

1
2 (10.15 am)
3 (Delay in proceedings)
4 (10.39 am)
5 THE CHAIRMAN: Good morning. I'm sorry I'm late. Sorry for
6 keeping you waiting, Mrs Millar. Would you come
7 forward, please?
8 MRS ELIZABETH MILLAR (called)
9 Questions from MR WOLFE
10 MR WOLFE: Good morning. Is it Mrs Millar?
11 A. Yes.
12 Q. Mrs Millar, I'm going to ask you some questions about
13 your role in the nursing and care of Raychel Ferguson.
14 Before I begin, can I ask you to confirm that you
15 provided the inquiry with two witness statements? One
16 was dated 30 June 2005; the second, more recently,
17 20 June 2012.
18 A. Yes.
19 Q. Can you confirm for the record that those statements are
20 accurate and that you wish to adopt them as part of your
21 evidence?
22 A. Yes.
23 Q. Your evidence will, of course, be supplemented by what
24 you tell us in the course of today.
25 Can I start by asking you this. You've said in each

1 office, but I was there all morning up until 1.30/1.45
2 and I was happy with Raychel's progress at that stage.
3 Q. Yes. So to summarise this opening explanation, you
4 would say that in two respects nursing care was
5 deficient. Firstly, the records left something to be
6 desired.
7 A. Yes, I would agree with that. I think our documentation
8 was not adequate and, looking back now, our urinary
9 measurement and the vomit measurement, although at that
10 time we did not measure vomit, it was the practice at
11 that time to document the first passing of urine, which
12 was done at 10 o'clock, and following that we didn't, at
13 that time, routinely document urinary output.
14 Q. We'll come to the detail of that in a moment. I just
15 want to establish our baseline here. So record keeping,
16 you would accept left something to be desired, and
17 whether --
18 A. The fluid balance sheet could have been better, yes.
19 Q. And the second point that you make is that, looking at
20 all things now, you would accept that a doctor should
21 have been brought to Raychel's bedside at an earlier
22 point in time and you point to the time of 1 o'clock.
23 A. No. At that time, 12 years ago, I was very happy with
24 Raychel during the day.
25 Q. Yes.

1 of your witness statements, Mrs Millar, that you're
2 confident that Raychel received the highest standard of
3 care from the nursing staff in Ward 6.
4 A. Yes.
5 Q. You recall saying that in your statement?
6 A. Yes.
7 Q. Do you stand by that assertion?
8 A. Well, at the time I wrote my statement, I did believe
9 that and I did, at the time, believe we were delivering
10 a high standard of care to Raychel. Raychel received
11 the same care that any other child in the ward would
12 have been given. We did fall down on our documentation,
13 there's no doubt about that, but overall I think we did
14 give a good standard of care.
15 Q. Are you of the view that nurses have nothing to reproach
16 themselves for in the care that they delivered to
17 Raychel?
18 A. I think looking back now on what we know now that our
19 documentation could have been better; it was deficient.
20 Also, what we know now, we would have been getting
21 a doctor to see Raychel, if it was me, probably around
22 the 1 o'clock vomit. But at the time I was fully sure
23 and happy with Raychel's progress from the time I came
24 on in the morning until the time I left at 5.30.
25 I hadn't been there early afternoon, I was in my

1 A. No, I would not have got a doctor at 1 o'clock. I did
2 call a doctor at 3 o'clock. But looking back now at
3 that time and what we know now, 12 years later, yes, we
4 know now that we should have called a doctor at
5 1 o'clock.
6 THE CHAIRMAN: That's on the basis of knowing what you know
7 now which you didn't know then?
8 A. Yes.
9 THE CHAIRMAN: Can I take it that in a way, maybe like
10 Mrs Noble and some others -- in fact, some much more
11 senior people in Altnagelvin -- you feel a bit let down
12 that some lessons which might have been learnt earlier
13 in other parts of Northern Ireland and in the Royal
14 hadn't made their way through to Altnagelvin
15 by June 2001?
16 A. Yes. If there was something known about the fluid at
17 that stage, we didn't know about it. I had never heard
18 of hyponatraemia in post-surgical children and I had, at
19 that stage, been nursing for 35 years. I had seen
20 hyponatraemia in medical paediatric patients, especially
21 children with -- they would have been brought in with
22 severe gastroenteritis, they would have been in the
23 treatment room being resuscitated and the electrolytes
24 would have been done as an emergency and I would know
25 that the doctor would say the child is hyponatraemic,

1 low sodium, potassium would probably be abnormal, and
2 the urea would be raised, but the actual scientific side
3 of it I didn't know.
4 THE CHAIRMAN: We're jumping around a bit and Mr Wolfe will
5 go through these issues in more detail, as I think
6 you'll understand. But if for instance the Royal had
7 stopped using Solution No. 18, that's something that you
8 would have liked to have known --
9 A. Yes.
10 THE CHAIRMAN: -- in Altnagelvin.
11 A. Yes, I would have. I didn't know.
12 THE CHAIRMAN: And you'd have liked to have known why and
13 what it had been replaced with.
14 A. Yes, if it had been changed in the Royal, but I wasn't
15 aware it was changed.
16 THE CHAIRMAN: Going on Mrs Noble's evidence, there seems to
17 have been a very strong adherence to Solution No. 18 on
18 Ward 6.
19 A. Yes. I came to Altnagelvin in 1976 and I came from the
20 Royal. The solution there, I always -- all my nursing
21 career up until 12 years ago was always Solution No. 18.
22 I had seen Hartmann's used in children with severe burns
23 and I remember back in the 80s, late 80s and early 90s,
24 if we got in a very, very severe child with scalds or
25 burns, those children would be transferred to Belfast,

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1 A. Yes.
2 Q. Does that make you one of a number of sisters or were
3 you the only sister?
4 A. No, I was the senior sister and there were two junior
5 sisters.
6 Q. Right.
7 A. I not only had Ward 6, I also had outpatients
8 department, a day-care unit, and we were in the progress
9 of getting together a transitional care unit for
10 children with life-limiting illnesses, a three-bedded
11 unit.
12 Q. We're going to look at your various roles just now, but
13 if I could have up on the screen what might serve as
14 your CV at 056/1, please, at page 1. WS056/1. You'll
15 recognise this, Mrs Millar, as the first page of your
16 original witness statement to the inquiry.
17 A. Yes.
18 Q. At the top of the page, helpfully set out is really
19 a list of your various posts.
20 A. Yes.
21 THE CHAIRMAN: You actually qualified as a children's nurse?
22 A. Yes, it was a three-year training, January 1968
23 to January 1971, and it was in the Children's Hospital
24 in Belfast.
25 MR WOLFE: You're fully qualified and registered as

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1 and very often they were on Hartmann's. That was the
2 only time I had seen Hartmann's being used long-term.
3 Again, I wouldn't have understood the actual reason why
4 the child was getting Hartmann's. I know it was high
5 sodium, but there was no sugar in it.
6 THE CHAIRMAN: Okay. Well, we'll let Mr Wolfe get back on
7 track.
8 MR WOLFE: We'll probably be coming back to those issues
9 very shortly in some detail. Picking up on the point
10 I made before the chairman intervened, the point that
11 I was asking you about was what you said about having
12 a doctor come in earlier. Just so that I understand it,
13 before we move off, you say that knowing what you know
14 now you would have probably got a doctor to see Raychel
15 earlier; is that your position?
16 A. That is my position. I would have -- 1 o'clock,
17 I was ... Even if I knew then what I know now, I still
18 would have been happy up to -- "happy" may be not the
19 word, but satisfied with Raychel up until the
20 10 o'clock, even though she did vomit at 10 o'clock.
21 The 1 o'clock vomit, if I knew, as I say now, what --
22 I would call a doctor at that stage, or ask a doctor to
23 see her to give her an anti-emetic.
24 Q. I will explore that with you in some detail as we go on.
25 In June 2001, you were the sister for Ward 6.

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1 at January 1971.
2 A. Yes.
3 Q. And you took up a staff nurse position in the Royal
4 Children's Hospital.
5 A. Yes, I stayed there -- I was a staff nurse
6 from January 1971 to September 1974. I got a sister's
7 post in 1974 there on a medical ward until August 1976,
8 when I went to Derry. I started in Altnagelvin
9 in August 1979 to October 1985. Then I was -- oh yes,
10 I was an acting sister then from October 1985
11 to July 1986 when I got my present post. That post
12 started as a sister's post and then, as I was then what
13 they call a G grade, and an H grade, which -- I had gone
14 up the ladder a bit.
15 Q. In or about 2004, I think you tell us, you became
16 an H-grade paediatric unit manager --
17 A. Yes.
18 Q. -- in Altnagelvin.
19 A. Yes.
20 Q. Was that the same as a sister's role or was that
21 a development?
22 A. My role had developed over the years. I had started out
23 with a 32-bedded ward on the 10th floor and then we were
24 amalgamated with a baby unit, which had been on the
25 fifth floor, and we went from 32 beds to 43 beds. We

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1 also -- the outpatients moved up to the sixth floor as
2 well. It was two wings, it was the full sixth floor and
3 there were two wings. On the other wing there was the
4 outpatient department and the day-care unit.
5 Q. Just while we have it here on the screen, you set out
6 helpfully a list of all the training that you'd received
7 over the years.
8 A. Mm-hm, yes.
9 Q. I think you tell us in your witness statement that you
10 received no formal training in relation to fluid
11 management for children.
12 A. That's right, I didn't.
13 Q. You've now retired from practice; is that correct?
14 A. Yes.
15 Q. You retired as of?
16 A. Over two years, two years and three or four months, yes.
17 Q. If we could have up on the screen WS056/2, please,
18 page 2. You say, Mrs Millar -- it's a point you've made
19 already -- that as of June 2001 you had responsibility
20 for a children's unit and your duties comprised of four
21 specific areas; is that correct?
22 A. Yes.
23 Q. So --
24 A. Well, sorry, three specific areas and we were in the
25 process of developing the transitional care unit.

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1 A. Yes. When I came on duty in the mornings, if the ward
2 wasn't busy and it was well staffed, I would have spent
3 the day in my office. But sometimes I came on, there
4 may have been a staff nurse sick, there could have
5 been -- the day Raychel ... On 8 June, there were two
6 staff went off sick that morning and I had to reallocate
7 the nurses. So I stayed that morning to do the ward
8 round and so release up a nurse that she could deliver
9 hands on care.
10 Q. Yes. It might be convenient to deal with the specifics
11 of that. On the morning of 8 June when Raychel came
12 under your care, you had two nurses responsible
13 generally for the care of Raychel on Ward 6.
14 A. Yes.
15 Q. That was Nurse Roulston and Nurse McAuley.
16 A. Yes. There was a nursing auxiliary as well,
17 Nurse O'Kane.
18 Q. In the morning of that day, you were available on the
19 ward for clinical care, clinical issues.
20 A. Yes.
21 Q. But in the afternoon, from in or about 2 o'clock, you
22 retired to your office to carry out administrative type
23 duties --
24 A. Yes.
25 Q. -- returning to the ward at or about 5 o'clock --

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1 Q. Okay. So in the middle of the page there --
2 A. Yes.
3 Q. -- we can see the description of your various roles.
4 You were responsible for the ward.
5 A. Yes.
6 Q. By that, you mean the ward where Raychel was cared for?
7 A. Yes, that's right. At that time I was moving away very
8 much from the clinical end because my role was
9 developing and becoming much more complex and I had
10 nearly 80 staff. So it was moving away. I had two
11 junior sisters and the clinical side was very much their
12 interest, whereas mine was more managerial and
13 organisational. However, I was still spending the
14 mornings in the ward and the afternoons in my office
15 because at that time I felt I had to have some input
16 into the ward to know what was actually happening, and
17 I felt that -- I just felt I didn't want to move away
18 from it. But a year later, I did have to because I just
19 couldn't do everything, I couldn't manage four areas.
20 Q. A year later from what?
21 A. In 2002.
22 Q. So at the time of Raychel's care in the hospital, which
23 was June 2001, you were juggling these various
24 responsibilities, still keeping your hand on the tiller
25 of the clinical responsibilities?

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1 A. Yes.
2 Q. -- for the purposes of seeing patients and then
3 finishing your shift at about 6 o'clock.
4 A. Yes. I went off some time before 6 o'clock. Half five
5 was my finishing time and I definitely was gone by six,
6 but I can't remember the exact time. I was gone by six.
7 Q. If we could have up on the screen your job description.
8 It's WS056/2 at page 30.
9 THE CHAIRMAN: Can I take it that if, because you were
10 in the office, which was in essence part of Ward 6,
11 there was anything of real concern or any type of
12 emergency, that the nurses would be free to come and
13 speak to you to bring you out?
14 A. Yes, they would. There were three very senior nurses on
15 the ward that day. Avril Roulston was in the nursery.
16 She originally had been looking after Raychel but then
17 she had to go and cover the nursery because Nurse Gibson
18 went off. Nurse Wilson, who was allocated to medicines
19 that day, who would substitute for me in my absence, she
20 was a very senior nurse, and Michelle Bryson was also
21 a very senior nurse. If they wanted to speak to me to
22 ask me anything, I was available, and as Nurse McAuley
23 rang me to say that Raychel had vomited again --
24 THE CHAIRMAN: Yes.
25 A. So I'm always available.

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1 MR WOLFE: This was your job description at the point of
2 your appointment in Altnagelvin in 1989; is that
3 correct?
4 A. I think, yes, that was -- yes, that was one of them.
5 Q. Well --
6 A. When I say one of them, that was my G grade, I think.
7 Q. Yes, it says in the top of the page, "Grade charge
8 nurse G".
9 A. Yes.
10 Q. And you were accountable to the medical nursing officer.
11 A. Yes.
12 Q. Could you explain within the organisational structure
13 where he or she was?
14 A. At the time it was Irene Duddy, and she had
15 responsibility for paediatrics and maternity. As far as
16 I know, she had responsibility for us.
17 Q. When you say "at the time" --
18 A. For paediatrics.
19 Q. When you say at the time, 2001?
20 A. Yes.
21 Q. You were accountable to her?
22 A. Yes.
23 Q. Did that involve her supervising your work directly or
24 did it involve something on a more macro level?
25 A. No, it wouldn't have -- she wouldn't have been

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1 "[You] must aim to provide a high standard of
2 individualised patient care within the ward."
3 Presumably, that was an obligation to ensure that
4 the staff under your command were reaching the highest
5 of standards --
6 A. Yes.
7 Q. -- when you yourself weren't directly involved?
8 A. That's right. Each patient that came in, there was an
9 assessment of that patient, a care plan devised through
10 the DM Nurse computerised system, and an evaluation.
11 Q. And you were required to supervise the work of nursing
12 staff and endeavour to maintain a high standard of care.
13 A. Yes.
14 Q. So in practical terms, how was that to be achieved if
15 you were, for half of the day, in an office away from or
16 separated from the clinical environment?
17 A. Well, I relied very much on my senior nurses and they
18 were very competent and reliable. I was always made
19 sure that there was always somebody very senior. There
20 were two junior sisters, Nurse McKenna and --
21 Sister McKenna and Sister Little. The rota would --
22 there would always be one of us on, if possible, every
23 day. Some days there weren't, that wasn't possible with
24 holidays and sickness, but there was a team of very
25 senior nurses. Nurse Roulston would have been one of

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1 supervising my work directly, but she was available for
2 consultation. It would be mostly to do with staffing
3 levels and, you know, refurbishment of the ward,
4 education and training. I would ask her -- I would try
5 and access funds for nurses for courses, things like
6 that, but she wouldn't be directly supervising me. She
7 was there for consultation and guidance.
8 THE CHAIRMAN: Would it be wrong to view it, Mrs Millar, as
9 you were effectively the most senior nurse in
10 paediatrics?
11 A. Yes.
12 THE CHAIRMAN: And Ms Duddy was the medical nursing officer
13 for the whole Trust?
14 A. Yes.
15 THE CHAIRMAN: So she is effectively relying on you to work
16 with her and to keep the paediatric nursing running.
17 A. Yes.
18 THE CHAIRMAN: So if you have any particular issues or
19 problems you go to her.
20 A. I'd have gone to her, yes.
21 THE CHAIRMAN: Thank you.
22 MR WOLFE: If we go over the page, please, to page 31.
23 You have a number of specific responsibilities listed in
24 your quite extensive job description. Can we look at
25 some of them? 4.1:

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1 them -- Nurse Wilson, Nurse Bryson -- and they would
2 always act in my absence.
3 Q. At 4.3, you were responsible for:
4 "... monitoring standards of care on the ward and
5 ensuring high standards were maintained."
6 A. Yes.
7 Q. Let's work with a specific example: after Raychel's
8 death, you must have been aware that aspects in her care
9 plan had not been complied with, and you set out an
10 example at the very start of your evidence, that note
11 keeping wasn't up to scratch. In your role as a monitor
12 of standards of care, what did you do about that?
13 A. Yes, well, very soon after Raychel died, as I say, we
14 did recognise that our standard of record keeping or
15 documentation of our fluid balance was not what we would
16 have hoped. We held our hands up and said, "Yes, it
17 could have been better. There were areas lacking". So
18 soon afterwards, during the critical review meeting on
19 12 June, one of the issues that was discussed was record
20 keeping. There were two main things that came out of
21 that meeting. One of them was that we measure urine on
22 all children who are on IV fluids and that we are much
23 more rigorous in documenting our urinary output and the
24 vomit and also any oral fluids that would be given to
25 a child.

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1 The day that Raychel -- on 8 June, she was allowed
2 oral fluids, but because of the vomit at 8 o'clock they
3 had been delayed. But she had very, very little that
4 morning because she had vomited again. I think she had
5 a few sips before 10 o'clock or 10.30, but she vomited
6 again, so they were withheld again. There is nowhere on
7 her fluid balance sheet that she had got fluids and that
8 was a deficiency in our recording.

9 I also -- at the handover reports in the morning,
10 I would have reminded staff that they were to be
11 absolutely rigorous in their documentation. And whilst
12 we endeavoured to measure urine at that time, it wasn't
13 always achievable because frequently parents or indeed
14 the children would go to the toilet themselves and
15 we wouldn't know that they had gone, and we were very
16 reliant on parents at that time to work with us and tell
17 us if the child had gone to the toilet. And most
18 parents did that, but children still ran into the toilet
19 on their own. With four or five year-olds, it was very
20 difficult to ...

21 Q. But looking at the fluid balance chart, which we will in
22 more detail perhaps later, you're aware that there was
23 only one recording of passing urine?

24 A. Yes.

25 Q. Whereas by the evidence that you've given to the

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1 went on and some time after that, certainly before
2 I went to lunch at 1.45, he passed me again. I was on
3 the phone this time, but Mr Ferguson passed again with
4 Raychel. And yes, I did know -- I mean, I presumed she
5 had gone to the toilet, but yes, I didn't document it.
6 At that time, the first passing of urine was very, very
7 important because some children retained urine following
8 an anaesthetic, so we were always very rigorous in
9 documenting the first passing of urine. We weren't at
10 that time measuring all urine, but after Raychel died we
11 did endeavour to do so.

12 Q. I wish to come to the specific detail of those issues in
13 a moment. But just for now, you would accept that you
14 should have documented those visits to the toilet or at
15 least, to put it another way, enquired of the parents
16 whether the child had passed urine?

17 A. Well, I did -- yes, I presumed she had gone to the
18 toilet.

19 Q. Yes.

20 A. But at that time we were not documenting all passing of
21 urine.

22 Q. Okay.

23 A. But we do now and we know now that at that time we
24 probably should have as well.

25 Q. Moving on down the job description, if we could move

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1 inquiry, you were aware that the child had been taken to
2 the toilet.

3 A. Yes.

4 Q. You say on two occasions in or between midday and
5 2 o'clock?

6 A. Yes.

7 Q. You would have been aware that the child was being
8 brought to the toilet?

9 A. Yes.

10 Q. You would have been in a position to enquire of the
11 parents whether the child had passed urine?

12 A. Yes.

13 Q. And you didn't make an entry in the record?

14 A. No, I didn't. I was at the reception desk when

15 Mr Ferguson passed me with Raychel. It was around --
16 the first lunch breaks had left ... There's two lunch
17 breaks, two teams of nurses, and I was at the desk.

18 I can't remember what I was doing. But I noticed

19 Mr Ferguson and Raychel walking past. I said,
20 "Mr Ferguson, I can bring a bedpan, Raychel doesn't need
21 to walk to the toilet". He said, "No, she wants to go
22 like this". Because I was concerned that she was
23 actually fit to go to the toilet, I thought after having
24 her surgery, that perhaps she wouldn't be able to walk,
25 but she was walking, albeit holding her tummy. They

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1 down the page slightly, at 4.7, you were obliged, in
2 pursuance of your job description, to:

3 "... participate in teaching and assessment of
4 learners, ensuring that learner's objectives are
5 available in the unit and that they're met."

6 A. Yes.

7 Q. Next one:

8 "Actively involved in induction, in-service training
9 and counselling of staff, and will identify training
10 needs in the ward."

11 A. Yes. 4.7, "Teaching and assessment of learners". Those
12 were the students that were coming to the ward. We
13 could have had two, three, four, five students. These
14 were students that came for paediatric placement. They
15 were each allocated a mentor and the students would have
16 been allocated on the rota to work with her mentor. So
17 that was my -- my duty with that was to ensure that the
18 mentor was on with the students and that the student,
19 you know, accessed or achieved her objectives whilst her
20 stay in the ward.

21 The other one, induction and in-service training,
22 again that would be for new staff coming to the ward.
23 Again, they would be offered an induction period, and
24 I would have initially met them, and there was an
25 induction list that I would have gone down and completed

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1 with them and then allocated them again a senior staff
2 nurse to work alongside, usually for a period of six
3 weeks, and ...
4 Q. Could I ask you this question about training as
5 a general point? In many of the statements which the
6 inquiry has received to date, and indeed in the evidence
7 that the inquiry's heard over the past day or so from an
8 experienced nurse, Mrs Noble, there appears, on the face
9 of those statements, to have been a confusion between
10 what was meant by maintenance fluids and replacement
11 fluids. First of all, before I ask you about that sense
12 of apparent confusion, would you have known the
13 difference between a maintenance regime and
14 a replacement regime?
15 A. No. I didn't know anything about a replacement regime.
16 I had never had any training on IV fluid administration.
17 Solution No. 18 was the fluid that I understood to be
18 a safe fluid because it had a little sugar in it.
19 Q. I'm sorry, I'm not talking about the type of fluid, I'm
20 talking about the aim of the regime.
21 A. No, I didn't understand the replacement, no.
22 THE CHAIRMAN: Just to be more specific, if a child is
23 repeatedly vomiting, then there is material leaving her
24 body, which alters the make-up of her body and her
25 blood; is that right?

