAN: I'll get it to Mr Johnson. If I can, I'll
17 get it to you as well.
18 MR STITT: The final point is the mea culpa, and it's this.
19 I have spent the last two-and-a-half hours with
20 Mr Johnson going through the DLS inquest file. I had
21 looked at it before, it seemed to me that prima facie
22 a large number of documents within the file were
23 privileged, but it is much more important to refine that
24 and if one is going to, and if the client instructs,
25 that my advices are based on a thorough search of the

1 file and a consideration of the documents. There are
2 quite a lot of them, 200 and something. They've all
3 been looked at and -- hopefully accurately -- I have
4 given advices in relation to each of them.
5 THE CHAIRMAN: Right.
6 MR STITT: What we have done is we have taken the original
7 index, which you have, and we have noted those documents
8 which the inquiry already has through the Western Trust
9 file, which was given many years ago. And then on top
10 of that, we have noted those documents in which my
11 advice will be no privilege be claimed and those
12 documents which my advice, from a legal perspective as
13 counsel, would be that they are appropriate to raise
14 a form of privilege claim.
15 That new index will be ready for tomorrow. So we
16 await instructions and then I can then indicate,
17 depending on my instructions, the extent to which any
18 claim for privilege will be raised.
19 THE CHAIRMAN: Okay. So if the Trust decides on considering
20 this to maintain a claim for privilege, I will have
21 tomorrow a list of the documents for which that
22 privilege is claimed?
23 MR STITT: Yes.
24 THE CHAIRMAN: Right. And this is all legal professional
25 privilege?

1 MR STITT: Legal professional privilege in a wide sense,
2 yes.
3 THE CHAIRMAN: Right. We'll see how wide we go. We need to
4 pin this down because tomorrow's Wednesday, we are
5 sitting on Thursday, and then we break until Monday. At
6 what point tomorrow can I realistically expect you to
7 have finalised your position on the Trust's general
8 position and the specific position about legal
9 privilege?
10 MR STITT: I have asked that everything be clarified by
11 lunchtime.
12 THE CHAIRMAN: Okay. Thank you very much.
13 There's nothing more to take up on that. We'll see
14 what develops.
15 MR COYLE: Just to comment about the Francis report, we've
16 had a quick look at that, and we'd urge the Trust to
17 take that on board. I'm sure Mr Stitt will.
18 THE CHAIRMAN: This is an idea that has been around for
19 a while, but Mr Francis has developed it by getting the
20 Trust lawyers to give evidence at his inquiry. He can't
21 rewrite the law of privilege and I am bound to accept
22 a claim for privilege if it's properly founded. If the
23 Trust decides to maintain a claim for privilege, which
24 is well-founded, then that will stand.
25 MR COYLE: Yes. Obviously we would wish to be heard in

1 respect of it.
2 THE CHAIRMAN: Of course. If it is well-founded.
3 MR COYLE: Thank you.
4 THE CHAIRMAN: Mr Wolfe, tomorrow we've got Dr Devlin and
5 Staff Nurse Roulston; is that right?
6 MR WOLFE: That's right.
7 THE CHAIRMAN: What's the running order?
8 MR WOLFE: The running order is not with me at the moment.
9 Perhaps the secretary knows.
10 THE CHAIRMAN: We've got through yesterday and today on
11 schedule. I'm very keen to do everything we can to get
12 through two witnesses tomorrow and the two witnesses on
13 Thursday because I now understand that it looks as if
14 we are going to run into the start of the week of
15 Monday, 25 March, which I was hoping not to do, but
16 I said I would do if it became absolutely necessary.
17 We have two part-heard witnesses, Mr Zafar and Mr Makar,
18 and I want to make sure that if we do have to run into
19 that week at all that we contain it. I don't want to
20 just drift on. So we'll push on as best we can.
21 Thank you everybody for your help today, 10 o'clock
22 tomorrow morning.
23 (5.25 pm)
24 (The hearing adjourned until 10.00 am the following day)
25

1 I N D E X
2

3 MRS FIONA BRYCE (continued) 2
4 Questions from MR WOLFE (continued) 2
5 MRS MICHAELA MCAULEY (called) 42
6 Questions from MR WOLFE 42

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