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1 did unless a child who was very, very ill and was losing
2 a huge amount of fluid through a naso-gastric tube or
3 maybe a child that had severe intussusception or
4 obstruction, although those children went to Belfast,
5 but they may need stabilisation before they go. They
6 may have got other fluids, but they would have been
7 resuscitation fluids. I very, very rarely saw that
8 in the surgical side. Those children were extremely ill
9 and were being transferred to Belfast.
10 THE CHAIRMAN: There seems, on the evidence, to have been
11 a very strict line taken that only Solution No. 18 was
12 given on Ward 6.
13 A. Yes.
14 THE CHAIRMAN: Where did that come from?
15 A. I don't know where it came from. That was the practice
16 when I came in 1976.
17 THE CHAIRMAN: You know I've heard evidence over the last
18 few days that doctors who wanted to prescribe Hartmann's
19 were being told in terms that you have to justify that
20 because the position on Ward 6 is that we give
21 Solution No. 18. As it turns out, the doctors here
22 didn't feel strongly enough to say, "No, it must be
23 Hartmann's", but it seems to me to be rather curious
24 that, for instance, an anaesthetist or a surgeon who
25 wanted to give Hartmann's was being required to justify

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1 A. Yes.
2 THE CHAIRMAN: In Raychel's case she's given a fluid which,
3 as you now know, does not replace the losses which she's
4 suffering, the sodium losses. Do I understand your
5 answers to Mr Wolfe to indicate that what you were aware
6 of was the need to keep the child hydrated rather than
7 the need to keep her levels of sodium at an appropriate
8 level?
9 A. Yes. I think that Raychel was on IV fluids and
10 I believed -- I was reassured by those IV fluids. I did
11 not recognise that her vomiting could dehydrate her
12 because I thought her loss was being replaced by the
13 fluid.
14 THE CHAIRMAN: Right. And you knew, in a general way, that
15 it was regarded as a safe fluid, so whatever she was
16 losing, she was having that replaced with something
17 which you thought was safe?
18 A. Yes.
19 THE CHAIRMAN: And that happened not just in Raychel's case,
20 but on the evidence we have heard from Mrs Noble and
21 others, this would be the sort of fluid which is given
22 to other children who had a bad reaction to surgery or
23 to anaesthetic and who vomited a lot afterwards. They
24 all got Solution No. 18.
25 A. Well, to my -- yes. Well, my experience was that they

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1 himself because that wasn't the practice.
2 A. All I can say is that Solution No. 18 was the fluid that
3 was used. As a nurse, we were told that -- or it was
4 the general opinion that Hartmann's was a dangerous
5 fluid for children because it didn't have any sugar.
6 THE CHAIRMAN: Sorry, where were you told that? Were you
7 told that in Altnagelvin or the Royal?
8 A. No, no, that was my understanding.
9 THE CHAIRMAN: Is that your understanding from training
10 in the Royal in the late 1960s and then from working
11 in the Royal over the next five or six years?
12 A. I didn't get any training on IV fluids in the Royal.
13 Those were the fluids that were being used in the Royal,
14 Solution No. 18. I didn't -- I don't remember seeing
15 Hartmann's used in the Royal except, as I say, on severe
16 burns.
17 THE CHAIRMAN: Thank you.
18 MR WOLFE: Just finally on this segment, on 4.10 on the
19 screen in front of us, it states that with one of your
20 responsibilities was:
21 "[To] cooperate with medical staff in
22 a problem-solving approach to treatment, investigation
23 and general care of patients."
24 Again, I would assume, Mrs Millar, that that is
25 a principle or an approach which all nurses would have

24

1 had to comply with.
2 A. Yes.
3 Q. So when you interact with a doctor, it's to adopt
4 a problem-solving approach?
5 A. Yes.
6 Q. Just to echo a point that Mrs Ramsay has made -- you
7 would have seen the report of the expert nursing
8 practitioner, Sally Ramsay -- and she has said the role
9 of a nurse, in her opinion, is:
10 "To monitor a patient's progress and to advise
11 medical staff of any changes or variations from an
12 expected recovery pathway."
13 Do you agree with that as a broad principle?
14 A. Yes, I do. I agree with that.
15 Q. Does that involve, in practical terms, when you're
16 interacting with the doctor, you or your nursing
17 colleagues making sure that doctor is properly appraised
18 of the patient's history, giving all relevant details so
19 that the doctor can work out an approach, a plan and
20 a diagnosis?
21 A. Yes. Well, I mean, the doctor would also have the
22 notes, the medical notes.
23 Q. Of course.
24 A. But in our liaison with the doctor, it would be
25 important for us to communicate any changes such as rise

25

1 nurse may say the child would need an anti-emetic, but
2 I never knew a doctor to actually ... Well, I just need
3 to gather my thoughts.
4 We would never tell a doctor to give an anti-emetic.
5 The doctor would have to make that final decision and
6 prescribe the drug. We can suggest it or maybe prompt
7 the doctor, but we would never say to the doctor, "Give
8 an anti-emetic". The doctor should assess as to whether
9 the child needed the anti-emetic and maybe by looking at
10 the child or talking to the parent.
11 Q. In absolute fairness to Mrs Noble, she added that
12 principle or that caveat that, in her opinion, the
13 proper way of doing it would be for the doctor then to
14 make his own assessment.
15 THE CHAIRMAN: It depends to some degree on the experience
16 of the doctor and how the doctor interprets that,
17 doesn't it? Because an inexperienced doctor who's
18 working with experienced nurses might think wrongly,
19 "Well, there's the anti-emetic, I'll give the
20 anti-emetic", but he shouldn't just do that, sure he
21 shouldn't.
22 A. No. Usually we would tell the doctor first the child
23 had vomited, we felt the child needed an anti emetic.
24 But they may ask us how many times, when did the child
25 have his or her surgery --

27

1 in temperature, pulse, vomiting if they were a problem
2 or if a child was deteriorating. It would be important
3 that we would say, "This child's respirations have
4 increased, the colour has -- the child is pale, the
5 child is drowsy". So it would be important to convey
6 any concerns or worries to the doctor. But he would
7 have the medical notes as well to --
8 Q. So what you're saying is that while you convey
9 information to a doctor, he will also be expected to
10 consider relevant portions of the medical notes and work
11 things out for himself?
12 A. They would, yes.
13 Q. We heard evidence yesterday from Mrs Noble, who in the
14 context of the 10 pm scenario, after you had gone off
15 the shift, they summoned a doctor and left out for him
16 the anti-emetic. While we haven't heard all of the
17 evidence around this issue, the request that appears to
18 have been made to the doctor is to prescribe the
19 anti-emetic and, as I say, the medication was left out
20 for the doctor. To what extent in your experience were
21 nurses prescriptive of the solution that a patient would
22 need? In other words, "This child needs an anti-emetic
23 there's the drug on the table, get on with administering
24 it".
25 A. Well, that wouldn't be what I would understand. The

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1 THE CHAIRMAN: I think the trouble here is that the doctor
2 was telephoned and asked to come down. We're not clear
3 exactly what was said to him on the phone, but when he
4 did come down, he doesn't appear to have spoken to
5 either of the nurses who were there, nor does he appear
6 to have spoken to Mr Ferguson who was with Raychel.
7 A. Was this at ...
8 THE CHAIRMAN: 10-ish. So he doesn't appear to have spoken
9 to anybody. We'll ask the doctor what he did. But it
10 depends how -- do I understand from your perspective
11 that you think there's nothing wrong with the nurses
12 leaving the anti-emetic available for the doctor, but
13 that doesn't relieve his duty to do his part of the job
14 properly? He doesn't automatically give the anti-emetic
15 because it's left out; he has to form his view that the
16 anti-emetic is the appropriate course to take.
17 A. Yes.
18 MR WOLFE: Just to finalise on that point. Would you expect
19 the nurse and the doctor to search each other out and
20 have a conversation, the detail of which might vary from
21 case to case, but there should be a conversation between
22 doctor and nurse before --
23 A. Yes, I would expect some conversation about how many
24 times the child had vomited, maybe when the child had
25 his or her surgery, how the child was progressing,

28

1 albeit we knew the child was vomiting. Yes, I would
2 expect that. Very often, if a doctor is busy, very
3 busy, and covering a lot of wards, it may be difficult
4 to have a very in-depth conversation.
5 Q. Would you expect the nurse to attend a doctor at the
6 patient's bedside where, for example, an invasive
7 procedure such as an injection is being administered to
8 a child?
9 A. Yes. Well, we always endeavour to go with the doctor
10 when they came on the ward or even the doctors that are
11 on the ward, the paediatric doctors. But there are
12 times, especially during tea breaks and lunch breaks,
13 if -- I mean, three or four doctors could come on the
14 ward at one time. I've actually known five or six to
15 come on the ward. You would not be able to free up
16 a nurse to go with every doctor. Some doctors will wait
17 and they won't go to a patient until a nurse comes, but
18 there are other doctors who are happy to see a patient
19 without a nurse. But the usual thing would be for
20 a nurse to go with a doctor.
21 Q. Moving on, Mrs Millar, your awareness of hyponatraemia
22 by June 2001 appears to be more developed than some of
23 your nursing colleagues who have given evidence or are
24 about to give evidence to the inquiry. You had heard of
25 hyponatraemia.

29

1 A. In combination.
2 Q. Because the Solution No. 18, self-evidently, wouldn't
3 correct the sodium deficit.
4 A. No. It was too low in sodium.
5 THE CHAIRMAN: Of course, the point there is that you knew
6 what the sodium level was because the electrolyte tests
7 had been done --
8 A. Yes.
9 THE CHAIRMAN: -- and the critical omission in Raychel's
10 case was that there was no electrolyte test done all day
11 Friday; isn't that right?
12 A. Yes.
13 MR WOLFE: We'll come back to this in a second, but just in
14 passing we note from your statement that after Raychel's
15 death, you found yourself in possession of some
16 information in relation to Lucy Crawford. One of the
17 paediatric consultants told you about her death.
18 A. No, he didn't tell me. I heard it in conversation with
19 consultants. I didn't know anything about Lucy Crawford
20 until after Raychel died. I think I heard
21 a conversation between consultants that maybe there was
22 a link between the two children. But it was some time
23 after Raychel died. I hadn't heard about Lucy Crawford,
24 I didn't know anything about her.
25 Q. So you obviously didn't know about Lucy until after

31

1 A. Yes.
2 Q. Without getting into the complexity of it, you had heard
3 it was consistent with low serum sodium in blood --
4 A. Yes.
5 Q. -- and you had direct experience of seeing it in
6 non-surgical patients.
7 A. Yes, I had very few, but I had seen it. During my years
8 of nursing, maybe three or four children. There may
9 well have been more, but I cannot remember. It was not
10 a big issue in medical paediatrics. We very, very
11 rarely got a child in with hyponatraemia and certainly
12 in recent years -- I mean, we may get a child in with
13 a low sodium, but just maybe 130 or a low potassium and
14 urea would be raised. Those electrolytes would be
15 corrected with Solution No. 18, usually. These were
16 only mildly dehydrated children, but I have seen
17 children with hyponatraemia and these were mostly severe
18 gastroenteritis children who had to be resuscitated.
19 Q. Did I just hear you say that there were times when you
20 might have had:
21 " ... a child in with low sodium, maybe 130 [it says
22 on the transcript]. These electrolytes would be
23 corrected with Solution No. 18"?
24 A. Solution No. 18 plus normal saline.
25 Q. Yes. In combination?

30

1 Raychel had died.
2 A. Mm-hm.
3 Q. In what context did this conversation take place that
4 you heard about?
5 A. Well, I think there was a discussion. It wasn't at
6 a meeting, it was just an informal discussion. I think
7 Dr Nesbitt had been in contact with the Department of
8 Health and I think it had come down through the medical
9 staff that maybe there was a link. I mean, I wasn't
10 actually told it directly, I just overheard it in
11 conversation and I was wondering, you know, if this
12 child had died in Enniskillen, I didn't hear anything
13 about it. But that's really all I knew at that time.
14 Q. Let me see if you can help us with trying to pinpoint
15 this a little further. Lucy died in or
16 about April 2000. Raychel died 14 months later
17 in June 2001. Between those two deaths, a consultant
18 paediatrician based at Altnagelvin, Dr Murray Quinn, had
19 carried out some work on behalf of the Sperrin Lakeland
20 Trust in assessing or analysing issues around Lucy's
21 death. And then of course, as I say, we have Raychel's
22 death.
23 First of all, did you know Dr Quinn?
24 A. I did, yes.
25 Q. Clearly, you are reflecting a conversation that was

32

1 taking place possibly linking the causes of death in
2 Lucy and Raychel, obviously at a time after Raychel's
3 death. Can you say where that conversation took place?
4 A. No, I can't remember.
5 Q. Sorry, can you remember whether it was in Altnagelvin
6 Hospital?
7 A. Yes, it was. It was at work, yes.
8 MR LAVERY: Mr Chairman, it occurs to me that a lot of the
9 matters that my learned friend is going into at the
10 moment are matters that should be more properly dealt
11 with during governance.
12 THE CHAIRMAN: I'm not sure that we particularly want to
13 bring Mrs Millar back for governance. This is in her
14 second witness statement at page 24. I'm happy for this
15 to be probed just to see. I'm not sure how far
16 Mrs Millar can help us on specifics, but I think
17 it would be relevant to see if she can help us to try to
18 pin down in terms time when any such conversation ...
19 We know that after Raychel died there's then an inquest,
20 that then triggers Mr Millar and the Health Council to
21 recall there's a connection because he knew the
22 Crawfords through his help to them in making a complaint
23 against Sperrin Lakeland.
24 MR LAVERY: Yes, Mr Chairman.
25 THE CHAIRMAN: If it comes that far down the line after the

33

1 cases and that there may be a link. I'm not sure how
2 long it was after Raychel died that I learned of that,
3 but I had no knowledge of Lucy Crawford before Raychel
4 died.
5 THE CHAIRMAN: Mrs Millar, let me ask you this very briefly
6 about it, but we don't want to dwell too long on this.
7 Were you here for Mrs Noble's evidence yesterday?
8 A. No.
9 THE CHAIRMAN: She told us that at the critical incident
10 meeting on 12 June, she said you were quite vociferous
11 at various points about electrolyte testing, about
12 mistakes which had been made, but also that one of the
13 issues which exercised you -- and I think exercised
14 others -- was your concern that there was information
15 which was held in the Royal and maybe elsewhere which
16 had never reached Altnagelvin and you wanted to make the
17 point or the group wanted to make the point, "Look, if
18 there are lessons to be learned about how Raychel was
19 treated and how she died, not only do we learn them in
20 Altnagelvin, but they are learned throughout
21 Northern Ireland". Is Mrs Noble right about that, in
22 general terms, with her recollection of that meeting
23 that you were quite forceful in asserting and setting
24 out your views at it? I may say, she wasn't being in
25 any way hostile to you at all, in fact the tone of it

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1 details of Lucy's death begin to emerge then it's hardly
2 surprising there's a conversation in Altnagelvin linking
3 the two because that's an obvious link. If however it
4 happens at a much earlier stage, that's a slightly
5 different matter.
6 MR LAVERY: I do accept that, certainly in terms of
7 Nurse Millar coming back at a later date, it would be
8 desirable to have this dealt with at this stage.
9 I accept that, Mr Chairman.
10 MR WOLFE: The conversations were taking place in
11 Altnagelvin?
12 A. It wasn't conversations, it was a conversation, and it
13 was in passing.
14 Q. Yes. Let me just try to put a structure on this. Was
15 this conversation or discussion part of a formal meeting
16 about something?
17 A. No, it wasn't.
18 Q. Was it by contrast something you overheard at the lunch
19 table or was it more formal than that?
20 A. Yes, it was something like that, maybe just -- I cannot
21 remember, but it was in Altnagelvin.
22 Q. Yes.
23 A. But it was some discussion between consultants or
24 doctors, and I wasn't really involved, but
25 I overheard -- I mean, they were talking about the two

34

1 was that she admired the way you spoke out. Does that
2 ring a bell with you about 12 June?
3 A. I'm sorry, but could you ask me again?
4 THE CHAIRMAN: Mrs Noble was asked yesterday a number of
5 questions about the meeting on 12 June, just after
6 Raychel had died. There's a meeting, quite rightly,
7 held at which a lot of people are brought together, they
8 sit down round a table. As I understand it from reading
9 Dr Fulton's statement again last night, this isn't
10 in the context of people pointing the finger at each
11 other, but it's people being fairly blunt and, if
12 necessary, quite forceful about what should be done
13 better in Altnagelvin in future. And Mrs Noble said
14 that you spoke up quite forcefully at that meeting about
15 things that could be learnt. Okay?
16 A. Yes.
17 THE CHAIRMAN: She also said that one of the points that
18 people were getting exercised about was that if there
19 were lessons being learnt elsewhere in Northern Ireland,
20 why had nobody in Altnagelvin been told what those
21 lessons were. Okay? Is that all correct?
22 A. I don't have a lot of recollection about the meeting on
23 12 June. It is possible that I was vociferous in
24 putting forward my views because I would be, that would
25 be me.

36

1 THE CHAIRMAN: Okay.
2 A. I have very little recollection of that meeting.
3 THE CHAIRMAN: We'll go on to the detail of the meeting
4 perhaps towards the end of your evidence. The point I'm
5 intervening on is just this: that if you had thought
6 immediately after Raychel died that lessons should have
7 been learnt and should have filtered through to
8 Altnagelvin, which would have made a difference to
9 Raychel's treatment, and then you heard some time later,
10 "Look, there's another girl who died in the Erne", would
11 that not have made you even more exercised about saying,
12 "Why weren't we told about that one either?". Because
13 that -- if you'll excuse my words -- really rubs in that
14 if these things are going wrong then they're not being
15 discussed in the way that they should be to make sure
16 that more children don't suffer the same death in the
17 future --
18 A. Yes.
19 THE CHAIRMAN: So when you heard a discussion or overheard
20 a discussion that there was -- well, apart from what we
21 knew, that the Royal had information before, it now
22 turns out that there's another child who died in
23 Sperrin. Would that not have --
24 A. Yes, well --
25 THE CHAIRMAN: That would register with you, wouldn't it?

37

1 it was months after.
2 THE CHAIRMAN: Okay, thank you very much.
3 MR WOLFE: I'm not going to prolong this, but if we could
4 just have up on the screen, to see if it assists the
5 witness, WS056/2, page 24, please.
6 If we could focus on the top third, answer 25(a):
7 "I became aware of Lucy Crawford's case after
8 Raychel died, but not immediately. As far as I can
9 recall, I first [heard] about Lucy from one of the
10 paediatric consultants."
11 Who was the paediatric consultant you were talking
12 to?
13 A. I can't remember.
14 Q. Was it a paediatric consultant permanently on the staff
15 in Altnagelvin?
16 A. Yes, it would have been. They were all permanently on
17 the --
18 Q. How many permanent consultants were there?
19 A. Five.
20 Q. Looking back on it, who do you think it was, Mrs Millar?
21 A. I honestly don't know.
22 Q. Was it Dr Quinn?
23 A. No. No, I don't think it was.
24 Q. So we can rule him out?
25 A. Yes. I cannot remember. I cannot remember who it was.

39

1 A. It is possible that at that meeting it was discussed
2 that the Royal had -- and I understand now that they,
3 I think, had stopped using Solution No. 18. This is
4 what I understand. But we weren't aware of that. I was
5 quite shocked if that was the case because I just
6 couldn't understand it because we had close liaison with
7 doctors coming and going, the registrars were mostly
8 based in the Royal in Belfast, and would have come for
9 their year. I couldn't believe that we hadn't heard
10 about it or that -- the other thing, I didn't know
11 whether it would have come from the Department of Health
12 or where it would have come from, but we hadn't been
13 informed.
14 THE CHAIRMAN: The point I'm on is a slightly different one.
15 That being the case, if you later heard that a girl who
16 turned out to be called Lucy Crawford had died as
17 a result of her treatment in the Erne, and that links
18 could be established between the cause of her death and
19 the cause of Raychel's death, would that not have
20 annoyed you even more?
21 A. Yes, it would.
22 THE CHAIRMAN: That's why I'm asking you, does that help you
23 fit into the time frame about when you heard about
24 a link between Lucy and Raychel?
25 A. I can't remember. It was some time -- it wasn't weeks,

38

1 It wasn't Dr Quinn, I know that.
2 Q. You go on to say:
3 "After some time, I became aware of a link between
4 the cases of Lucy and Raychel."
5 Did that link arise out of the conversation with the
6 paediatrician?
7 A. Yes, that was the time I became aware that there may
8 have been a link.
9 Q. And thinking back on it now, how do you describe the
10 link, what was the link between the two cases?
11 A. I understood the IV fluid, the Solution No. 18, which
12 I think both children had been on, and that's what
13 I understood, that there was some problem with the
14 Solution No. 18.
15 THE CHAIRMAN: Was there not another issue about the amount
16 of fluid? Because the amount of fluid in Raychel's case
17 is an issue.
18 A. Yes, well I knew that. I'm not sure what period after
19 Raychel died that I understood that Raychel had been
20 getting too much fluid. I think she should have been on
21 67 ml an hour, but she was on 80. Again, it was quite
22 some time after.
23 THE CHAIRMAN: We were re-reading this last night and it
24 turns out that that's a specific issue which is
25 discussed on 12 June, according to Dr Fulton's statement

40

1 to the police. He says at the 12 June meeting that
2 there was a discussion about the amount of fluid she got
3 and it was too much. So that would have been
4 information, since you were at the meeting on the
5 12 June --
6 A. I was, yes.
7 THE CHAIRMAN: Whether you remember it now, that's
8 information you would have had at June 2001.
9 A. I have no recollection of that.
10 MR WOLFE: You go on to say at (b) that:
11 "The Lucy/Raychel link was also discussed with the
12 risk management department after Raychel died."
13 Do you see that?
14 A. Yes.
15 Q. Were they formal risk management meetings?
16 A. They were formal risk management meetings. I'm not sure
17 when we commenced those meetings. I think they were
18 commenced before Raychel died. I cannot remember the
19 dates, but they would have involved the consultants,
20 myself and risk management, Therese Brown, and some
21 senior staff, and it was really incidents that would
22 have occurred, anything to do with medications. It
23 could have been anything that we regarded as being
24 a risk that we would discuss. Maybe even the simple
25 thing of children tripping in the corridor, you know.

41

1 Q. Yes. And therefore, in terms of the causes of
2 electrolyte imbalance in such children, you're pointing
3 to gastroenteritis, in other words vomiting and
4 diarrhoea, and the excretion of sodium-rich fluids.
5 You were asked in your witness statement whether you
6 were aware of the factors that could cause an
7 electrolyte imbalance in a child following surgery.
8 Were you aware of the kinds of problems that could
9 follow from surgery, such as post-operative vomiting?
10 A. Yes. Well, I had seen ... I mean, post-operative
11 vomiting wasn't unusual in surgical children.
12 Q. Yes.
13 A. Of course, they didn't all vomit, and in my younger days
14 of nursing, you could say they nearly all did vomit
15 because anaesthetics in those days were ...
16 THE CHAIRMAN: Crude?
17 A. Yes. They've improved. So post-operative vomiting,
18 we would see -- you know, we wouldn't see it every day,
19 but you would have seen a child maybe once a fortnight,
20 maybe once a week, that may have had prolonged vomiting.
21 So you asked me was I aware ...
22 MR WOLFE: I'm asking you this, just to move on: were you
23 aware that, with prolonged and severe vomiting, a child
24 could be at risk of electrolyte imbalance?
25 A. No. I wasn't aware with Raychel.

43

1 So it was really to try and look at these and reduce the
2 risk.
3 Q. Yes. In any event, those were formal meetings and one
4 would expect them to have been minuted.
5 A. Yes.
6 Q. Moving on then, could I ask you about the issue of your
7 awareness or knowledge of the kinds of circumstances in
8 which electrolyte imbalances could occur in children.
9 Did I pick you up correctly when you said earlier
10 that you had experience of seeing children with sodium
11 depletion? Whether it was called hyponatraemia perhaps
12 doesn't matter. But you had experience of seeing such
13 patients in hospital and observing their treatment?
14 A. Very, very few of these patients I saw. As I say, they
15 would usually have been very sick babies with
16 gastroenteritis. I don't recall seeing it in any other
17 children.
18 Q. But you would have been aware, therefore, that --
19 A. Yes --
20 Q. Some of the causes --
21 A. These children would have come in, they wouldn't be up
22 on IV fluids, but the initial electrolytes would have
23 shown that they were hyponatraemic, and that would be
24 corrected then with IV fluids. These were all on the
25 paediatric side, the medical side.

42

1 Q. No, no, I'm not dealing specifically with the case of
2 Raychel.
3 A. No, I wasn't.
4 Q. I'm dealing with the case more generally.
5 A. No.
6 Q. Are you saying that, simply put --
7 A. I was aware --
8 Q. You'll have to wait for the question, Mrs Millar.
9 The question is this: in circumstances where a child
10 has severe and prolonged vomiting, are you telling the
11 inquiry that you would not be concerned for the risk of
12 electrolyte imbalance?
13 A. Yes. I would be, if that child didn't have IV fluids,
14 I would. I would be calling a doctor to do an
15 electrolytes and put up IV fluids. In a child who has
16 IV fluids up and who is vomiting, I would not have
17 recognised that the child could become dehydrated and
18 needed replacement fluids. I did not know at that time.
19 I was aware of the opinion that the fluids were up and
20 even though the child was vomiting and they weren't
21 large vomits, that the fluid was being replaced.
22 Obviously I was -- what I know now is different, but at
23 that time I didn't know. I was reassured with the IV
24 fluids.
25 Q. So you now know that the IV fluids that were in place

44

1 were maintenance fluids. In Raychel's specific case,
2 she was receiving Solution No. 18 at a rate of 80 ml
3 an hour, and that was maintenance.
4 A. Well, that's what I believed at that time.
5 Q. Yes. In terms of replacement, a child, as the
6 chairman's explained to you earlier, is losing
7 sodium-rich contents from her body through vomit. Did
8 you not understand at that time that those fluids that
9 were being lost needed to be replaced with sodium-rich
10 fluid?
11 A. No, I didn't.
12 THE CHAIRMAN: Okay. If a child comes in with
13 gastroenteritis, then what you said earlier was that the
14 balance is restored by giving the child Solution No. 18,
15 plus saline; right?
16 A. Yes.
17 THE CHAIRMAN: Okay. So that's how you restore an imbalance
18 which has come about because of vomiting and diarrhoea.
19 A. Yes.
20 THE CHAIRMAN: So when a child is in hospital as Raychel as
21 after surgery and she is vomiting regularly through the
22 day, how can you restore the balance only by giving her
23 Solution No. 18 without also giving her saline?
24 A. Well, at that time I didn't understand that.
25 THE CHAIRMAN: I'm sorry, maybe I've picked you up wrong,

45

1 sodium depletion; right?
2 MR CAMPBELL: Yes.
3 THE CHAIRMAN: And that will show up if you do an
4 electrolyte test. That's confirming what you would
5 expect, that the sodium levels are depleted; isn't that
6 right?
7 A. Yes.
8 THE CHAIRMAN: In fact, if a child came in with
9 gastroenteritis and you did a blood test, you'd be
10 surprised if the sodium was not depleted because you
11 can't vomit and have diarrhoea for any period without
12 suffering a sodium depletion; isn't that right?
13 A. Yes.
14 THE CHAIRMAN: So I accept your point, Mr Campbell, that
15 there was no electrolyte test done on Raychel on Friday,
16 which is an omission for which I accept the nurses don't
17 carry the primary responsibility. But if a child is
18 vomiting and repeatedly vomiting, I'm not sure how it
19 isn't realised by a sister of your experience that that
20 will also likely lead to a sodium deficiency. Are you
21 just saying that that didn't occur to you?
22 A. Well, Raychel's vomits were not large vomits during the
23 day. She had vomited at 8, 10, 1 and 3. She appeared
24 to be well, she was up and about, she was bright and
25 alert. She was on her IV fluids, she was walking to the

47

1 but I thought you did understand that if a child came in
2 with gastroenteritis that child got Solution No. 18 plus
3 saline. That's right, isn't it?
4 A. Yes.
5 THE CHAIRMAN: Right. So if the child with gastroenteritis
6 whose sodium levels will be depleted from vomiting and
7 diarrhoea needs Solution No. 18 plus saline, why does
8 the child who is repeatedly vomiting after surgery not
9 similarly need Solution No. 18 plus saline?
10 A. Well, I didn't link the two, you know.
11 THE CHAIRMAN: Okay.
12 MR WOLFE: Let's separate this out --
13 MR CAMPBELL: Mr Chairman, the witness did earlier say that
14 that type of patient who came into hospital with
15 critical gastroenteritis would have been electrolyte
16 profiled at that early stage, and therefore the profile
17 would have been understood from an early point and
18 appropriate action taken. There's a distinction in this
19 case because Raychel came back from surgery, she had
20 a relatively peaceful night and had a vomit early on and
21 then was mobilising in the morning. So there's quite
22 a distinction to be drawn between that type of early
23 picture and a patient who's admitted with critical
24 gastroenteritis.
25 THE CHAIRMAN: But a consequence of gastroenteritis is

46

1 toilet. I did not realise that she was losing sodium.
2 MR WOLFE: Mrs Millar, I'm anxious to make this clear.
3 We'll come to Raychel's specific case in a moment. What
4 I'm exploring at the moment, for the avoidance of all
5 doubt, is your assertion that you did not know about the
6 risk of electrolyte imbalance in a child vomiting
7 post-surgery. What I'm suggesting to you is that your
8 earlier indication that you were aware of the need to
9 replace fluids in gastroenteritis patients with normal
10 saline is a clear illustration that you did have that
11 knowledge and that there's no distinction to be drawn
12 between a gastroenteritis patient and another kind of
13 patient who is vomiting.
14 A. No, I did not -- I had never seen a child,
15 a post-operative surgical child, with hyponatraemia.
16 Q. That isn't --
17 A. And I didn't link -- I didn't make a link between the
18 two.
19 Q. Yes. But the question is this -- and clearly,
20 Mrs Millar, you're only on for half the day, you leave
21 duty at 6 o'clock when there's further vomiting, which
22 is clearly a relevant fact for the inquiry to consider.
23 But in terms of your general knowledge, whether a child
24 comes into hospital with gastroenteritis or whether
25 a child is vomiting profusely in the different setting

48

1 of post-surgery, the common denominator, if you like, is
2 the fact that the patient is losing sodium-rich fluids
3 from his or her body; isn't that right?
4 A. Yes, well, I know that now, but at the time I didn't
5 know --
6 Q. You didn't --
7 A. -- for the post-surgical children.
8 Q. Hold on, what's the difference between a child who has
9 gastroenteritis and is vomiting and the child who is
10 post-surgery and is vomiting in relation to the issue of
11 sodium depletion?
12 A. Well, there's very little. But I did not make that link
13 at that time.
14 Q. The point is, Mrs Millar, that you had the knowledge to
15 be able to make the link; would you agree with me?
16 A. No, no.
17 Q. Explain to me why you weren't in a position to make the
18 link.
19 A. I had seen hyponatraemia in very, very few children in
20 my time, and these were mostly children who were brought
21 in, resuscitated, and very often transferred to Belfast.
22 They were extremely ill children. I probably had two or
23 three in my lifetime of nursing, maybe half a dozen, but
24 I had never seen hyponatraemia in post-surgical
25 children.

49

1 nurses think that, regardless of the child's output, the
2 simple fact that she's getting an intravenous fluid
3 rendered her safe.
4 A. Yes.
5 Q. Whereas in fact, what nurses and the medical staff ought
6 to have been thinking about is what was the composition
7 of that fluid. You're nodding your head. You seem to
8 agree with that, that nurses and medical staff ought to
9 have been thinking about the composition of the fluid
10 that Raychel was receiving.
11 A. Well, as nurses at that time we did not know -- we had
12 no training -- I had no training in IV fluids, neither
13 did my nurses. So I didn't know anything about
14 replacement fluid. I had seen, as I say, children
15 getting different fluids over a short period in
16 resuscitation and being transferred to Belfast. But
17 I did not think that Raychel that day was -- she had
18 vomited a number of times, but because her general
19 appearance -- her observations, her colour, she was
20 bright and alert during the time I was on -- I did not
21 warrant that she was in a deteriorating condition.
22 Q. Again, we're drifting back into Raychel's specific case.
23 THE CHAIRMAN: I think you've taken it as far as you can,
24 Mr Wolfe.
25 MR WOLFE: In terms of post-operative management of fluids

51

1 Q. Again, Mrs Millar, that is not the point. The point is
2 this: you have two categories of patient. One has got
3 gastroenteritis, the other is vomiting post surgery.
4 They're suffering from a similar problem, both of them
5 are releasing from their body vomit, maybe in
6 gastroenteritis you have diarrhoea as well. Do you not
7 accept the similarity in the cases in that if both are
8 losing fluids from their body, they're also losing
9 sodium?
10 A. Yes. Well, I have to accept that now, yes.
11 Q. And indeed you'll have considered the report of
12 Sally Ramsay, who says that, at a minimum, she would
13 expect a registered nurse to be aware that fluid loss
14 from vomiting, if not replaced intravenously, can result
15 in dehydration and electrolyte imbalance. You've seen
16 that?
17 A. Yes, I have.
18 Q. And do you accept that?
19 A. Well, I do accept that, yes.
20 Q. What surprises her, Mrs Millar, is that all of the
21 nurses, with the possible exception of Nurse McGrath,
22 who have given statements to the inquiry, have
23 articulated the view that they thought Raychel was safe
24 because she was in receipt of an intravenous fluid. And
25 what she says is that she is surprised that experienced

50

1 in Altnagelvin at that time, who had the responsibility
2 for initial post-operative fluids?
3 A. It could have been the anaesthetist or the surgical JHO
4 or SHO. Usually when a child went to theatre, their
5 preoperative fluids were written up by the admitting
6 doctor, then in theatre the anaesthetist would look
7 after the fluids. Sometimes the child came back with --
8 the anaesthetist may have written up fluids, very often
9 there were no fluids written up. And we would have had
10 to get a surgical doctor to rewrite the fluids. But
11 usually, the Solution No. 18 was continued -- it was
12 usually Solution No. 18 was the fluid -- and that was
13 continued after the child came back to the ward.
14 THE CHAIRMAN: Sorry, it was continued from when?
15 If we take Raychel as an example, it wasn't continued
16 from the surgery. When you say that, "Usually the
17 Solution No. 18 was continued", do you mean continued
18 from pre-surgery or during surgery?
19 A. No, pre-surgery.
20 THE CHAIRMAN: So a child comes in and is given
21 Solution No. 18, goes into surgery, and is given
22 whatever the anaesthetist decides, and after surgery
23 goes back to Solution No. 18?
24 A. When the child came back to the ward, it goes back, the
25 child went back on Solution No. 18. That was the

52

1 practice at that time in Altnagelvin.
2 THE CHAIRMAN: Where did that practice come from?
3 A. I don't know. That was the practice when I came in the
4 mid-1970s and also it was the practice in the Royal
5 at the time when I was working there.
6 MR WOLFE: What would happen in the scenario, Mrs Millar,
7 where an anaesthetist decided that it was in the best
8 interests of the child to write a new prescription or,
9 for example, to advise that the fluids that were running
10 intraoperatively, which were particularly Hartmann's,
11 the inquiry understands, ought to continue for the
12 initial post-operative period?
13 A. Well, it was the practice then to continue the child on
14 Solution No. 18 because, as I've said, Solution No. 18
15 was perceived to be the safe fluid. Because the
16 Hartmann's had no sugar, we looked upon it as the safe
17 fluid. It was the practice then to continue the fluid.
18 And very frequently, you know, people ... If you
19 continued the child on Hartmann's, it was deemed to be
20 wrong and unsafe. So it was the practice then. I don't
21 know where it originated from, but I had worked with the
22 same practice in the Children's in Belfast.
23 Q. So notwithstanding the fact that the anaesthetist may
24 have directed the continuation of the intraoperative
25 fluids, perhaps even written a prescription in that

53

1 MR WOLFE: Is it your understanding that if the child
2 arrives back from surgery without a prescription at all
3 that the nurses ought to have got a surgeon to rewrite
4 the pre-op fluids, in other words rewrite the
5 prescription for pre-op fluids?
6 A. Well, the practice at that time was to continue the
7 pre-op fluids until the bag had finished and then
8 we would have got the prescription rewritten.
9 THE CHAIRMAN: So you don't need to write a new prescription
10 at that point because, for instance, when Raychel goes
11 up from the ward, Ward 6, to surgery, there's still some
12 fluid left in the bag, which stays on Ward 6? So when
13 she comes back down, in essence she's hooked up to the
14 same fluid to finish the bag.
15 A. That was the practice at that time.
16 THE CHAIRMAN: Okay.
17 MR WOLFE: When you refer to this as being the practice,
18 can you tell us how well-known this practice was? Put
19 it this way: there doesn't appear to have been a written
20 practice; is that right?
21 A. That's right.
22 Q. So there was no protocol set out?
23 A. No.
24 Q. Was this practice known to the anaesthetists?
25 A. I'm not sure. I would have thought that the surgeons,

55

1 respect, it's your understanding that that wouldn't be
2 applied when the child reached the ward?
3 A. No. As I say, the practice at that time was to put the
4 child back on Solution No. 18 and what would have
5 happened with the nurse who was looking after the
6 child -- or whoever was in charge -- may have contacted
7 the anaesthetist, you know, to say, "This is the
8 practice on the children's ward", and they usually --
9 well, they would have changed the fluid and said --
10 because ... They did take advice from us.
11 THE CHAIRMAN: As I read the papers, and subject to
12 correction, there was no fresh fluid prescription
13 written after Raychel came back from surgery, but there
14 was almost an automatic reversion to the fluid
15 prescription for Solution No. 18, which had been written
16 before surgery. So the earlier fluid prescription is
17 reactivated --
18 A. Yes.
19 THE CHAIRMAN: -- after surgery's over?
20 A. Yes. Until the bag is finished, until the litre of
21 fluid would run in, if we would have continued the IV
22 fluid.
23 THE CHAIRMAN: Okay.
24 A. Once it was in, a new prescription would then be
25 written.

54

1 during their induction -- the anaesthetists, when they
2 came and during induction, that they would have been
3 inducted into the IV fluids for children, but I'm not
4 sure about that. It would have been a medical matter.
5 Q. It would clearly have been good practice to induct them
6 to that effect.
7 A. Yes. I would have thought they were. I know they are
8 now, but at that time I'm not aware whether they did get
9 any training.
10 Q. Again, it would have been good practice to induct all of
11 the surgeons into that practice.
12 A. Yes.
13 Q. Because the inquiry has heard from Mr Makar, who was the
14 surgeon in Raychel's case, who wrote the prescription
15 for preoperative fluids. He has expressed his surprise
16 that the prescription that he wrote preoperatively was
17 then taken and used post-operatively. He says he's
18 surprised on a number of levels, but primarily he said
19 he would not be writing blind a prescription for the
20 post-operative situation when he doesn't know what that
21 post-operative situation is. Again, that was the
22 practice.
23 A. Yes.
24 Q. Looking at it now, it was clearly an unsafe practice;
25 would you agree?

56

1 A. Well, with what we know now, yes, I would agree.
2 Q. In terms of those who knew or ought to have known about
3 this, could I have up on the screen, please,
4 026-014-028? This is a letter directed to
5 Mr Paul Bateson, clinical director, surgical
6 directorate, from Dr Nesbitt. You're alluded to in the
7 middle paragraph, Mrs Millar, and I understand from your
8 witness statement that you acknowledge receiving a copy
9 of this letter.
10 A. Yes.
11 Q. You are copied into it, clearly referenced at the bottom
12 of the page. He is at that stage clearly in the throes
13 of putting into place and perhaps has put into place
14 a change in the post-operative fluid regime for
15 paediatric cases. He's moving from No. 18 Solution to
16 Hartmann's. He says in the middle paragraph:
17 "The problem in the children's ward seems to be
18 that, even if Hartmann's was prescribed, it was changed
19 to No. 18 by default. I therefore asked Sister Millar
20 to change this policy so that, for surgical children,
21 the default solution became Hartmann's."
22 Clearly, you had an interaction or liaison with
23 Dr Nesbitt on this issue.
24 A. Yes. That was the day following the critical review
25 meeting on 12 June. There was a lot of discussion

57

1 anaesthetising children at that stage.
2 Q. But did he know that when a prescription for Hartmann's
3 was written, it was changed by default?
4 A. I cannot say. I don't know.
5 Q. Who actually was changing by default?
6 THE CHAIRMAN: Dr Jamison knew, didn't she, in effect? If
7 Dr Nesbitt didn't know, he might be the only one who
8 didn't know.
9 MR WOLFE: Dr Jamison was the second anaesthetist to Raychel
10 in the surgery and she gave evidence to the inquiry
11 that, in her experience, if a prescription was written
12 for Hartmann's, it was simply changed on the ward, it
13 became a ward matter.
14 THE CHAIRMAN: And Nurse McGrath said the same.
15 MR WOLFE: The implication, Mrs Millar, being it was hardly
16 worth the while of an anaesthetist writing
17 a prescription because it was going to be changed
18 anyway.
19 A. It wouldn't be changed without the doctor being
20 contacted and advised that this was the practice.
21 THE CHAIRMAN: But what Mrs Noble said yesterday or maybe
22 the day before yesterday now was that if the doctor
23 insisted on it, Hartmann's would be what the child would
24 receive, but she would then have to make a specific
25 entry in the medical records, justifying that --

59

1 around the use of Solution No. 18 and whether we should
2 continue it with the surgical children. I can't
3 remember the exact discussion. At one stage they were
4 going to change at that day, there and then, but at the
5 end of the meeting Dr Nesbitt said that he would make
6 some enquiries through other hospitals and at the moment
7 we were to continue to use the Solution No. 18.
8 However, I remember the next morning he rang me --
9 it would have been the 13th -- and he said they had
10 rethought and that the surgical children were now to go
11 on Hartmann's with the electrolytes 12-hourly, at
12 least post-operatively 12-hourly, and six-hourly blood
13 sugars.
14 Q. In terms of the specific point, Mrs Millar, that he's
15 reflecting there in the middle paragraph:
16 "The problem in children's ward seemed to be that
17 even if Hartmann's was prescribed, it was changed to
18 No. 18 by default."
19 Was that something you informed him about or how did
20 he discover that?
21 A. Well, that was probably information at the critical
22 review meeting the day before, I would think. But
23 I would have expected Dr Nesbitt to have known that
24 Solution No. 18 was being used in Ward 6
25 post-operatively because he would have been

58

1 A. Yes.
2 THE CHAIRMAN: -- because the point would be picked up by
3 her seniors. She didn't name you, but I guess you must
4 be one of the sisters who she would have to explain the
5 use of Hartmann's to. Mrs Noble was putting it in quite
6 strong terms: that if the anaesthetist prescribed
7 Hartmann's and if I gave Hartmann's, I would then have
8 to justify that to my nursing sisters. And in order to
9 do that, I would have to speak to the anaesthetist and
10 make a specific entry in the medical records to the
11 effect that I had spoken to the anaesthetist and this
12 was the justification and they were deciding that it was
13 Hartmann's. Does that --
14 A. Solution No. 18 was used in the ward at that time.
15 THE CHAIRMAN: Okay.
16 MR WOLFE: Sir, it's 12.20.
17 THE CHAIRMAN: We'll take a ten-minute break, Mrs Millar,
18 and we'll resume at 12.30. Thank you.
19 (12.20 pm)
20 (A short break)
21 (12.37 pm)
22 MR WOLFE: Mrs Millar, can I just check a discrete point
23 with you? If we could have up on the screen WS056/2,
24 page 15. If you focus on the second half, answer 10.
25 You're asked in a series of questions about the

60

1 post-operative fluid management arrangements at 2001.
2 In answer (c) you're asked:
3 "In any event, how were the arrangements for
4 post-operative fluid management communicated to nursing
5 and medical staff?"
6 And you say:
7 "Written practice that Solution No. 18 was the
8 default solution to be used for all children."
9 A. No, that's not right. It wasn't a written practice, so
10 that's wrong.
11 Q. You wish to correct that?
12 A. It wasn't a written practice, it was a known practice,
13 but not written.
14 Q. Okay.
15 A. That's wrong.
16 THE CHAIRMAN: You say, in fact, it even preceded your
17 arrival in the mid-1970s.
18 A. Sorry?
19 THE CHAIRMAN: When you arrived in the mid-70s at
20 Altnagelvin, that was already the practice?
21 A. Yes.
22 MR WOLFE: That was simply an error, you're telling us?
23 A. Yes, it must be because there's no written practice.
24 Q. You wrote it, that's why I'm asking, Mrs Millar.
25 A. No, that's wrong.

61

1 a handover provided by Nurse Noble.
2 A. Yes.
3 Q. Can you recall how Nurse Noble described Raychel's
4 overnight condition?
5 A. I think she reported that Raychel was progressing well
6 following her post-operative surgery. She was on IV
7 fluids and I recall that she hadn't passed urine at that
8 time and that her observations were within normal
9 limits.
10 Q. Were you aware that the record of the surgeon had
11 established that Raychel's appendix was mildly
12 congested?
13 A. Yes.
14 Q. And we've heard from Mrs Noble yesterday about, if you
15 like, a straightforward appendicitis and a more serious,
16 severe appendicitis. She would have Raychel falling
17 into the former category, that this was a mild case of
18 appendicitis and she had had a good overnight recovery.
19 A. Yes.
20 Q. It was her expectation -- and perhaps you could comment
21 on this -- that Raychel, she anticipated, would continue
22 on IV fluids during the day, taking sips of water,
23 decreasing the need for IV fluids, would become
24 increasingly mobile and would perhaps be eating by the
25 end of the day. Was that a reasonable anticipation at

63

1 Q. You did write it?
2 A. I did write that, yes, but it's a mistake.
3 Q. It's a mistake?
4 A. Yes.
5 Q. Okay. Could we then turn to the nursing handover that
6 took place at or about 8 o'clock on 8 June. You
7 commenced duty at 7.50 in the morning; is that correct?
8 A. I was usually on about 7.30, but the handover report
9 starts at 7.50.
10 Q. As we know from earlier, the nurses who you allocated to
11 Raychel's care on that day were Rice -- we call her
12 McAuley for the purposes of the record -- and Staff
13 Nurse Roulston.
14 A. Yes, and a nursing auxiliary.
15 Q. Staff Nurse Roulston, as you have said, was the
16 experienced member of staff --
17 A. Yes.
18 Q. -- whereas Nurse McAuley had one year's experience
19 before coming to Altnagelvin.
20 A. She had done her paediatric training through Altnagelvin
21 and I think she was 18 months, maybe, at that stage,
22 after qualification. So she would have done her
23 placements in Ward 6.
24 Q. And Raychel's condition and, indeed all of the patients
25 on the ward, their condition, was reported to you at

62

1 that point?
2 A. Yes, that would have been the expected pathway for
3 Raychel to have followed, that she would be seen by the
4 doctor post-operatively in the morning, oral fluids
5 would be introduced slowly if she wasn't vomiting, and
6 once she was established on the oral fluids, we would
7 hope to reduce the IV fluid to maybe half at lunchtime
8 or pre-lunchtime, and you would hope by the evening, 5
9 or 6 o'clock, the IV fluid would be discontinued.
10 Q. Yes. In terms of the specific allocation of nursing
11 care to Raychel, you were a nurse down that day; is that
12 right?
13 A. I was two nurses down that day.
14 Q. And so Staff Nurse Roulston was specifically allocated
15 at some point, according to her, to the infant unit.
16 A. Yes.
17 Q. The infant unit was a distinct unit separate from the
18 ward; is that right?
19 A. No, it was within the ward. It would have been the --
20 Raychel's room was room I and the two rooms -- nearer
21 the entrance there were two larger --
22 Q. Sorry to cut across you. Let me try and assist you with
23 that. There's a plan available to us and I want to ask
24 you some questions in relation to the plan. At
25 316-016b-001. Just take a moment to orientate yourself.

64

1 You can see various locations highlighted in pink.
2 Could we start with -- could you confirm that room I is
3 as is indicated there on the right-hand side of the L?
4 A. Yes.
5 Q. You were talking about the infants' unit; at that time,
6 where was that?
7 A. The infants' unit was the two rooms below that, below
8 the room I. It was room G and room H.
9 Q. Very well, that's helpful. Then across from
10 room I we can see a nurses' station.
11 A. Yes.
12 Q. Then if we could pan out again, please. Sister's office
13 is identified on the left-hand side of the screen at the
14 bottom.
15 A. Yes.
16 Q. Is that where it was in 2001?
17 A. Yes.
18 Q. And when you say in your witness statement that you
19 spent from 2 o'clock in your office, is that the
20 location to which you refer?
21 A. Yes. It would have been. I didn't go to lunch until
22 about 1.45, so it would have been from approximately 20
23 past 2, half 2, to a time I returned to the ward.
24 Q. I ask you about that specifically -- and perhaps
25 Mrs Noble was confused, but she pointed to a location

65

1 I see it's just in the corner.
2 A. It would be the first room as you come through the
3 middle doors.
4 THE CHAIRMAN: Okay thank you.
5 MR WOLFE: In terms of the toilet facilities, we can see
6 a number of them on the screen. You have said, and
7 we'll deal with this presently, that you observed
8 Raychel's father bringing her to the toilet on two
9 occasions, I think you've said.
10 A. That's right, yes.
11 Q. Which toilets are they? Which toilet was Raychel
12 brought to?
13 A. It was next to the treatment room, just below the
14 treatment room.
15 Q. Above --
16 A. You see the treatment room on the left.
17 Q. Yes, I can see a toilet.
18 A. There's a toilet below that. It would have been that
19 one.
20 Q. So just above the words "zone 4"?
21 A. Yes.
22 Q. On each of the occasions you say you saw her father
23 bringing her to the toilet, was that the toilet that he
24 went to?
25 A. Yes.

67

1 behind the nurses' station as being sister's office back
2 in those days.
3 A. No, that's incorrect.
4 THE CHAIRMAN: Was it ever around there?
5 A. No. There was the reception desk with a computer, but
6 the back -- what we call the back office was really for
7 nursing notes, the doctors used it, the children's
8 charts were kept in there.
9 THE CHAIRMAN: That's opposite room I, is it?
10 A. Yes.
11 THE CHAIRMAN: Okay.
12 A. But it was never sister's office.
13 THE CHAIRMAN: So in those days you were invariably working
14 from the area which is marked "sister's office" on the
15 map?
16 A. Yes. The room in -- in all the other wards, the room
17 that would have been sister's office was room E, but
18 because our ward was reorganised and redesigned in 1996,
19 room E, which was the sister's office, was made into an
20 isolation room.
21 THE CHAIRMAN: Is that somewhere on the right-hand side of
22 the map?
23 A. Yes.
24 THE CHAIRMAN: I can't quite make it out. Could you
25 highlight the right side of the screen, please? Yes,

66

1 Q. And where were you standing on each of those occasions?
2 A. The first time I was at the reception desk. I was
3 standing at the reception desk. I think I was talking
4 to somebody.
5 Q. Where is the reception desk?
6 A. Opposite room I. The nurses' station. Well, the
7 outside desk reception was what I know it as.
8 Q. On the first occasion you were standing there.
9 A. I was standing there and I was talking to another parent
10 and Mr Ferguson, with Raychel, passed me. As I said
11 earlier --
12 Q. We'll come to the detail of that in a moment. But just
13 for the purposes of the map, you were standing there on
14 the first occasion.
15 A. Yes.
16 Q. And the second occasion?
17 A. I was there on the phone, the second occasion.
18 Q. Very well. Apart from the information you received
19 at the handover, did you take any other steps to
20 familiarise yourself with Raychel's condition at or
21 about that time?
22 A. No. No, I had got the handover report on all the
23 children and I had actually been in room I prior to the
24 hand over report because I had gone in to retrieve
25 a chair to use for the handover report. I went back in

68

1 again to put that chair back afterwards.
2 Q. You would have appreciated at that time that Raychel was
3 continuing on intravenous fluids at a rate of 80 ml per
4 hour. That would have been said to you at handover,
5 would it?
6 A. Yes, that was she was on IV fluids.
7 Q. And the fact that she was on IV fluids would have
8 presumably triggered in your mind certain monitoring
9 requirements?
10 A. Yes. Any child on IV fluids -- within the medical side,
11 the paediatricians saw the children every day and any
12 children on IV fluids, they had electrolytes carried
13 out.
14 Q. How often would paediatric medical patients have had
15 their electrolytes --
16 A. Every day.
17 Q. So at some point in the working day, perhaps when
18 convenient, it would be done?
19 A. Yes. During the handover report, the nurse giving it
20 would identify the children on IV fluids on the medical
21 side, also on the surgical side. But at that time, the
22 practice was that the children on the medical side, they
23 had electrolytes done every day.
24 Q. Yes.
25 A. And it would have been 12 hours, but it wouldn't really

69

1 A. Yes.
2 THE CHAIRMAN: It was the paediatricians' way of doing
3 things, that we've got a child in Ward 6 on the medical
4 side, one of the paediatric team will take the blood
5 sample and we'll get that tested for the electrolytes.
6 A. Yes.
7 THE CHAIRMAN: On the surgical side, the surgeons just
8 didn't follow the same routine.
9 A. No.
10 THE CHAIRMAN: Right.
11 MR WOLFE: And are you aware of why the surgeons didn't
12 follow the same routine?
13 A. No.
14 Q. Because presumably, the need was the same regardless of
15 whether you had the label "paediatric medical patient"
16 stamped on your form or whether you were a surgical
17 patient?
18 A. Yes. No, at that time the electrolytes, which would be
19 24 hours before the electrolytes would have been done on
20 a surgical patient, who was still on IV fluids ...
21 Q. Just repeat that. It would be 24 hours before
22 a surgical patient --
23 A. If the child -- if for instance a child was on IV
24 fluids, like Raychel, and it was hoped that the fluid
25 would be down before teatime, before 5 or 6 o'clock, but

71

1 matter what time, they still had them done, even if
2 they'd come in at 10 o'clock the night before, they
3 would have had them done that morning or even if it was
4 2 am in the morning, they still would have done them in
5 the morning.
6 Q. So plainly, that was to address the concern that if
7 a child was continuing on intravenous fluids for any
8 length of time, you need to have information about their
9 urea and electrolytes to avoid the kind of complications
10 that we ultimately saw in Raychel's case?
11 A. Yes.
12 Q. We haven't seen any documentation in relation to it, but
13 let's call it an unwritten rule of paediatrics, the
14 paediatric medical side. Was that rigorously enforced?
15 A. Yes, it was.
16 THE CHAIRMAN: It ends up not being unwritten, doesn't it?
17 Because the electrolyte test is as a result of a blood
18 sample taken by a doctor; isn't that right?
19 A. Yes.
20 THE CHAIRMAN: So in order for a child on the medical side
21 to have her electrolytes or his electrolytes tested,
22 then a paediatrician takes the blood sample and it goes
23 for testing.
24 A. One of the junior doctors would have taken it, yes.
25 THE CHAIRMAN: So that's how it's done.

70

1 if that child had required to continue on IV fluids
2 until the next day, if she had or he had vomited
3 a number of times and oral fluids were not established,
4 the IV fluids would have been continued.
5 Q. Yes.
6 A. And the next morning, that was the usual that happened,
7 there would be electrolytes done then the next morning.
8 THE CHAIRMAN: Next morning here being -- if Raychel comes
9 in on Thursday evening, the next morning being the
10 Saturday morning?
11 A. The Saturday morning, unless there was deterioration
12 in the child's condition.
13 THE CHAIRMAN: So in fact, that becomes 36 hours before the
14 blood is tested, from Thursday night to Saturday
15 morning?
16 A. Yes.
17 THE CHAIRMAN: The surgeons are doing it in 12 hours, you
18 said?
19 A. The paediatricians, yes.
20 THE CHAIRMAN: And the surgeons do it in 36, as the timeline
21 happens to fall on Raychel's case.
22 A. Yes, well, there was no set guidelines as to when the
23 surgical children had electrolytes. But it usually
24 would have been -- as I say, in Raychel's case it would
25 have been Saturday. If she had deteriorated, which she

72

1 did, sooner than that it would have been done.
2 MR WOLFE: Let me tease this out for you now that we're at
3 this. I intended to deal with this slightly later in
4 the sequence, but now that we're here. Re-familiarising
5 yourself with the timeline, Raychel's fluids, as the
6 chairman indicated, commenced at or about 10.15 on the
7 evening of 7 June. She was on fluids for approximately
8 45 minutes to a hour and was then brought to theatre.
9 She was on Hartmann's during theatre and in recovery,
10 and then returned to the ward at 2 am, at which point
11 intravenous fluids were commenced as per the
12 preoperative prescription at a rate of 80 ml per hour
13 and were to continue at that rate throughout the day of
14 8 June, during which time you were supervising her
15 treatment for half of the day; isn't that right?
16 A. Yes.
17 Q. And as we know, Raychel commenced vomiting at 8 o'clock,
18 and during the course of the day when you were on duty
19 she had vomits at 8 o'clock, 10 o'clock, 1 o'clock and
20 3 o'clock recorded on the fluid balance sheet. We'll
21 come to the question of whether there was more vomit
22 than that in due course, but you agree with all of that
23 so far?
24 A. Yes.
25 Q. And then she had further vomiting at and between

73

1 Raychel, that she should have had her bloods taken at
2 about 9 pm, is that what you're saying with the
3 advantage of hindsight or --
4 A. No.
5 THE CHAIRMAN: If you had been there --
6 A. No, if I had been there and if I'd been on duty at
7 9 o'clock, I would have been prompting a doctor to do
8 her electrolytes.
9 THE CHAIRMAN: And the prompt for that would have been,
10 what, the --
11 A. That she hadn't settled, she had vomited again, she
12 hadn't settled despite the anti-emetic.
13 THE CHAIRMAN: Thank you.
14 MR WOLFE: So what you've said, Mrs Millar, is very helpful
15 and clarifies much of what we want to explore here.
16 You, on duty in the afternoon, recognised the need for
17 an anti-emetic.
18 A. Yes.
19 Q. But at that point you didn't recognise, you didn't feel
20 that there was a need for electrolyte assessment. But
21 when the anti-emetic wasn't shown to have effect, had
22 you been on duty, you would have prompted a doctor to
23 come and asked him to consider an electrolyte
24 assessment?
25 A. Well, I would have asked for the patient to have another

75

1 9 o'clock and 10 o'clock, in which coffee grounds were
2 produced, and then further vomiting at 11 pm, by which
3 stage approximately she was at the 25th hour of
4 intravenous fluids; do you agree with all of that?
5 A. Yes.
6 Q. In that scenario, in that specific scenario that
7 I described, would you have anticipated that Raychel's
8 electrolytes and urea would have been assessed, in other
9 words, a blood assay would have been taken for
10 assessment of her electrolytes?
11 A. Yes. I would think that she should have had them done
12 at the 9 o'clock period or maybe even earlier.
13 Q. Before she went to sleep?
14 A. Well, when she vomited I think at 9 o'clock that night,
15 I -- yes, I would think she should have had electrolytes
16 done.
17 THE CHAIRMAN: Sorry, I just want to get this clear. This
18 is even under the old regime, under the -- I know things
19 changed afterwards. I know you started your evidence by
20 saying that you now regret and recognise that blood
21 tests should have been taken at about 1 pm-ish; right?
22 A. A doctor to see --
23 THE CHAIRMAN: Sorry, a doctor should have been called to
24 see her at 1 pm -- [OVERSPEAKING]. When you are saying
25 here today that, on your knowledge of what happened with

74

1 anti-emetic. If I'd been on. And also I would have
2 prompted maybe that electrolytes might be advised.
3 Q. And you would have articulated that message to the
4 doctor because of a concern that there was a risk of
5 sodium or other electrolyte depletion because of the
6 vomiting?
7 A. Yes. I would have been concerned that the vomiting
8 hadn't stopped, despite the anti-emetic, at 5.30 or
9 6 o'clock. And then there was a further vomit, I think,
10 at 9.
11 Q. There was.
12 A. Yes.
13 Q. And in terms of the need for electrolyte assessment, you
14 would have prompted the doctor because, by that stage,
15 you would have been concerned that there was an
16 underlying problem that needed to be measured.
17 A. Yes. Well, as I say, the main -- Raychel hadn't stopped
18 vomiting. I would have expected her to have ... That
19 the anti-emetic would have taken effect and that she
20 would have stopped vomiting. Now, I may have prompted
21 the doctor -- it would have been up to the doctor to
22 carry out the electrolytes if he deemed that she needed
23 them.
24 Q. Yes.
25 A. And normally, they would assess the patient and

76

1 decide -- he wouldn't just do it because I told him.
2 Q. Of course.
3 A. He would assess the patient.
4 Q. The question is why would you want the electrolytes done
5 at that point? An anti-emetic is designed to stop the
6 vomiting, isn't it?
7 A. Yes.
8 Q. And you have said you might have asked for a second
9 anti-emetic, but you've also said that you might have
10 prompted or you would have prompted the doctor to
11 consider electrolytes; why?
12 A. Well, that would be to assess her sodium, potassium,
13 urea, and maybe her blood sugar as well.
14 Q. Yes. We got into that inadvertently. I want to come
15 back to the morning. In the morning, as I say, you were
16 aware that this patient, Raychel, was on an IV fluid
17 regime. I asked you about monitoring and that's how we
18 got into the electrolyte debate. But in terms of the
19 episodic care plan, you would have observed from that
20 that there was a need to measure and monitor certain
21 inputs and outputs; isn't that right?
22 A. Yes.
23 Q. In terms of inputs, there was a need to observe and
24 record any oral fluids that the child had during the
25 day.

77

1 Do you see that, the third up from the bottom?
2 A. Yes.
3 Q. Could I have up on the screen, please, WS056/2 at
4 page 20? At answer (d), you're asked questions about
5 the care plan:
6 "The care plan records 'observe/record urinary
7 output'; how were nurses expected to comply with this
8 aspect of the plan and state ..."
9 You say:
10 "It was practice to record when a child passed urine
11 until the patient is discharged."
12 A. Yes.
13 Q. That doesn't appear to be what you're saying this
14 morning. You seem to be saying that the practice was to
15 record the first incidence of passing urine and no more.
16 A. Yes, well, we obviously failed on that.
17 Q. No, no. I am conscious that you say that you failed in
18 it, but in terms of what you've just told the inquiry
19 about the practice, that wasn't right, was it?
20 A. No, that is incorrect by what I've written here.
21 THE CHAIRMAN: Sorry, what you've written is incorrect?
22 Because what you have said this morning is it was not
23 the practice to record when a child passed urine until
24 the child was discharged.
25 A. Yes.

79

1 A. Yes.
2 Q. There was a need to observe and record the fact of any
3 urination that she might have had during the day.
4 A. Well, certainly the initial passing of urine would have
5 been very important to document.
6 Q. Does the care plan say that?
7 A. It ... The nurse had reported that Raychel hadn't
8 passed urine that morning.
9 Q. In your witness statement for the inquiry, do you not
10 indicate that in terms of recording output, it was
11 important to do that until the patient was discharged
12 from hospital?
13 A. Yes.
14 Q. Isn't that what should have been done?
15 A. Any child on IV fluids would need to have any oral
16 intake documented.
17 Q. Yes.
18 A. Urinary output at that time, as I said, was not
19 routinely done except if a child was being specialed
20 [sic] -- a one-to-one -- it was a renal patient or the
21 medical staff had asked specifically for it to be done.
22 Q. Could I have the care plan up, please? 020-027-063. On
23 the right-hand side you will see the various steps that
24 are indicated in the care plan. It says:
25 "Observe/record urinary output."

78

1 THE CHAIRMAN: That was not the practice? It should have
2 been --
3 A. It should have been.
4 THE CHAIRMAN: -- but it wasn't the practice.
5 A. No.
6 THE CHAIRMAN: Thank you.
7 MR WOLFE: Okay, so the practice was as what happened,
8 is that the situation? You didn't typically record each
9 event of going to the toilet, albeit that should have
10 been the practice?
11 A. Yes.
12 Q. Okay. So the episodic care plan, as written by Staff
13 Nurse Patterson, it wasn't followed?
14 A. No, not properly, no.
15 THE CHAIRMAN: Sorry, just to be fair to Staff
16 Nurse Patterson, in a sense that's not really written by
17 her, is it? Is it not a printout?
18 A. It's a core care plan that has been downloaded from the
19 system.
20 THE CHAIRMAN: Yes. We've looked at care plans,
21 particularly in Claire's case, which were handwritten or
22 typed, and were specifically designed to the individual
23 child. This is a different style of plan altogether,
24 isn't it?
25 A. Yes.

80

1 THE CHAIRMAN: In fact, if you feed in some information here
2 like the child's name and so on, you're going to get an
3 automatic printout of things to do. On this pro forma,
4 one of the requirements is to observe and record urinary
5 output. That's what the package that Altnagelvin had
6 for the care plan required, but it was not Altnagelvin's
7 practice to do that, to follow that particular aspect of
8 the printout; is that fair?
9 A. Yes, that's fair, yes.
10 MR WOLFE: Mrs Ramsay, in her report, cites various nursing
11 texts, and in particular she cites Hubbard & Trig. She
12 explains that:
13 "Where a child has surgery and her hydration needs
14 are being met by IV fluids, as in Raychel's case,
15 a fluid balance chart is crucial to monitor all input
16 and output. All intake and output to be recorded."
17 She concludes that:
18 "In Raychel's case there was a failure to record
19 fluid balance accurately."
20 Do you accept that that --
21 A. I do accept that, yes.
22 THE CHAIRMAN: When you retired, was this sort of pro forma
23 printout being used, the care plan?
24 A. Yes, I think they were. They had reverted to the
25 evaluation by free text, I think around the time that

81

1 your deposition to the coroner at Raychel's inquest. If
2 we go back a page, just so that the witness can
3 familiarise herself with it. Take your time to identify
4 that and read it if you need to. (Pause).
5 I want to draw your attention to the section
6 starting "Mr Foster". Mr Foster was counsel
7 representing the Ferguson family at the time of
8 the coroner's inquest. The coroner would have recorded
9 your evidence in answer to Mr Foster's questions. He
10 has recorded:
11 "I was the most senior nurse. Nurse Wright [that
12 must have been Nurse Rice, I would suggest, but leaving
13 that] was a junior staff nurse at the time.
14 Nurse Roulston was also involved with the care of
15 Raychel. It was not routine to note each passage of
16 urine or the quantity on each occasion. It may be
17 important to note if a patient actually passed urine.
18 I did not personally see any of the vomits. The
19 10.30 am was slightly larger than the other. The nurses
20 described the vomits for me. I cannot recall which
21 nurse I handed over to."
22 That's into a different issue.
23 Has the coroner recorded your evidence correctly
24 where you say --
25 A. I saw the 10.30, the 10/10.30 vomit.

83

1 I left, but I think the core care plans are still in
2 use.
3 THE CHAIRMAN: Okay.
4 MR WOLFE: Another aspect of recording, perhaps a very
5 important aspect of recording that ought to have been
6 supplied with, was vomiting. Any vomiting should have
7 been recorded. There is a dispute on the facts of
8 Raychel's situation with regard to how much vomiting
9 there was in terms of both volume and incidence of
10 vomiting. Could I ask you, Mrs Millar, did you actually
11 physically see any of the vomit, any of the vomiting?
12 A. Yes, I saw the vomit at 10 o'clock. Well, it was
13 between 10 and 11 o'clock, I was in the room with the
14 paediatricians doing the ward round. I happened to
15 notice that there was a vomit bowl on Raychel's bed
16 table. There was some vomit in it and initially
17 I thought, "Why is that there? Who has left it?". So
18 I gave it to Nurse McAuley to dispose of.
19 Q. Who recorded that in the note?
20 A. I think it was Nurse McAuley.
21 Q. And that's the vomit that was identified as a large
22 vomit?
23 A. Yes.
24 Q. Could I have up on the screen, please, 012-041-203?
25 Just to orientate you, Mrs Millar, this is a record of

82

1 THE CHAIRMAN: Sorry, do I understand it that you didn't see
2 Raychel vomiting --
3 A. No.
4 THE CHAIRMAN: -- at any time, but you saw what she had
5 vomited at one point?
6 A. Yes.
7 THE CHAIRMAN: Okay.
8 A. Yes, that's probably what -- yes, I ... I didn't see
9 Raychel vomit at any time during the day, but I did --
10 and the only vomit I saw was the vomit between 10 and 11
11 or 10.30. That was sitting in a bowl on her bed table
12 during the paediatric ward round.
13 MR WOLFE: Where you say, "the nurses described the vomit
14 for me", that doesn't apply to the 10.30 vomit?
15 A. No, it applies to the 1 o'clock vomit. The 8 o'clock
16 vomit in the morning, I actually didn't know she had
17 vomited until I went with the doctor to look at her,
18 when he came to see her post-operatively. That vomit, I
19 think, happened during the handover report, and it was
20 documented by one of the night staff.
21 Q. Dealing with that, what we call the 8 o'clock vomit,
22 it's recorded in that slot between 8 o'clock and
23 9 o'clock on the fluid balance chart; did you see that
24 vomit?
25 A. No.

84

1 Q. How were you aware of it?
2 A. I saw it on the -- when I went in with the doctor to see
3 Raychel, it was between 9 and 10 o'clock. I saw on the
4 fluid balance sheet the vomit at 8 o'clock.
5 Q. The doctor who --
6 A. At least I saw it documented.
7 Q. Yes. The doctor who came to attend Raychel as part of
8 the surgical ward round, was it Dr Zafar?
9 A. Yes.
10 MR WOLFE: I want to pick up with you, after lunch, your
11 dealings with Dr Zafar.
12 THE CHAIRMAN: Okay. We'll stop now. It's 1.20. We'll
13 start at about 2.10. Thank you.
14 (1.20 pm)
15 (The Short Adjournment)
16 (2.10 pm)
17 (Delay in proceedings)
18 (2.19 pm)
19 MR WOLFE: Good afternoon, Mr Chairman. Good afternoon,
20 Mrs Millar.
21 Could I have up on the screen, please, 021-068-159?
22 This is a statement which you composed on 15 June 2001,
23 Mrs Millar, shortly after the critical incident meeting
24 on 12 June.
25 A. Yes.

85

1 A. And I said to Mr Zafar that Raychel was progressing
2 well, her observations were normal, there was nothing of
3 major concern, except I pointed out or said to him she
4 had had a vomit at 8 o'clock.
5 Q. Very well. Looking at the statement, as I've said,
6 you haven't indicated that there was to be any delay
7 in the use of oral fluids. And we'll look at that in
8 the context of what you're now saying. In the next
9 paragraph, you set out the vomits that Raychel had and
10 you say:
11 "Raychel vomited undigested food at 10.30 and again
12 at 1 and 3."
13 Nowhere in that statement do you refer to the
14 8 o'clock vomit.
15 A. No, because I -- that had happened with the night staff.
16 I was only concerned at this stage that -- from the time
17 I was on duty, to the time of going off.
18 Q. Yes. Could I ask you to look at your first statement to
19 the inquiry, please, WS056/1 at page 4? At point 3,
20 halfway down the page you say:
21 "Approximately between 9.30 am and 10 am I was in
22 room I doing the ward round with the medical doctor
23 (there were two medical patients in room I)."
24 So that's the medical doctor as distinct from
25 Dr Zafar?

87

1 Q. As I understand the position, Dr Fulton at that meeting
2 directed members of staff to prepare witness statements,
3 which he told you might be used if a coroner's inquest
4 was required.
5 A. I don't remember that, but, yes, he may well have done.
6 Q. In any event, this is a statement which you submitted,
7 and within the statement you set out the events of the
8 day. You started at 7.50 am, coming on duty:
9 "Raychel in good form, her dad was with her, she was
10 bright and alert. Early in the morning, the surgical
11 SHO, Dr Zafar, saw Raychel and was happy for her to have
12 small amounts of clear fluids orally. The IV fluids
13 were to continue as prescribed."
14 I introduced this sequence of the evidence in this
15 way for two reasons. When we come to look at what you
16 later say about your interaction with Dr Zafar, you tell
17 us, I think, that it was his view that oral fluids
18 should be delayed because he was aware of the 8 o'clock
19 vomit.
20 A. Yes. I informed -- I went into the room with Mr Zafar
21 to see Raychel and, as I would do, I lifted the
22 observation sheets, fluid balance, at the end of the
23 bed. And I noted she had had a vomit at 8 o'clock.
24 I didn't know about that prior to that.
25 Q. Yes.

86

1 A. Yes.
2 Q. You say:
3 "I noticed a vomit basin on Raychel's bed table with
4 a small amount of vomit in it, just covering the bottom
5 of the bowl. I understood this to be the vomit as from
6 8 am that morning and it had not been removed and
7 discarded."
8 A. Yes. Initially, I did think it was the 8 o'clock vomit,
9 but --
10 Q. This is 2005 when you're writing this statement.
11 A. Yes. This was for the coroner's --
12 Q. No, no, this is the statement that you have prepared for
13 the inquiry in 2005. So you start with a statement
14 prepared for the purposes of your employer in June 2001,
15 in which you omit to mention the 8 o'clock vomit, and
16 you've explained this morning why you chose not to
17 include that.
18 Moving on now to 2005, you make a specific point of
19 telling the inquiry that, in circumstances where you
20 were visiting Raychel's room with the medical doctor,
21 you identified:
22 "A ... vomit just covering the bottom of the bowl
23 and [you] understood this to be the vomit as from
24 8 o'clock that morning."
25 A. Yes.

88

1 Q. Whereas, as I understand your position to the inquiry
2 this morning, it is that in fact the vomit that you saw
3 was the one at 10.25.
4 A. Well, I had -- after I had written that initial
5 statement, I was talking with Michaela McAuley, the
6 nurse who was looking after Raychel, and I understood in
7 talking to her that that was the -- it was more likely
8 to be the 10 o'clock vomit.
9 Q. You've described here a vomit just covering the bottom
10 of the bowl.
11 A. Yes.
12 Q. Presumably that description would match a small vomit.
13 A. Yes.
14 Q. Whereas Michaela McAuley described a large vomit at
15 10.25.
16 A. Yes. I think I understand that Michaela McAuley, on
17 reflection, has said that it was not a large vomit.
18 Q. Indeed she has. But when you came to give evidence to
19 the coroner, when asked about this area, you described
20 the vomit at 10 o'clock, 10.30, as not being large.
21 A. Yes. It was hard to quantify the actual amount. The
22 bowl itself contains 550 ml. The vomit was covering the
23 bottom of the bowl. I estimated that there was not
24 100 ml, under 100 ml, because as I say, I have measured
25 the capacity of the bowl and of the kidney dish, the

89

1 tight as it should have been; is that not fair?
2 A. Yes. Well, that is true, yes.
3 THE CHAIRMAN: Okay.
4 MR WOLFE: In any event, Dr Zafar came, and you say that was
5 at what time?
6 A. Probably around 9 o'clock in the morning. Between 9 and
7 10, maybe slightly before 9.
8 Q. Did you accompany him to Raychel's room?
9 A. I did, yes.
10 Q. How long did that ward round in terms of his visit to
11 Raychel take?
12 A. No longer than about 10 minutes.
13 Q. As much as that?
14 A. Probably less. Five minutes. I can't put an exact time
15 on it, but it wasn't a long visit.
16 Q. Were you there throughout the visit?
17 A. Yes.
18 Q. And what tasks did he perform during the time he was
19 there?
20 A. He -- I showed him the observation sheets at the end of
21 the bed. He spoke to Raychel. As far as I remember, he
22 listened to her tummy for bowel sounds and he spoke to
23 her father.
24 Q. In terms of whether he read the notes, do you have
25 any --

91

1 disposable kidney dishes for vomit, and they both
2 contain similar amounts, 500, 550.
3 Q. It does, on the evidence, the various sources of the
4 evidence, appear quite confused, Mrs Millar; would you
5 agree?
6 A. No, I'm clear that that vomit that I saw at 10 o'clock,
7 half 10, was the 10 o'clock vomit.
8 THE CHAIRMAN: Well, look at the introductory line on the
9 top of the screen at paragraph 3:
10 "Approximately between 9.30 and 10 am [you were]
11 in the room with the medical doctor."
12 You now think that --
13 A. It could have been between -- I'm not sure that it was
14 10, it could have been 9.30 to 10.30. It was some time
15 before 11.
16 THE CHAIRMAN: That's just the lack of clarity -- I think
17 the point Mr Wolfe is making to you is that this is all
18 a bit unclear, as people try to work out afterwards when
19 Raychel was sick and how much she was sick at any given
20 time because the records aren't as clear as they might
21 be. So you're left with Michaela McAuley trying to
22 remember, was that a big one or was that a small one,
23 what time was it at or what time was it at compared to
24 the next one. And the reason you're in that position is
25 because the extent to which records were made isn't as

90

1 A. Read the observation sheets?
2 Q. Yes.
3 A. I informed him, I informed -- I held up the clipboard
4 from the end of the bed and I said that Raychel was
5 progressing satisfactorily, that her observations were
6 within normal limits, but I said she has had a vomit at
7 8 o'clock. He talked to Raychel, he was asking her how
8 she was, had she any pain. That's really all. It
9 wasn't a long conversation, but he did speak to her
10 father as well.
11 Q. So just to be clear, you explicitly told him that
12 a vomit had occurred?
13 A. Yes.
14 Q. You had with you a book for the purposes of recording
15 what the ward round doctor was to say to you?
16 A. Yes. It was just a brief synopsis of what the doctors
17 or the consultants or whoever was doing the ward round
18 that morning. It was really guidance for the nurses
19 during the day and to remind me as well what was said.
20 I usually took that book with me when I went to see
21 a patient with the doctor.
22 Q. Could we take a look at that book? It's 095-018 --
23 sorry, let's go with that reference and then we'll look
24 at the book. Sticking with that reference,
25 095-018-077ca. This is a document produced by

92

1 Therese Brown, which provides an explanation of
2 a treatment book, which you tell us you had with you at
3 the time of Dr Zafar's visit and Therese Brown provided
4 this explanation to the PSNI during their investigation:
5 "The treatment book is something held on the ward,
6 which provides a guide to patient layout and allocation.
7 It details the age of the child, the consultant, and the
8 provisional diagnosis. It is used as general
9 information for all staff on the ward and is used as
10 a prompt for required action. If a patient is seen by
11 medical staff, a brief summary is recorded in the
12 treatment book. The book is used by nursing staff
13 during the consultant ward round when a brief summary of
14 action and the treatment plan is recorded. The book is
15 not used in isolation from the medical notes or nursing
16 notes. Generally something is written in the treatment
17 book about all patients in the ward on a daily basis
18 unless the patient is a 'long stay' patient."
19 Is that a description which you concur with?
20 A. Yes.
21 Q. And in terms of the treatment book itself, we can find
22 the relevant extract from it at WS056/2, at page 29.
23 The inquiry, Mr Chairman, has received as an addendum or
24 an appendix to Mrs Millar's statement a rather fuller
25 sheet containing the treatment for various patients, but

93

1 THE CHAIRMAN: Because if you don't write it then, you won't
2 remember it?
3 A. Yes, if I don't write it, then I won't remember. It's
4 certainly written before I leave the room.
5 MR WOLFE: Yes. That appears to be the only note that you
6 record in relation to Dr Zafar's visit.
7 A. That's right.
8 Q. Would it be practice to write a fuller note in the
9 nursing notes?
10 A. No. What I would have done was, I conveyed this to
11 Michaela McAuley and as far as I remember,
12 Avril Roulston was with her just outside the door, that
13 Raychel was allowed sips later because, when I told
14 Mr Zafar that Raychel vomited at 8, he had said to start
15 oral fluids and reduce IV fluids accordingly, which
16 would be -- mid-morning, the IV fluids you would hope
17 would be down to half because Raychel would be
18 tolerating oral fluids and you would hope by evening
19 time, 5, 6 o'clock, the IV fluids could come away. But
20 because Raychel had vomited at 8, I said to Mr Makar
21 [sic], "Can we delay giving the oral fluids?", and
22 therefore -- he said yes. I mean, I can't remember him
23 agreeing, but as far as I know he agreed with that.
24 MR CAMPBELL: Just for the record --
25 A. He didn't really just say anything.

95

1 for obvious reasons it has been redacted --
2 THE CHAIRMAN: Yes.
3 MR WOLFE: -- and that's why you see it in this form.
4 Mrs Millar, you can confirm perhaps that this is the
5 entry relevant to Raychel?
6 A. Yes. The line underneath is not relevant to Raychel.
7 "Regular nebs", that must be another child.
8 Q. Just read out the words which are applicable to Raychel.
9 A. "Allowed sips later. Seen by surgical doctor.
10 Analgesia. And if drinking, reduce IV fluids."
11 Q. Yes. Let me translate that. The "SB" on the first line
12 is "seen by"?
13 A. Yes.
14 Q. "Surgical doctor." And then it goes along, "if
15 drinking", and then you go below the line, there's an
16 arrow down.
17 A. Yes.
18 Q. "Reduce IV fluids."
19 A. Yes. That would be, "Reduce IV fluids according to the
20 tolerating of oral fluids".
21 Q. Yes. Could you paint the scene for us? When are you
22 writing this down?
23 A. I write that straight after the doctor. I had the book
24 with me and I just often put it on the bed table and
25 write it.

94

1 MR CAMPBELL: I think the witness there meant to refer to
2 Mr Zafar.
3 THE CHAIRMAN: And not Mr Makar, thank you.
4 A. No, Mr Zafar, yes.
5 THE CHAIRMAN: Page 95, line 2 of the draft transcript
6 should read "Mr Zafar". Thank you.
7 MR WOLFE: Have you appraised yourself of Mr Zafar's account
8 of your interaction with him?
9 A. Yes.
10 Q. And do you know that he recalls this event rather
11 differently?
12 A. Yes.
13 Q. Could I have up on the screen, please, Mr Zafar's first
14 statement for the inquiry, WS025/1 at page 2, please?
15 Maybe go to the next page. I've got a rogue reference
16 in my note.
17 You see at paragraph 1, Mrs Millar, that Mr Zafar
18 recalls that, on 8 June, he conducted a morning ward
19 round and he saw Raychel:
20 "She did not complain about nausea or vomit and the
21 ward staff did not mention any vomiting earlier that
22 morning. I have no recollection or knowledge of any
23 vomit at 8 am."
24 What do you say to that?
25 A. My recollection is I did tell him that Raychel had

96

1 vomited at 8 o'clock.
2 MR QUINN: Mr Chairman, I just want to come in here. My
3 client Mr Ferguson instructs me that most definitely his
4 recollection is that he was never told about the 8 am
5 vomit. He was never in a room when that was discussed,
6 he was never told about it, he had no knowledge of it.
7 THE CHAIRMAN: Okay. He was there when Mr Zafar came along?
8 MR QUINN: Yes. He will say, to go a little bit further,
9 Mr Zafar spoke to him. Not very long, but there were
10 a few words exchanged between Mr Zafar and Mr Ferguson.
11 He will say that the last section we looked at, none of
12 those instructions were given to him by this nurse.
13 THE CHAIRMAN: Sorry, the last part we looked at?
14 MR QUINN: The last bit that was on the screen about
15 what was told to him by this witness. He will say that
16 none of that information was given to him, there was no
17 real communication between himself and this witness, but
18 that there was a conversation, albeit brief, between
19 himself and Mr Zafar. But the main recollection that he
20 has was that there was no comment about the 8 am vomit.
21 THE CHAIRMAN: And are you saying Mr Ferguson didn't know
22 about the 8 am vomit?
23 MR QUINN: He didn't know about it.
24 THE CHAIRMAN: He was there while Mr Zafar and Sister Millar
25 were looking at Raychel?

97

1 to mention it.
2 A. Yes, I did, but I did -- I have clear recollection that
3 I told Mr Zafar that Raychel had vomited at 8 o'clock.
4 Q. And the next time you deal with it in terms of
5 a statement is in 2005 in your statement for the
6 inquiry, when you do bring the 8 o'clock vomit into it,
7 and at that point in time, as I've already indicated to
8 you, you're recalling having seen the 8 o'clock vomit
9 when in fact you're now saying --
10 A. I saw it written on the fluid balance sheet.
11 Q. No, but in your 2005 statement you refer to having seen
12 a vomit bowl between 9.30 and 10 --
13 A. No, between 10 -- it was between 10 and 11, I think,
14 I was in the room with the paediatricians. Was that the
15 paediatric ward round?
16 THE CHAIRMAN: Mr Wolfe is making the point that the
17 statement you had on screen a few moments ago, that's
18 not what that statement said. Your 2005 statement
19 didn't say that. Your 2005 statement said that, between
20 9.30 and 10, you had seen a small amount of vomit and
21 you understood this to be the vomit from 8 am that
22 morning. And this is the difficulty in trying to --
23 A. Well --
24 THE CHAIRMAN: -- make everything fit afterwards.
25 A. After reflection and talking to Michaela McAuley, I took

99

1 MR QUINN: Yes, which is why he says it was never discussed.
2 THE CHAIRMAN: Thank you.
3 MR WOLFE: Mrs Millar, you will recall that I started this
4 sequence by opening to you the statement that you
5 prepared merely three days, perhaps five days, after the
6 event of 8 June. And within that statement you didn't
7 refer to the 8 o'clock vomit.
8 A. No, that's correct, because, as I say, the 8 o'clock
9 vomit didn't occur when I was on duty. But I did point
10 it out to Mr Zafar. And I also spoke to Mr Ferguson
11 earlier on in the morning before Mr Zafar came to see
12 Raychel. When I went back into the room to replace my
13 chair, Raychel was sitting at the end of the bed,
14 colouring in, and I spoke to Mr Ferguson to tell him
15 what I thought the plan would be for the rest of the
16 day. Mr Zafar had not seen her at this stage, and
17 I said that it was hoped that oral fluids would be
18 introduced, that the IV fluids would be gradually
19 reduced, and that she could have analgesia if required.
20 And hopefully, the IV fluids would be down by the
21 evening.
22 Q. Yes, but the significance of the 8 o'clock vomit and the
23 fact that you articulated its occurrence to Mr Zafar
24 wouldn't have been lost on you if that was a correct
25 sequence of events back in June 2001 and yet you failed

98

1 it to be the 10/10.30 vomit.
2 THE CHAIRMAN: Okay.
3 MR WOLFE: Now --
4 A. I was wrong, it was not the 8 o'clock.
5 Q. You are, it appears to me, in your statement explaining
6 the fact that oral fluids were to be delayed because
7 Raychel had had a recent vomit; isn't that your --
8 A. Well, that was the usual practice, that if a child had
9 vomited we would delay giving oral fluids for an hour or
10 two.
11 Q. But if Mr Zafar hadn't been told or hadn't informed
12 himself from the fluid balance chart that there was
13 a vomit, then he wouldn't have had any reason or basis
14 to delay oral fluids; is that fair?
15 A. I asked him, could I delay giving oral fluids because
16 Raychel had vomited.
17 Q. In his statement -- and let me just ask you again for
18 your comments on this. If we go to WS -- actually, it's
19 on the page in front of us, I think. Yes. He says:
20 "She was fairly stable and I advised to start sips
21 of oral fluids and gradually reduce the IV fluids."
22 And he goes on in a subsequent statement to say, if
23 I could have up on the screen WS025/2 at page 9, (ii)
24 under (c). He says that:
25 "[He] didn't take any steps to check the type of

100

1 fluid because I had advised that the rate of fluid
2 should be reduced. Verbal advice on the ward round
3 would not always be recorded in the medical notes."
4 THE CHAIRMAN: Mr Zafar's problem is that he hasn't made
5 a record; is that right?
6 MR WOLFE: That's right. He's made a record, but it doesn't
7 refer to the fluids. He goes on at (iii) to say:
8 "I advised that IV fluids should be stopped when
9 Raychel tolerated oral fluids."
10 If we could have the page open in full, please, or
11 zoom out. He goes on to say -- I'm not sure if I can
12 find it on that page -- that he reached the conclusion
13 that Raychel could manage with less IV fluids.
14 A. No.
15 Q. Sorry, it's at (d). I'm obliged to my colleague.
16 Raychel could manage with less IV fluids.
17 A. No, the plan was to start oral fluids. I said,
18 "Raychel's vomited at 8, can we delay for an hour to let
19 her recover?". He agreed to that. The IV fluids were
20 to be reduced, when Raychel was tolerating small
21 amounts, to half around lunchtime, late morning, and to
22 stop them, if all was well, by late afternoon. If
23 he had told me to reduce the fluids, I would have
24 reduced the volume on the Imed pump which we always did
25 when given instructions by the doctors, and I would have

101

1 that they are of the view that fluids post-operatively
2 should be reduced because of the risks of fluid
3 retention. As a general approach within Altnagelvin at
4 that time, were fluids ever reduced post-operatively in
5 your experience?
6 A. No. It was always once the patient had started to take
7 oral fluids and was tolerating that we would reduce to
8 half, hopefully by lunchtime, and then they would be
9 discontinued by the evening time.
10 Q. At this stage we were, as I say, eight or nine hours
11 after surgery, Raychel had had a strong overnight
12 recovery, there was no pain, there was no nausea, no
13 vomiting. Everything seemed to be on a even keel; isn't
14 that right?
15 A. Except for the vomit at 8 o'clock.
16 THE CHAIRMAN: A single vomit wouldn't overly concern you?
17 A. No. It wasn't unusual for children to vomit.
18 THE CHAIRMAN: So there was no real issue of concern?
19 A. At that point, no.
20 MR WOLFE: Mr Zafar's thinking is that in light of this
21 smooth overnight recovery, it was appropriate to reduce
22 the fluids, he seems to suggest, immediately, gradually
23 reduce the fluids, introduce sips of water, and
24 gradually stop the IV as oral fluid is tolerated. In
25 what respects do you say that wasn't the plan as you

103

1 written in my treatment book, communication book, "IV
2 fluids reduced to 40", or whatever they were reduced to.
3 I have never been given specific instructions on
4 reducing fluids by the surgical medical team. It starts
5 oral fluids and reduce the IV fluids accordingly.
6 Q. Yes. Well, let me ask you this: Raychel had been
7 prescribed 80 ml per hour preoperatively. She was now
8 out of theatre by the time of this ward round by
9 something in the order of eight or nine hours. Her
10 fluids were continuing at 80 ml per hour. Was it the
11 practice in Altnagelvin at that time to continue the
12 fluids at the same rate post-operatively as was the case
13 preoperatively?
14 A. Yes, to continue the fluids until the patient was taking
15 adequate oral fluids.
16 Q. At the same rate as the preoperative rate?
17 A. Yes. I have never got instructions about reducing IV
18 fluids in children, specifically reduction in IV fluids,
19 in other words to say: reduce the fluid to 30 ml or
20 reduce the fluid to 40 ml. I have never got that.
21 Q. I'm not talking about any type of oral instruction,
22 I'm -- let me approach it in this way. You will have
23 read perhaps the reports of Mr Orr and Mr Foster, the
24 expert surgeons who have been retained by the DLS/Trust
25 and the inquiry respectively. And you will have read

102

1 understood it?
2 A. He didn't tell me to reduce the fluids immediately. If
3 he had, I would have reduced it on the pump, on the Imed
4 pump, and I would have written it in the nursing notes.
5 Q. Are you familiar with any of the methods or formulae for
6 calculating paediatric IV fluids?
7 A. No.
8 Q. At that time --
9 A. At that time, no.
10 Q. So you would never yourself have had --
11 A. No. But if a child was getting excessive fluid, I mean
12 if Raychel had been written up or getting 100 ml
13 an hour, I would know that that was excessive or if she
14 had been getting 30, 40 ml an hour, I would know that
15 that was too little. But for her age, she was 9, I know
16 it's a guess, but it was through experience over the
17 years that I had seen different age groups get different
18 amounts of fluid, but I did not know how to calculate IV
19 fluids. I was never shown or never educated in that,
20 but certainly, if a child was getting excessive fluids,
21 I would know and I would be very quick to say.
22 THE CHAIRMAN: So you would know from your experience
23 what was obviously too much or obviously too little?
24 A. I would, yes.
25 THE CHAIRMAN: Okay.

104

1 MR WOLFE: Mr Foster for the inquiry suggests that
2 maintenance rate for Raychel should have been 65 ml per
3 hour and then that figure should have been reduced by
4 20 per cent more post-operatively, bringing it down to
5 something in or around 52. Would you have appreciated
6 that that difference, something in the order of 30 ml
7 an hour, was the situation in Raychel's case? I didn't
8 ask that question very well, I'll ask it again.
9 Would you have appreciated that Raychel's fluids
10 after an operation should be reduced?
11 A. After, sorry?
12 Q. After an operation, after surgery?
13 A. No, that was not the practice at that time and I did not
14 know -- I had never seen it. I had never seen IV fluids
15 reduced. It was always half the fluids around lunchtime
16 if the patient was tolerating, and hopefully they would
17 be gone, they'd be out 5, 6 o'clock, but I had never
18 seen IV fluids reduced immediately on a surgical ward
19 round. Never.
20 Q. So in terms of the plan, as you understood it, which was
21 to introduce sips of oral fluids, it was your
22 understanding that that should be done after some delay?
23 A. Yes, because I had said to Mr Zafar, "Raychel has
24 vomited, can we delay?". That was a usual practice that
25 we would delay giving the oral sips, maybe for an hour,

105

1 with him, I had gone out, just outside the door at that
2 stage with Mr Zafar. But they spoke to each other,
3 Mr Zafar and Mr Makar, in passing. They did speak to
4 each other.
5 Q. In terms of the conduct of ward rounds, did
6 paediatricians have ward rounds as well as surgical
7 staff. Do they broadly follow the same pattern or do
8 paediatric ward rounds take longer or shorter? Are they
9 more involved?
10 A. They are more involved and take longer, yes.
11 Q. Is that because the patients have different needs in
12 your experience or is it because surgeons perhaps are in
13 rather more of a hurry to get off to theatre?
14 A. Well, some of the paediatric patients would have been
15 complex cases, not always, but there could be maybe two
16 or three children who would have complex needs and
17 those children would take quite a long time to examine,
18 talk to parents, give advice. There may be a child
19 there with prolonged asthma or a child that has been
20 fitting over a number of hours on and off. So those
21 children would need a lot of input. And the consultants
22 or the doctor would be looking at observation sheets,
23 fluid balance sheets and medication and deleting or
24 adding as needed.
25 Q. In terms of the personnel who attend upon a surgical

107

1 until the child had settled and was able to tolerate.
2 Q. And that's what was done in Raychel's case?
3 A. Well, Raychel had vomited at 10 or 10.30, and we didn't
4 at that stage get introducing the fluid until late
5 morning. I think she got some sips and they -- yes, she
6 got some sips before lunchtime.
7 Q. And did she tolerate them?
8 A. Well, she vomited again at 1 o'clock.
9 Q. Was there ever a period when she did tolerate oral
10 fluids?
11 A. No, she got very little oral fluids during the day
12 because of her vomiting, the vomit at 10 and 1. And I'm
13 not sure if she got any during the afternoon. But
14 I understand she did get some late afternoon.
15 Q. After Dr Zafar had seen Raychel or perhaps at or about
16 the same time, Mr Makar was present in Ward 6.
17 A. Yes.
18 Q. And he came to see Raychel; is that right?
19 A. Yes.
20 Q. He made no change to her treatment?
21 A. No. He came -- as Mr Zafar and I were leaving, he came
22 in the door of the room and I said -- he said he was
23 here to say Raychel. I said, "Raychel's just been seen
24 by Mr Zafar". I didn't go with him, but he did go over
25 to Raychel and he did speak to Mr Ferguson. I wasn't

106

1 ward round, it's notable in the eyes of the surgical
2 expert retained by the inquiry, Mr Foster, that nobody
3 more senior than a senior house officer saw Raychel and
4 nobody more senior than a senior house officer saw
5 Raychel throughout her stay. So it was a senior house
6 officer who attended the ward round and subsequently she
7 was attended by junior house officers until the point of
8 her collapse when the paediatricians came to her
9 assistance.
10 In terms of the ward round specifically, in your
11 experience, did the consultant attend at that?
12 A. Did they come that day?
13 Q. Generally to the ward round, the morning ward round,
14 if we call it that.
15 A. Not every day.
16 THE CHAIRMAN: Does that mean that they were as likely or
17 not to be there, or were they even -- I've begun to get
18 the impression that they were there relatively
19 infrequently.
20 A. Yes, that would be correct.
21 MR WOLFE: If a consultant under whose care a child is
22 admitted can't see a child at the ward round, would you
23 expect him or her to make arrangements to see the child
24 at a later stage in the day?
25 A. Well, usually the registrar came. It would usually be

108

1 a registrar who would see the children. They were
2 senior with experience. Normally, if they were worried
3 about the child, or the patient, they would convey those
4 concerns to a consultant. But in my experience,
5 I always thought that the registrars were competent
6 and ... The word has gone.

7 THE CHAIRMAN: Was this an unusual day then that a registrar
8 didn't see Raychel?

9 A. I thought Mr Makar -- was he a registrar?

10 MR WOLFE: Senior house officer.

11 A. I can't remember. Yes, I -- it would be preferable for
12 a registrar to see children.

13 THE CHAIRMAN: Yes, I have no trouble agreeing with you on
14 that. What I was asking you is something slightly
15 different. Was it unusual that there wasn't a registrar
16 on the ward round that day?

17 A. Yes. Usually there would be a registrar, yes.

18 MR WOLFE: So after the ward round, things settled down and
19 you got on with the nursing day. And as we understand
20 your account, you were on or about the ward until
21 2 o'clock when you went to your office?

22 A. No, I went to lunch about 1.45 and then, after lunch,
23 I went to my office.

24 Q. So between the hours of 1.45 and, I think you say
25 5 o'clock in your witness statement --

109

1 round with the other two children. That was the time
2 that I saw the vomit bowl on the bed table. That was
3 between 10, 10.30, 11. And I spoke to Mr Ferguson at
4 that stage as well. I reassured him, because I had
5 known that Raychel had had the two vomits, and
6 I reassured him that, yes, Raychel had vomited but
7 I wasn't unduly -- he should not be unduly concerned as
8 this wasn't unusual in post-operative children. And
9 I said, "I'm sure she will settle quite soon and we will
10 be able to start the oral fluids and get her fluids down
11 in due course". And I remember very clearly speaking to
12 him because I left the doctors on the other side of the
13 room, where the other two children were, to go to talk
14 to him.

15 Q. You appear in your witness statement to have clearly
16 identified Mr Ferguson as being the parent through whom
17 you had either visual or verbal contact on the morning
18 of 8 June --

19 A. Yes.

20 Q. -- whereas, just to be clear, Mrs Ferguson tells the
21 inquiry in her witness statement that she returned to
22 the hospital, having left it in the early hours of the
23 morning, at or between 9.30 and 10, and spent the rest
24 of the day with her daughter through until 3 o'clock in
25 the afternoon when she left for a short period of time

111

1 A. Um, yes, I think ... I came back over to the ward,
2 I had -- Nurse McAuley had rung me some time after 3, it
3 could have been 3.30, I'm not -- I cannot say for
4 definite. But she rang to say that Raychel had vomited
5 again. I said, "Please get a doctor to see her".
6 I think that was about half 3, maybe 3.40, maybe 3.20,
7 around that time. And about half an hour,
8 three-quarters of an hour later, maybe around 4.30,
9 I rang over to ask Nurse McAuley whether she'd got
10 a doctor and she said no.

11 Q. We'll come to the detail of that. I don't wish to cut
12 you off, but if we can deal with it in segments. My
13 question to you is simply what time you returned to the
14 ward.

15 A. Around 5. I can't be definite, but it was around 5.

16 Q. So in that period after the ward round in the morning
17 through to 1.45, you were a presence on the ward. And
18 at any time during that period can you recall whether
19 you went in to see Raychel directly?

20 A. During the morning period?

21 Q. Yes.

22 A. Yes, I -- well, as I've told you earlier, I saw Raychel
23 before Mr Zafar. I was with Mr Zafar as well.

24 Q. Post ward round?

25 A. After that, I was with the paediatricians doing the ward

110

1 and then returned. I don't need to extend the narrative
2 beyond that. Whereas just to make the position clear to
3 you, Mr and Mrs Ferguson tell the inquiry that he left
4 the hospital at 11 o'clock or thereabouts, not returning
5 to the hospital until about 1.30, something around 1.30,
6 leaving again at 3 o'clock with his wife, obviously, to
7 pick up the other children.

8 So within that context, let me explore what contact
9 you had with Raychel on that morning. You have said in
10 your statements that you saw Raychel go to the toilet on
11 two occasions.

12 A. Yes.

13 Q. And as you illustrated earlier, by reference to the
14 plan, you were standing at or about what you called the
15 reception desk, which is the nursing station. And on
16 each occasion, you say she was with her father.

17 A. Yes.

18 Q. Just to orientate this in time, maybe we should get your
19 witness statement up at WS056/1 at page 4. Paragraphs 3
20 and 4, please. You say:

21 "Between 12 midday and 1 o'clock, I was at the
22 reception desk opposite Raychel's room. Mr Ferguson and
23 Raychel came by the desk, Raychel was walking in front
24 of Mr Ferguson, who was pushing the IV drip stand behind
25 her. Raychel had her hand on her abdomen and was

112

1 slightly stooped over ..."
2 Mr Ferguson is clear in his witness statement that
3 he wasn't at the hospital at that time, Mrs Millar.
4 A. No, I am absolutely clear that I saw Mr Ferguson walking
5 with Sarah [sic] to the toilet on two occasions between
6 12 and 1.45.
7 THE CHAIRMAN: Raychel.
8 MR WOLFE: You used the name Sarah there to describe her.
9 A. I'm sorry, Raychel, I'm sorry. I apologise.
10 Q. And by contrast with your account again, Mrs Millar,
11 Mrs Ferguson recalls that she in fact carried her child
12 to the toilet at midday because the child had become
13 increasingly unwell during the morning, needed to go to
14 the bathroom, and as she was about to leave the
15 bathroom, she produced a large vomit of undigested food
16 into the sink, and she reported that incident to --
17 I think she describes "a small nurse with dark hair".
18 Clearly, both versions of events cannot be correct.
19 Either Mr Ferguson was in the hospital or he wasn't.
20 A. No, I saw Mr Ferguson with Raychel on two occasions
21 between those times.
22 Q. If we move the time parameters, could you be mistaken in
23 terms of the time?
24 A. No. No, because I -- it was definitely over the
25 lunchtime period. And usually, the nurses are divided

113

1 explain why you didn't complete the record if it is the
2 case that you did see her going to the toilet?
3 A. I did see her go to the toilet and I should have either
4 documented it myself or I should have asked somebody
5 else to document it. I didn't.
6 Q. So if Mrs Ferguson was there during the morning from
7 9.30 to 3 o'clock, you couldn't have failed to see her;
8 is that what you're saying?
9 A. Yes, if she was there, I would have seen her. I didn't
10 see Mrs Ferguson from 9/9.30 until I came over to the
11 ward at 5 o'clock. I'm not saying she wasn't there, but
12 I didn't see her, and I was in the room on several
13 occasions before 11 o'clock that morning.
14 THE CHAIRMAN: If she was there in Altnagelvin, the place
15 where she was most likely to be was at Raychel's
16 bedside.
17 A. Yes, or --
18 THE CHAIRMAN: She might go off to the toilet or she might
19 go off to get a coffee or something.
20 A. She may have gone for a coffee or to the canteen.
21 THE CHAIRMAN: That's right. So although she's in the
22 hospital because she's worried about Raychel, she wants
23 to be at Raychel's bedside, parents don't automatically
24 sit there non-stop for three or four hours.
25 A. No, mostly they come and go.

115

1 into two groups for lunch and the first group go about
2 12/12.15. I would have stayed back, I didn't go to
3 early lunch because I would cover for their absence in
4 answering the telephone and dealing with parents, and
5 I'm absolutely sure that I saw Mr Ferguson twice with
6 Raychel going to the toilet.
7 Mrs Ferguson, I saw her -- when I came in in the
8 morning at 7.30, and went into the room to collect the
9 chair, Mrs Ferguson was there. When I came back after
10 the handover report, she wasn't in the room.
11 Q. On Mrs Ferguson's account, again, I don't have the
12 precise timing my head --
13 A. Well, about the precise timing ... But I didn't see
14 Mrs Ferguson from approximately 9 o'clock until I came
15 back over to the ward, around 5, and Mrs Ferguson was
16 sitting at the bed with Raychel.
17 Q. Of course, Mrs Millar, if you'd been complying with the
18 requirements of the episodic care plan to record
19 Raychel's urine output, you would have engaged with
20 whoever brought Raychel to the toilet to discover
21 whether there was anything to report for the purposes of
22 the fluid balance chart.
23 A. Yes.
24 Q. Given that that was an obligation and given that you say
25 you knew Raychel was going to the toilet, can you

114

1 THE CHAIRMAN: And in a sense that's the easy bit. But the
2 more difficult bit is the suggestion that you saw
3 Mr Ferguson, who says he wasn't there. That's the more
4 difficult bit to sort out, isn't it?
5 A. No, I saw Mr Ferguson, yes.
6 THE CHAIRMAN: Thank you.
7 MR WOLFE: So if we can turn to just examining your view of
8 Raychel's condition through that morning. You've told
9 us that during the morning Raychel became more mobile
10 and was able to walk to the bathroom with her father,
11 she was sitting at the table colouring in, she was
12 generally bright and happy, albeit that you note that
13 she vomited at 10.30 and again at 1 o'clock. You say
14 that you weren't concerned because vomiting was not an
15 unusual feature in children post-operatively.
16 A. Yes.
17 Q. Whereas by contrast, Mrs Ferguson would say that when
18 she arrived at the hospital she found a happy, content
19 child at or about 9.30, colouring in, with materials
20 that her father had brought up from the hospital shop,
21 but that from in or around 11 o'clock she began to
22 become increasingly unwell, producing a slime-like
23 vomit, and then at 12 o'clock she had what Mrs Ferguson
24 describes as a large or significant vomit, which she
25 reported. Moreover, a Mrs Duffy, who was the mother of

116

1 a child occupying the same room as Raychel, she told the
2 police in a witness statement as part of their
3 investigation in 2005 -- perhaps if we could have it up
4 on the screen, please. It's 095-007-022.

5 Within that document, Mrs Duffy has said -- if
6 we can take the section down towards the bottom, the
7 last four lines:

8 "From midday onwards, Raychel started to be very
9 sick, she started to vomit. The nurses had left trays
10 in the ward for her and she used them. During the
11 course of the day (I went home around 9 pm) [when her
12 husband came to the hospital], she had vomited so many
13 times, I could not say exactly how many."

14 So the picture being painted by her is of
15 a straightforward post-operative recovery until about
16 midday, and then Raychel becomes very sick continuously.
17 Mrs Ferguson paints a picture of a child making a good
18 recovery until a point mid-morning -- she has it at
19 about 11 o'clock -- and then a large vomit at midday.

20 You certainly observed a deterioration in Raychel's
21 condition during the morning in the sense that she
22 vomited three times, counting the 8 o'clock vomit,
23 whereas the overnight report had been of a child not
24 nauseous, not vomiting, and giving no cause for concern.
25 I see you nodding, but for the record you would agree

117

1 got the call during the afternoon from Nurse McAuley?
2 A. No, there was a 1 o'clock vomit, and I was aware of that
3 through Nurse Roulston.
4 THE CHAIRMAN: Okay.

5 MR WOLFE: Well, when Raychel vomited on those occasions
6 during your working day, 10.30 and 1 o'clock, you didn't
7 go to examine her; is that correct?

8 A. No.

9 Q. Did you make any suggestion or give any direction to
10 your nursing staff with regard to monitoring or
11 observing Raychel during this new phase, if you like,
12 where Raychel is starting to vomit?

13 A. Well, at 10 o'clock Raychel had had her observations
14 done, I think it was 9 o'clock, 9 or 10 o'clock. She
15 was sitting at the end of the bed, colouring in her
16 book, she was bright and alert, her colour was good,
17 I had no concerns about her. I spoke to her father at
18 that time. I think it was Nurse Roulston who documented
19 the 1 o'clock vomit because she told me that Raychel had
20 vomited. And again, I think she had observations done
21 at 1 o'clock, as far as I can recall.

22 Q. Yes.

23 A. I would have had no worry about her at that stage up to
24 the time I went for my lunch.

25 Q. Those experts who have looked at the fact that Raychel

119

1 with me --

2 A. No, I didn't see that. Raychel vomited, as you say, at
3 10 and 1 o'clock. I observed Raychel walking to the
4 toilet with her father over the lunchtime period. She
5 was bright, yes, she was stooped over, she was obviously
6 in some discomfort, which would have been normal. But
7 I didn't see a deterioration in Raychel over that time.
8 To the time that I went to my lunch at 1.45, she was
9 still walking around, her observations were stable.
10 Yes, her IV fluids were in situ and she wasn't lying
11 down, she didn't appear to have increasing drowsiness.
12 And the vomits that have been mentioned, I didn't see
13 them, and none of the nurses reported them to me.

14 Q. Sorry, you've told us that you did see the 10.30 vomit.

15 A. The three vomits, but other than that I understand
16 that --

17 Q. Just to be clear, in terms of the vomiting, you saw the
18 10.30 vomit?

19 A. Yes. Not the child vomiting, but I saw the --

20 THE CHAIRMAN: Your evidence, Mrs Millar, is that you say
21 you're aware of the 8 o'clock vomit from the entry in
22 the record. You saw the 10.25 or so vomit in the bowl.

23 A. Yes.

24 THE CHAIRMAN: And am I right that the next time that you
25 were alert to Raychel having vomited more was when you

118

1 vomited on three occasions in that morning session,
2 if we count 1 o'clock as being part of the morning for
3 these purposes -- certainly three vomits in five
4 hours -- have indicated that this was the time to bring
5 in a doctor for the purposes of providing an anti-emetic
6 and perhaps ...

7 THE CHAIRMAN: Review?

8 MR WOLFE: I'm just looking at exactly what Mr Orr says. He
9 says that:

10 "By 1 o'clock there were three recorded vomits,
11 omitting the large vomit described by Mrs Ferguson at
12 12 noon."

13 He says:

14 "[He] would have expected the nursing staff to
15 contact the surgical team after two or three occasions
16 of vomiting."

17 And it seems to be his view that:

18 "In circumstances where there are recurring episodes
19 of vomiting, in order that she can be assessed and fluid
20 therapy investigated as required, a doctor should have
21 been brought in at that point."

22 A. Yes. Well, up until that point, as I say, I was -- up
23 until I went to lunch, I was happy with Raychel's
24 progress. The vomits were not large vomits. She was
25 bright and she was up and about, she was able to walk to

120

1 the toilet -- I saw her on two occasions -- but knowing
2 now what I didn't know then, at that stage, I would have
3 called a doctor.
4 THE CHAIRMAN: I think the difference is that the experts
5 who are saying this, they're not saying, looking back on
6 it with hindsight, that's what should have happened.
7 They're saying, by the standards of 2001, that's what
8 should have happened. But that's not your experience?
9 A. No, it wasn't.
10 THE CHAIRMAN: Sorry, can I ask you it this way -- and if
11 you can't answer this, just tell me -- how many vomits
12 would it take for you to call in a doctor?
13 A. Well, when she vomited at 3 o'clock -- it would depend
14 on the volume of the vomits and the frequency.
15 THE CHAIRMAN: So what swung it for you was when
16 Nurse McAuley told you, at some time after 3, that
17 Raychel had vomited again, that went from three vomits
18 in five hours to four vomits in seven hours and, for
19 you, that was time to get the doctor?
20 A. Yes.
21 THE CHAIRMAN: Okay.
22 MR WOLFE: If we look at the fluid balance chart, please, at
23 020-018-037, you can see the vomits documented there.
24 You've said on a number of occasions that the vomits
25 weren't large, but of course Nurse McAuley documented

121

1 Q. So you have two medium vomits here. One at 3 o'clock,
2 one at 1 o'clock, and a vomit that was described as
3 large that you are now calling small.
4 THE CHAIRMAN: Small to medium.
5 MR WOLFE: Small to medium. Was the fact that you were of
6 the view that that was a small-to-medium vomit a factor
7 in you deciding not to call the doctor in at about
8 1 o'clock?
9 A. Yes. I didn't see the vomit at 1 o'clock, but
10 Nurse Roulston informed me that it was not a large
11 vomit. And Raychel was not appearing to be in any
12 distress or in any difficulty. So I was still happy
13 with her condition at that time.
14 Q. So just to be clear, the one at 10 o'clock is small to
15 medium?
16 A. Yes.
17 Q. Is that what you told the coroner?
18 A. I'd say it was more small than medium.
19 Q. Could we have up on the screen, please, 098-018-044,
20 please? This is a note composed by counsel or solicitor
21 for the Trust at the inquest. Perhaps it's on the page
22 before, 043. If we could have 043 and 044 up together,
23 please.
24 We need to start at the bottom of the left-hand
25 page:

123

1 a large vomit, and you also saw that vomit. Presumably,
2 you had a discussion about it, if both of you are
3 seeing the vomit at or about the same time.
4 A. I can't remember. I did ask Nurse McAuley to dispose of
5 the vomit. I can't remember if we had any discussion on
6 it.
7 Q. You say you asked her to dispose of it. Why didn't you
8 dispose of it yourself if you saw it?
9 A. Because I was on the ward round with the
10 paediatricians --
11 Q. Right.
12 A. -- so I asked her to do it.
13 Q. Okay. So she saw it and formed her view that it was
14 large.
15 A. Yes.
16 Q. But if you had been writing up the notes, you wouldn't
17 have written "large"?
18 A. Well, that particular vomit, I would have said, "Small
19 to medium", or two pluses.
20 Q. What's one plus?
21 A. Small.
22 Q. What's two pluses?
23 A. Medium, approximate.
24 Q. And three pluses is large?
25 A. Would be large or -- yes.

122

1 "It was put that at 10.30 am there was a large
2 vomit, which the sister [that's yourself] described as
3 medium to large."
4 Do you see that?
5 A. Yes.
6 Q. Trusting to the accuracy of this note, do you think
7 that's what you said?
8 A. I presume I must have said that if it's documented. But
9 the vomit was no more than a small to medium vomit.
10 THE CHAIRMAN: I'm not sure where -- frankly, Mrs Millar,
11 I'm not sure how I can accept that. The hospital note
12 at the time says, "Large". You are asked at the inquest
13 and you say, "Medium to large", and you now say "small".
14 How can it get smaller as the years go on?
15 A. The vomit that I saw at 10.25/10.30 was not a large
16 vomit.
17 THE CHAIRMAN: Okay.
18 MR WOLFE: You see, in order to explain the fact that
19 a doctor wasn't involved much before 6 pm in the
20 evening, you justify your position by suggesting that
21 the vomits were small or medium.
22 A. Yes.
23 Q. Whereas in fact, you didn't know how much was produced
24 in the 8 o'clock vomit; is that right?
25 A. No, I didn't see that, no.

124

1 Q. One of your colleagues described the 10.30 vomit as
2 large, and you seemed to have agreed with the coroner,
3 much closer to the time than you are now sitting in
4 2013, that it was medium to large, and now today you
5 want to have it small, closer to small than medium. Is
6 this not rewriting the history of this, Mrs Millar, with
7 all due respect?
8 A. The vomit that I saw at 10/10.30 was not a large vomit.
9 MR QUINN: Mr Chairman, can I also ask that we put up on the
10 screen 012-041-204 and ask the witness to explain, five
11 lines from the bottom, where it says --
12 THE CHAIRMAN: Slow down. Just to help the witness, this is
13 the handwritten note at the end of her evidence to
14 the coroner; is that right?
15 MR QUINN: Yes. First of all, could we ask the witness:
16 is that her signature on the bottom right-hand corner?
17 THE CHAIRMAN: I presume it is, Mrs Millar.
18 A. Yes.
19 MR QUINN: Does that mean that you said that the 10.30 vomit
20 was large?
21 A. Yes, well, it's documented here.
22 MR QUINN: Were you under oath?
23 A. Yes.
24 THE CHAIRMAN: She was, that's okay. I don't need that,
25 Mr Quinn.

125

1 to be your initial position, and then you've moved away
2 from it because I think perhaps, what is a natural
3 tendency, that you tried to remember with your other
4 nurses exactly what happened then and you tried to
5 construct a common recollection, but it's not right.
6 That's my concern, Mrs Millar.
7 A. I accept that.
8 THE CHAIRMAN: Okay. Let's take a break for a few minutes
9 for the stenographer and we'll resume in about ten
10 minutes.
11 (3.39 pm)
12 (A short break)
13 (4.00 pm)
14 MR WOLFE: Good afternoon, Mrs Millar.
15 THE CHAIRMAN: When Mr Campbell comes back, I just want to
16 raise something with him. (Pause).
17 Mr Campbell, I wanted to raise one thing. I think
18 it's a bit of a stretch for Mrs Millar's evidence to
19 finish this afternoon, but we will get it -- Mr Zafar's
20 flying in tomorrow morning, but he won't be here,
21 I think, until about 11, maybe 11.30, so we have an hour
22 in the morning to finish off Mrs Millar's evidence.
23 MR CAMPBELL: I wasn't sure how much more Mr Wolfe had for
24 this witness. I was hopeful that we might, with a
25 slightly late start, get her finished this evening,

127

1 In fact, what seems to be deleted there is it seems,
2 Mrs Millar, that line starts to read:
3 "The 10.30 am vomit was between -- "
4 And the word "medium" is started. And then the word
5 "between" is deleted and the start of the word "medium"
6 seems to be deleted and it's replaced with "large".
7 MR QUINN: That was the next point I was going to make.
8 THE CHAIRMAN: You're specifically accepting to the coroner
9 that it was large, which accords with the note at the
10 time. Does this not bring you back to the questions
11 that Mr Wolfe was asking you some time ago about, if
12 there was a smaller vomit, was it not the one at
13 8 o'clock, and the confusion which might appear from
14 your earlier letter and statements about which vomit was
15 which? I don't want you to paint yourself into a corner
16 and, frankly, not being helpful to the inquiry by
17 rewriting the size of a vomit from being large to closer
18 to small and medium.
19 A. Well, all I can say is that the vomit that I saw at
20 10.30 or after 10 o'clock in the bowl on the bed table
21 was not a large vomit.
22 THE CHAIRMAN: Could that not be because, as we saw from
23 a statement that you wrote much closer to the time, you
24 saw a vomit, not after 10 o'clock but between 9.30 and
25 10, and that was a smaller vomit? Because that seemed

126

1 but --
2 THE CHAIRMAN: There's one point which concerns me, which is
3 the one I want to raise. Mrs Millar said she isn't
4 familiar with Mrs Noble's evidence from yesterday
5 afternoon. In her evidence yesterday afternoon,
6 Mrs Noble spoke about the two meetings, the 12 June
7 internal meeting and the 3 September meeting with the
8 Ferguson family. I think it would be helpful to your
9 client to see what Mrs Noble said about those meetings.
10 MR CAMPBELL: She was given a flavour of what that evidence
11 was, but of course not in the sort of detail the
12 transcript could provide.
13 THE CHAIRMAN: If we get to that point in the evidence
14 today, we can provide a transcript of that portion of
15 Mrs Noble's evidence for Mrs Millar to look over
16 tonight. It's about the last hour or so of Mrs Noble's
17 evidence yesterday evening -- so it is not that long,
18 Mrs Millar, I'm not giving you too much homework, but it
19 might speed up your questioning tomorrow morning because
20 Mrs Noble, as I indicated to you this morning, was
21 speaking in positive terms about your contribution to
22 the internal Altnagelvin meeting on 12 June, and then
23 there were concerns expressed about what happened when
24 the Altnagelvin team, of which you were part, met the
25 family on 3 September. There's a contrast on the face

128

1 of the documents and on what Mrs Noble says between
2 what was discussed and faced up to internally and what
3 the Fergusons were told when they met the Altnagelvin.
4 I think, since you're going to be asked to cover some of
5 the same ground as a person who was at both meetings,
6 it would help you because you say your memory's a bit
7 short on that area. Okay?
8 MR CAMPBELL: I think that would be helpful too.
9 THE CHAIRMAN: If we do that, that means that when we get up
10 to the stage this evening of the critical incident
11 review and the later meeting, we can stop at that point
12 and give Mrs Millar the transcript.
13 MR CAMPBELL: Is the plan to start with Mrs Millar tomorrow?
14 THE CHAIRMAN: Yes, we'll start with Mrs Millar tomorrow so
15 she's finished tomorrow morning.
16 MR CAMPBELL: Very good.
17 MR WOLFE: Mrs Millar, just before we enter the afternoon
18 phase of Raychel's care on 8 June 2001, you've said
19 repeatedly that, with the benefit of hindsight perhaps,
20 that by 1 o'clock, when you think about it, knowing what
21 you know now, a doctor should have been brought to
22 Raychel. Do you agree with me that really if you had
23 thought about it and thought about the issues at that
24 time, applying the standards of that time, the three
25 vomits in the morning ought to have led you to encourage

129

1 Now, I didn't see Raychel at 1 o'clock in between
2 the time her dad took her to the toilet, between --
3 I saw her walking, but I didn't see her in her room.
4 I hadn't been in the room.
5 Q. Yes. A doctor attended to deal with the prescription of
6 fluids at 12.10, Dr Butler --
7 A. Yes.
8 Q. -- who was the senior house officer on the paediatric
9 side. Did you have any dealings with her when she
10 attended?
11 A. No.
12 Q. By this stage, Raychel's fluids had been running for
13 some 14 hours or so, and Dr Butler was being asked to
14 write up a second bag of Solution No. 18, by which stage
15 Raychel had vomited at least twice on the record, if not
16 more, according to her mother. Should that doctor have
17 been advised of the vomiting prior to writing up
18 a further bag of Solution No. 18?
19 A. Well, I'm not sure what the nurse said to Dr Butler, but
20 at that stage she would have told Dr Butler that Raychel
21 had vomited --
22 Q. Sorry, I am not asking that question. I'm
23 asking: should the doctor have been advised of the
24 vomits?
25 A. Well, I presumed she did know about the vomits.

131

1 a doctor to attend Raychel?
2 A. Well, if I had known what I know now at that time,
3 12 years ago, I think as I said earlier, I would have
4 called a doctor at that time. But I was still content
5 with Raychel's progress at that time and up until I had
6 left for lunch, I still -- but looking back and with
7 hindsight, it would have been maybe prudent to have
8 called a doctor, but at that time I was still happy with
9 her progress.
10 Q. You would accept that when a child is vomiting,
11 producing three sets of vomits, that's very likely to be
12 uncomfortable for a child?
13 A. That's right, it would be.
14 Q. It would be stressful for a young child?
15 A. Yes, but as I say, Raychel's condition appeared to me to
16 be -- she wasn't complaining of pain. Staff
17 Nurse Roulston had -- I think it was 1 o'clock her
18 observations were done, as far as I can recall.
19 Q. Yes.
20 A. And she had said, as far as I know, at that time, "not
21 complaining of pain". I hadn't seen Raychel vomit.
22 It's not a pleasant experience, I accept that. But she
23 didn't give me -- her general demeanour, her appearance,
24 and what the nurses were telling me, I wasn't alarmed at
25 that stage.

130

1 I wasn't with her when she came, but I'm sure when --
2 the nurse who was with her probably informed her. I
3 cannot be sure on that point.
4 Q. That's why I'm asking the question in the way I am.
5 Should she have been informed of the vomits?
6 A. Yes, she should.
7 Q. You can't say whether she was informed?
8 A. No.
9 Q. The issue of vomiting is clearly a key issue in
10 determining the need for or the type of intravenous
11 fluids. Moreover, here was an opportunity to appraise
12 a doctor of vomiting and ask her to review the child;
13 isn't that right?
14 A. Yes. Well, I understood that -- I didn't see Dr Butler,
15 I didn't have any dealings with her. But I understood
16 she was asked to write up the prescription.
17 Q. Yes.
18 A. I'm not -- I cannot -- I do not know what was said to
19 her, but I would expect that she was asked to write up
20 the IV fluids.
21 Q. Yes.
22 A. And I cannot say whether she was informed of the vomit,
23 of her vomiting.
24 Q. Dr Butler was an SHO on the paediatric side of the
25 house. Would it be common practice at that time to, if

132

1 you like, simply grab any doctor coming through the ward
2 to write up a further bag of fluids, or should the
3 surgical team have been contacted for that purpose?
4 A. Well, it was mostly the surgical team who wrote up the
5 surgical patients, but if we were unable to get them,
6 we would ask one of the paediatric staff.
7 Q. And should efforts be made to obtain the attendance of
8 somebody from the surgical team?
9 A. The usual thing was to contact one of the surgeons.
10 That was the usual procedure.
11 Q. And do you know whether any attempt was made in this
12 case at 12 noon or thereabouts to do so?
13 A. I'm not -- I cannot say. I don't know. I don't know.
14 Q. You see, the expectation at ward round was that sips of
15 fluid would be introduced slowly perhaps and then
16 gradually reduce the need for intravenous fluids.
17 A. Yes.
18 Q. But clearly, by 12 noon, that wasn't happening.
19 A. No, we had made several attempts, I think, to introduce
20 later in the morning, but Raychel had vomited at
21 1 o'clock.
22 Q. So the plan that Dr Zafar articulated wasn't going to
23 plan, if you like, wasn't working as expected.
24 A. Raychel wasn't following the plan that we had hoped for
25 her.

133

1 1 o'clock and 2 o'clock?
2 A. Yes. And before I went off duty at half five, I saw her
3 in her bed. In between times, I didn't see her.
4 Q. We'll come to that. Mr Ferguson returned to the
5 hospital between 1 and 1.30. He tells the inquiry in
6 a witness statement that Raychel seemed to be going
7 downhill. She was not speaking properly, she was in
8 bed, and he took three kidney trays of vomit out to the
9 nurses during that period of time.
10 Those vomits, on his account, occurred before he
11 left the hospital at 3 o'clock. They don't appear to
12 have been recorded, unless one of them is the 1 o'clock
13 vomit in the fluid balance sheet. Could I ask you
14 this: when a child vomits and perhaps vomits repeatedly
15 within a short period of time of, say, an hour or so,
16 are nurses expected to record each single episode, for
17 example each single kidney tray, or might they take an
18 abbreviated approach and record all vomits in a period
19 as being one vomit?
20 A. No. Raychel was on her four-hourly observations and if
21 we had seen Raychel to be copiously vomiting, vomiting
22 continually, increasing drowsiness, we would have done
23 her vital signs more regularly, maybe every two hours.
24 But we did not see any vomits other than what are
25 documented in the fluid balance sheet.

135

1 Q. And the surgical team had not been advised of that?
2 A. No, not at that stage.
3 Q. Into the afternoon of 8 June, you go to your office from
4 after your lunch break, your lunch break starting at
5 1.45 --
6 A. Yes, I probably went to my office before 2.30.
7 Q. And prior to that, you were aware of Raychel's
8 condition, the fact that there had been three vomits,
9 a decision, it would appear, had not been taken to
10 contact a doctor to assess that. Had you any plan to
11 have Raychel's progress monitored as the day went on, or
12 was she still on the four-hourly observations?
13 A. Yes, well, she was still on her four-hourly
14 observations. I know that Nurse Roulston had no
15 concerns about her. Of course there was concern
16 about -- there's concern about every child on the ward,
17 but no significant concerns. Raychel was still
18 mobilising and she had started to take some little
19 drinks, but obviously had vomited at 1 o'clock. So up
20 until then, I didn't have any worries about her, and as
21 I say, I saw her walking to the toilet twice before
22 I went off to my lunchtime.
23 Q. So the last physical sight that you had of Raychel prior
24 to going off at lunchtime, you say, was seeing her
25 father bringing her to the toilet at some time between

134

1 Q. Sorry, my question was a specific one, Mrs Millar.
2 Do you need me to repeat it?
3 A. Yes.
4 Q. The question is this: if a child vomits more than once
5 within a confined period of time, say up to one hour,
6 say a child vomits three times into three separate
7 kidney trays within that period, would the nurse be
8 expected to record three separate episodes, or,
9 alternatively, because it's within a period of time,
10 would that be regarded as one vomit?
11 A. No, the episodes should be recorded.
12 Q. Mrs Ferguson recalls, by contrast with Mr Ferguson, who
13 recalls three kidney trays being brought out to nurses,
14 she recalls two kidney trays full of vomit being brought
15 out to the nurses before 3 o'clock in the afternoon.
16 She was being told by nurses that Raychel's stomach was
17 empty and she wouldn't vomit any more.
18 If Raychel was vomiting into the early afternoon, as
19 is described, on top of a vomit at 1 o'clock, that would
20 have been an indicator for bringing a doctor in; isn't
21 that right?
22 A. Yes, if she was, yes.
23 Q. During this period of the early afternoon, I suppose you
24 were reliant on your nursing staff to make reports to
25 you of what was going on in the ward --

136

1 A. Yes.
2 Q. -- or to make reports to -- is it Mrs Wilson you said
3 earlier?
4 A. Yes. Well, Nurse Roulston would have been the senior
5 nurse, although she was in the nursery, but she was
6 still covering Nurse McAuley's tea breaks. So she would
7 have been there for consultation. Nurse Wilson, who was
8 in charge of the medicines that day, she would have been
9 there as well, and there were more than, obviously,
10 three senior nurses, but those were the three --
11 Michelle Bryson was the other nurse. And then I was
12 there, one telephone call, I was available.
13 Q. Yes. Just to complete the picture, bringing it up to
14 mid-afternoon, a Margaret Harrison visited with Raychel
15 during her parents' absence. She has told the inquiry
16 that during the time of her visit Raychel didn't respond
17 at all to her attempts to converse with her, that she
18 didn't react to anything said, it was as though her mind
19 wasn't there. She is painting a picture of a child who
20 simply wasn't well. Not vomiting during that period,
21 I emphasise, in fairness, but not well enough to
22 communicate with somebody who she knew well. I believe
23 Mrs Harrison was her godparent.
24 Again, turning to your next contact with regard to
25 Raychel, it would appear that you were contacted by

137

1 A. Yes.
2 Q. If there was further vomiting, as the mother, according
3 to Mrs McAuley has described, that should have been
4 recorded?
5 A. Yes, it should. But we were not aware of any other
6 vomiting than the ones that were documented.
7 Q. You see, just to put the other side of this narrative to
8 you, Mrs Ferguson arrived back at the hospital at about
9 3.45, she would say. And it is her recollection that
10 Raychel was just lying on the bed when she returned, she
11 was listless, she was red and flushed, and the child
12 appeared very unwell. It wasn't until 5 o'clock that
13 Raychel vomited again on Mrs Ferguson's account.
14 Raychel tried to settle to sleep, the mother got into
15 bed beside her, there was retching. Then, at 5 o'clock,
16 Mrs Ferguson recalls the child vomited and, on this
17 occasion, the vomit had blood in it. She reported that
18 to a nurse and it was only at that stage that the nurse
19 said that she would contact a doctor.
20 A. No. No, the doctors were contacted earlier. As I say,
21 Nurse McAuley rang me over, some time after 3. I cannot
22 be specific in the exact time, but it was some time
23 after 3 o'clock. I asked her to contact a doctor, and
24 I understand that she did attempt -- she did try on two
25 or three occasions to contact one of the surgical

139

1 Nurse McAuley some time between 3 and 4 pm to discuss
2 whether an anti-emetic was needed.
3 A. Well, yes, that's correct. It was before 4 o'clock,
4 I know that. I'm not sure whether it was 3.30 or
5 slightly before or after. Nurse McAuley rang to tell me
6 that Raychel had vomited again and I asked her to get
7 the doctor to see Raychel.
8 Q. Nurse McAuley's account is that at or about 3 o'clock
9 Raychel's mother reported to her that Raychel was
10 continuing to vomit. The 3 o'clock vomit was observed
11 and written up by -- sorry, the vomit itself wasn't
12 observed, but the fact that there had been a vomit was
13 recorded by Staff Nurse Roulston, not Staff Nurse
14 McAuley.
15 A. That's right.
16 Q. And it would appear, on Staff Nurse McAuley's account,
17 that some time after 3 o'clock the mother reported to
18 Staff Nurse McAuley that Raychel is continuing to vomit.
19 That was the trigger, it appears, for Staff
20 Nurse McAuley contacting you. The first thing to take
21 out of that is that this continuing to vomit phase
22 doesn't appear to be recorded in the fluid balance
23 chart. There is a vomit, a medium vomit recorded at
24 3 o'clock, but nothing further. In fact, no further
25 vomiting recorded until 9 o'clock.

138

1 doctors. I think first of all the JHO and I'm not
2 sure -- it may be the SHO. So I understand that from
3 her. After she rang me, about 45 minutes later, an hour
4 later, I rang over to the ward to see if she had got
5 a doctor for Raychel. And she said, no, I haven't. So
6 I was -- it was coming on to 5 o'clock or thereabouts,
7 and I said, "Okay, I will go myself and see if I can get
8 somebody", because I thought I'll -- you know, it wasn't
9 acceptable that they were not there.
10 So I went over to the ward. Dr Devlin, one of the
11 other JHOs, he was standing at the desk, and
12 I understand he had come to admit another patient.
13 I asked Nurse McAuley -- there was somebody waiting to
14 speak to me, a parent, and I asked Nurse McAuley to ask
15 Dr Devlin would he give Raychel an anti-emetic or
16 something to stop her vomiting.
17 Q. Just to be clear, you had a conversation with Dr Devlin?
18 A. No, I had no conversation with Dr Devlin.
19 Q. At that stage, 5 o'clock, at least three hours had
20 passed since you'd last seen Raychel; is that right?
21 A. Yes.
22 Q. Did you go and see her at that point?
23 A. No, I didn't. Nurse McAuley hadn't given me any
24 information that would make me concerned about Raychel.
25 I saw Raychel in her bed and I saw Mrs Ferguson with her

140

1 and there were other people around her bed; I'm not sure
2 who they were. There was maybe one other person. But
3 Mrs Ferguson was there. I didn't see Mr Ferguson.
4 I hadn't got any information from the nurses on return
5 to the ward that Raychel was in great difficulty. I had
6 asked for the doctors to see her, to give her an
7 anti-emetic, and I had hoped that when she got that, she
8 would settle. But I didn't speak with Dr Devlin.
9 Q. Mrs Ferguson has described her child as being listless
10 during that period of the afternoon. That was an issue
11 that was raised with you during the coroner's inquest;
12 do you recall?
13 A. Yes.
14 Q. And you are recorded as having agreed with the
15 description that Raychel was listless.
16 A. Well, it was put to me --
17 Q. Isn't that correct?
18 A. That is correct, but it was put to me that Mrs Ferguson
19 had thought or said that Raychel was listless and, in my
20 answer, I was saying that children's parents know them
21 very well and we would always work alongside parents in
22 caring for children and we would listen to parents and
23 their concerns. But in my opinion -- and this was my
24 opinion and the nurses who I had spoken to -- I would
25 not have said that Raychel was listless.

141

1 Q. Well, one can -- sorry, Mr Campbell.
2 MR CAMPBELL: Mr Chairman, there is also the handwritten
3 note at the end of her deposition, which has appeared
4 earlier before us, which might be useful to consider at
5 this stage in this context.
6 MR WOLFE: 012-041-204.
7 THE CHAIRMAN: She says, "I would not agree that Raychel was
8 listless that day".
9 MR WOLFE: So there's a dispute between the records. But
10 just to be clear, you would say that if it's counsel --
11 I think we have written, sir, to the DLS to seek to
12 establish the origin of the note that I earlier referred
13 to. It's got a Brangam Bagnall facsimile record at the
14 top of the page, the last record we just looked at.
15 THE CHAIRMAN: I'm rather compelled, Mr Wolfe, aren't I, to
16 go with the note that's signed by Mrs Millar?
17 MR WOLFE: Of course.
18 You, of course, were dependent upon communications
19 to you from your nursing colleagues during the afternoon
20 because, while you arrived at the ward at 5 o'clock, you
21 hadn't seen Raychel for three hours.
22 A. Yes.
23 Q. And as I understand the position, while you saw her
24 through the glass door of the room, you didn't go and
25 examine her at or after 5 o'clock in the afternoon.

143

1 Q. Could I just put on the screen, please, the record of
2 what is recorded in respect of the coroner's inquest,
3 098-018-044? Again, allowing for the fact that these
4 are notes made by counsel or solicitor, the note says at
5 the end of the first paragraph:
6 "It was further put to her [that is yourself] that
7 Mrs Ferguson had thought the child was unwell during the
8 period. The sister had no concerns. The sister said
9 she would be prepared to agree with the description of
10 Raychel as being listless."
11 And then we see in your witness statement to the
12 inquiry that you deny that Raychel was listless, in
13 fact. Are you saying that what has been recorded here
14 hasn't captured the answer that you gave to the coroner
15 correctly?
16 A. Yes. It was put to me, as I say, at the coroner's
17 inquest that Mrs Ferguson felt that Raychel was
18 listless. And being her mother, I would have to --
19 I wouldn't argue with that, I can't argue with that.
20 That was her opinion and I wouldn't argue with a mother
21 who said her child was listless. But in my opinion, and
22 in the nurses that I spoke to about Raychel and the
23 observations and the communications that I got from
24 nurses, I could not say that -- I would not agree that
25 she was listless.

142

1 A. No, that's true.
2 Q. Was she lying on the bed when you saw her at 5 o'clock?
3 A. Yes, she was lying on the bed, yes, and she appeared to
4 be sleeping. And her mother was with her.
5 Q. So in terms of your independent personal observations,
6 you couldn't personally gainsay what Mrs Ferguson has
7 said in description of her daughter.
8 A. Well, I wasn't there, as you know, in the afternoon.
9 But during the morning I could not describe Raychel as
10 listless. And when I returned to the ward in the
11 afternoon, around 5 o'clock, if there had been concerns
12 about Raychel, I would have expected the nursing staff
13 to tell me that, you know, she was not well and that
14 things were ...
15 Q. Yes. You would also expect nursing staff to be making
16 records of all relevant vomits; isn't that right?
17 A. Yes.
18 Q. And if the fluid balance chart is to be accepted, there
19 were no further vomits between 3 o'clock and 9 o'clock;
20 isn't that correct?
21 A. Yes.
22 Q. Maybe if we get that up on the screen. The fluid
23 balance chart is ...
24 THE CHAIRMAN: 020-018-037.
25 MR WOLFE: That's it, yes.

144

1 On your account and the account of Mrs McAuley,
2 attempts were made to contact a doctor from maybe about
3 3.30 or so; is that right?
4 A. Approximately that time.
5 Q. And it is the case that neither yourself nor Mrs McAuley
6 made any note whatsoever about your attempts to contact
7 a doctor --
8 A. That's right.
9 Q. -- or about what he did when he arrived.
10 A. Well, I was gone before he arrived, but he saw the other
11 patient first, the child that he had come to see.
12 Q. Yes.
13 A. But I had gone off duty before he gave -- the
14 anti-emetic wasn't given.
15 Q. Okay, so you couldn't have made a note about what he did
16 when he arrived, but you would have expected your
17 nursing colleagues to have made a note?
18 A. Yes.
19 Q. Is it the case that, notwithstanding that the last vomit
20 was at 3 o'clock, there was no further vomits until
21 9 o'clock?
22 A. Well, that's what I understand. There was no vomits
23 reported to any of the nurses that were --
24 Q. Why would Raychel have needed an anti-emetic at
25 6 o'clock if she wasn't vomiting between 3 o'clock and

145

1 A. No. No, when Nurse McAuley rang me over, I asked her
2 was Raychel very ill, and she said no. I didn't have
3 anything more then until I returned to the ward and
4 Raychel was sleeping or appeared to be sleeping. But
5 I didn't ask about her condition at that time, but
6 I would have expected to be told that she, you know, was
7 in difficulty if she was.
8 Q. You're aware, as I've just told you, that Mrs Ferguson
9 witnessed a vomit at 5 o'clock. Have you read the
10 witness statement of Dr Devlin?
11 A. Yes, I have.
12 Q. And you're conscious of what he said about vomiting?
13 A. Yes, I am.
14 Q. He observed vomiting at 6 o'clock when he attended --
15 A. Yes. 6, yes.
16 Q. -- or thereabouts.
17 A. Yes.
18 Q. Because Dr Devlin didn't make a note of his attendance,
19 apart from to make an entry in the drugs kardex; isn't
20 that right?
21 A. That's right.
22 Q. He didn't sign it off with a time.
23 A. No.
24 Q. In terms of onward communications, the note keeping
25 around the attendance of Dr Devlin was pretty poor,

147

1 6 o'clock?
2 A. Well, there was a delay in trying to contact the
3 surgical doctors.
4 Q. But if this record is to be accepted, she's settled down
5 during that period and had no further vomiting.
6 A. We had tried to get the doctor to give Raychel the
7 anti-emetic after she'd vomited at 3, and we were still
8 endeavouring, but up until the time I went over to the
9 ward to try and get somebody -- but ... And Dr Devlin
10 had come on, as I've said, and he was asked by
11 Nurse McAuley.
12 Q. Yes. But it is the case that you decided that you'd
13 better leave your office and come round to the ward to
14 sort this out because a doctor hadn't arrived; isn't
15 that right?
16 A. Yes.
17 Q. And why were you still thinking she needed a doctor --
18 A. Because --
19 Q. -- if there was no vomiting?
20 A. Well, I was still keen that she would get the
21 anti-emetic to ensure that the vomiting would be treated
22 and that she would respond to that and that she wouldn't
23 vomit any more. That was my objective.
24 Q. Were you getting reports about her condition between
25 3 o'clock and 6 o'clock?

146

1 Mrs Millar; isn't that correct?
2 A. Yes, well, his attendance should have been documented by
3 somebody.
4 Q. Because it was going to be important for those taking
5 over her care, perhaps during the night shift, to
6 understand what she got, why she got it, the time she
7 got it at, and whether it was effective.
8 A. Yes. I think there was a note written by Nurse McAuley.
9 Q. The episodic care plan was printed off for the purposes
10 of the nursing handover --
11 A. Yes.
12 Q. -- and annotated to the printout was a note, indicating
13 that Zofran had been given "with fair effect".
14 A. Yes.
15 Q. Mrs Noble was asked about the meaning to be extracted
16 from the phrase "fair effect", and she explained to the
17 inquiry yesterday that she would interpret that as
18 meaning that there would have been initial effect, in
19 other words the anti-emetic had solved the problem for
20 a period of time, but had then ceased to become
21 effective; would you agree with that description?
22 A. Yes.
23 Q. So that by 7.30 or so, when Nurse McAuley was going off
24 duty -- I'm assuming that she was the author of the
25 annotation to the care plan -- the message that she was

148

1 sending out was that the anti-emetic was no longer
2 having an effect, it had ceased to have an effect,
3 presumably because Raychel had become nauseous again or
4 was, in fact, actually vomiting.
5 A. Well, as far as I know, Raychel didn't vomit again
6 during that period to Nurse McAuley going off.
7 Q. Mrs Ferguson --
8 THE CHAIRMAN: Sorry. When you say didn't vomit again, what
9 is your starting point from when she didn't vomit?
10 A. From 3 o'clock. I know there was the vomit that
11 Dr Devlin said he saw. That was not reported to us or
12 Nurse McAuley didn't see it.
13 THE CHAIRMAN: But then, so far as you know, she did vomit
14 again.
15 A. No.
16 THE CHAIRMAN: Well, unless we disbelieve Dr Devlin, and
17 frankly there's no reason to accept that Dr Devlin saw
18 her vomit at 6 o'clock and say the Fergusons are wrong
19 and that she vomited at 5 o'clock, is there? I mean, we
20 don't believe Dr Devlin because he's a doctor and
21 disbelieve Mrs Ferguson because she's a parent.
22 A. I thought he saw her at 5 o'clock --
23 THE CHAIRMAN: Dr Devlin saw her at 6 and Mrs Ferguson says
24 that Raychel vomited at 5 or about 5.
25 A. Right.

149

1 surgical doctors. And maybe the situation could have
2 been reviewed when Dr Devlin came. But I was still
3 anxious that Raychel should have her anti-emetic. I did
4 not know if Raychel was going to vomit again. That was
5 something I didn't know. I hoped she wouldn't, but
6 I still felt that it would be prudent to give her the
7 anti-emetic, and I would probably expect Dr Devlin to
8 ask Mrs Ferguson how Raychel was and assess her as to
9 whether there was a need for her to have the anti-emetic
10 at that stage.
11 Q. Assuming that there was an ongoing need for Raychel to
12 have the anti-emetic -- and that appears to be the view
13 that you reached -- was it acceptable that somewhere
14 between two hours and three hours passed by before the
15 doctor's actually brought to the bedside to administer
16 an anti-emetic?
17 A. No, that was too long.
18 Q. And it would appear that the approach that was adopted
19 by Staff Nurse McAuley was using the bleeping system to
20 try to attract a junior house officer on the surgical
21 side. You have said that your understanding of why you
22 couldn't get a JHO there was because the JHOs were in
23 surgery.
24 A. Yes.
25 Q. Who told you that?

151

1 THE CHAIRMAN: None of that ends up in the fluid balance
2 sheet. But we're assuming that Dr Devlin is right, that
3 he might remember when a child he has been called to see
4 vomits, but we'd also assume that Mrs Ferguson is right.
5 So after your attention, on your recollection, is drawn
6 to this by Nurse McAuley at about 3-ish, and you say,
7 "Get a doctor", there are at least two more vomits, one
8 at about 5 and one at about 6.
9 A. Well, as I say, they weren't reported to Nurse McAuley
10 and I have no --
11 THE CHAIRMAN: Is Dr Devlin capable of making an entry about
12 vomit?
13 A. He is, yes. He would have reported that vomit to one of
14 the nurses or certainly would have mentioned it before
15 he left the ward. I would have thought he would.
16 MR WOLFE: If there was no vomiting between 3 and 6 o'clock,
17 can I suggest to you that the need for an anti-emetic by
18 6 o'clock perhaps could have been reconsidered? Whereas
19 if Dr Devlin is right, that in fact there's active
20 vomiting, if Mrs Ferguson is right that there was
21 vomiting at 5 o'clock, that explains why there was a
22 continued need for an anti-emetic.
23 A. Well, I think what happened was that we had tried to get
24 a doctor from 3.30 or whatever time I had asked
25 Nurse McAuley, and we were unable to get one of the

150

1 A. No, I assumed that. I wasn't told that. When I rang
2 and asked Nurse McAuley had she got a doctor, she said
3 no. But I didn't know at that stage they actually
4 hadn't answered their bleeps. When I went over to the
5 ward, as I say, I saw Dr Devlin, but I had assumed that
6 she had either contacted the junior house officer or
7 even maybe Mr Zafar, and that they were in theatre,
8 because the usual thing was that they would answer the
9 bleep via a nurse in a clinic or in theatre, and that's
10 what I thought had happened. But that was my
11 assumption; I didn't ask if she had contacted anybody
12 specifically.
13 Q. You assumed that Nurse McAuley had attempted to contact
14 Dr Zafar or Dr Makar, according to your statement to the
15 inquiry.
16 A. Yes. That's who I assumed she had contacted.
17 Q. They were the senior house officers.
18 A. Yes. They were the two doctors that saw Raychel in the
19 morning.
20 Q. Yes.
21 A. It would have been prudent to have got them back, if we
22 could, to see her because they had seen her in the
23 morning.
24 Q. Were your instructions for her to contact a junior house
25 officer or a senior house officer?

152

1 A. No, a doctor. I don't remember specifying who she was
2 to contact. Usually, it would be a JHO to start with,
3 but if you couldn't get the JHO, you would then continue
4 to see if you could get an SHO or even a registrar.
5 Q. It would appear that she simply attempted to contact a
6 JHO and didn't, at that time, understand that you could,
7 in the absence of getting a JHO, try to make contact
8 with an SHO. That is her explanation.
9 A. Yes. No, well --
10 Q. You seem surprised by that.
11 A. Yes. Well ...
12 Q. Should she have been contacting an SHO to avoid this
13 delay?
14 A. Well, that's what I would expect, that if we couldn't
15 get the JHO, we would try and get the SHO.
16 Q. Moreover, on the ward, as we know, paediatricians are
17 accessible.
18 A. Yes.
19 Q. And a paediatrician was accessed for the purposes of
20 writing up fluid in the morning. This would have been
21 a straightforward solution to the problem of
22 a non-attending surgeon. Do you know whether that was
23 considered?
24 A. No.
25 Q. When Dr Devlin attended, it would appear that you didn't

153

1 Q. By this stage, we're almost 20 hours into Raychel's stay
2 in hospital, having been admitted at 10 pm the night
3 before. She had a reasonable initial post-operative
4 recovery and then began vomiting at 8 o'clock. Would
5 you accept that by this stage in the afternoon,
6 6 o'clock, she wasn't following the recovery pathway
7 that you had initially expected?
8 A. Yes. I would have expected her to have started to
9 settle at this stage. As a matter of fact, I think that
10 after 3 o'clock I thought the anti-emetic -- by giving
11 her the anti-emetic, it would have stopped her from
12 vomiting, but if she continued vomiting then that would
13 be of concern.
14 Q. Well, at this 20-hour mark, if I can call it that,
15 should the doctor have been told about all of the vomits
16 that had occurred?
17 A. Yes, and I think Dr Devlin was told that Raychel had
18 vomited several times during the day, as far as I can
19 recall.
20 Q. And should he have been told that, in light of this
21 vomiting, it might be a good idea to consider an
22 electrolyte test?
23 A. Yes, looking back, you know, at the whole scenario of
24 what had happened and with what we know now, I would be
25 prompting him or asking him to do an electrolytes.

155

1 speak to him.
2 A. No.
3 Q. Nurse McAuley is unsure, but she thinks that if she did
4 speak to him, she didn't actually attend at the bedside
5 with the doctor. In the circumstances of Raychel's
6 case, having vomited on several occasions in the morning
7 and then into the afternoon, would you have expected
8 a nurse to have attended the doctor?
9 A. Yes. Well, we would endeavour always to go with
10 a doctor. That is the practice, that is what should be
11 done. But I think I said earlier in the day that
12 sometimes there are periods during the day where the
13 nurses are reduced, they're either at a tea break or
14 evening break, and as far as I know when Dr Devlin came,
15 the nurses, the first group of nurses, were on their way
16 to their first break. So sometimes it's difficult to
17 get a nurse to go with a doctor, but in the ideal
18 circumstances there should be a nurse with a doctor.
19 Q. And --
20 A. Because that nurse will be there to reassure the child
21 and the parent, and also to know what's happening, and
22 that she got it and she's comfortable.
23 Q. It was poor nursing practice not to attend the doctor if
24 she was otherwise available to do so.
25 A. Yes, if she was available to go, yes.

154

1 Q. I think when we looked at this issue briefly this
2 morning, you said that the anti-emetic, not having had
3 full effect at 6 o'clock, certainly by 9 o'clock, with
4 this further vomiting that occurred and the
5 coffee-ground vomit, that you would certainly at that
6 time have been prompting an electrolyte test. But at
7 6 o'clock, with the four recorded vomits, continuing
8 intravenous fluids and the child vomiting in front of
9 the doctor, had you been present, would you have been
10 prompting the doctor to consider reviewing her
11 electrolytes at that point?
12 A. I may have.
13 THE CHAIRMAN: I'm not sure that Mrs Millar's going that
14 far. I think Mrs Millar is saying that after Raychel
15 got the anti-emetic from Dr Devlin at about 6 o'clock,
16 if that didn't settle her, that might prompt her to seek
17 an electrolyte test. Are you actually saying,
18 Mrs Millar, that you would have been prompting an
19 electrolyte test at 6 o'clock by Dr Devlin if you'd
20 known that Raychel was still vomiting at 6 o'clock?
21 A. If I had known that her condition was deteriorating,
22 I would, but I understand that Nurse McAuley at that
23 stage was not worried about her.
24 THE CHAIRMAN: That's what I thought. I thought that what
25 you were expecting was the anti-emetic to be given late

156

1 afternoon, it ended up later than you thought because it
2 didn't come until about 6 o'clock. But if that didn't
3 work --
4 A. Then after that, when Raychel vomited, I think again at
5 9 o'clock -- I think it was 9 o'clock --
6 MR WOLFE: Just to be clear, Mrs Ferguson has the child
7 vomiting within one hour of the anti-emetic being
8 administered.
9 Then a visitor to the hospital at 8 o'clock -- I'll
10 come to the name tomorrow perhaps -- observed the child
11 vomiting when he arrived to visit his daughter in the
12 same room.
13 THE CHAIRMAN: Mr Duffy?
14 MR WOLFE: Mr Duffy.
15 A. Yes.
16 Q. If I can put it in these terms: the characterisation of
17 the anti-emetic having fair effect, which was written by
18 Staff Nurse McAuley before she went off duty at 7.30, we
19 understand, that's consistent with the child becoming
20 nauseous again.
21 A. Yes, well, I wasn't on duty at that time.
22 Q. No. We can ask her about that.
23 A. It's difficult to say. But I understand that there were
24 no recorded vomits between the 3 o'clock and the
25 9 o'clock, I think.

157

1 afternoon, on 27 February. It has been printed out from
2 page 167 onwards. It runs through to page 201. There's
3 probably stuff towards the end which is some legal
4 exchanges, but it starts at page 167. The full
5 transcript is on the inquiry website, but that's for
6 your convenience, Mrs Millar. If you could take a while
7 to look at that tonight, it might help your evidence
8 tomorrow morning.
9 MR CAMPBELL: Chairman, can you just confirm that I have
10 permission to speak about those notes with the witness
11 tomorrow morning, as opposed to her evidence?
12 THE CHAIRMAN: Sorry, about which note?
13 MR CAMPBELL: The transcript from yesterday.
14 THE CHAIRMAN: I'm doing this in ease of your client in
15 order to facilitate her giving evidence tomorrow
16 morning. I'm making available to her in hard copy
17 a document which she would have access to anyway if she
18 had turned on the inquiry website. I don't really think
19 it's appropriate for you to consult with her about that
20 portion of the evidence before she gives it.
21 MR CAMPBELL: Very well.
22 THE CHAIRMAN: Unless there is anything further, we'll
23 resume tomorrow morning at 10 o'clock.
24 Mrs Millar, we'll finish your evidence tomorrow
25 morning and then we'll get Mr Zafar's -- he is flying in

159

1 Q. Yes. And clearly, if Dr Devlin is to be believed, if
2 Mrs Ferguson is to be believed, and Mr Duffy is to be
3 believed, that note --
4 A. Well, from what I understand, the staff or the nurses
5 were not informed of these vomits, they were not aware
6 of them.
7 THE CHAIRMAN: Sorry, Dr Devlin is a member of staff.
8 A member of staff was aware of the vomit at 6 o'clock
9 because he had witnessed it.
10 A. Yes. Yes, I'm not saying that he didn't see it or that
11 Raychel didn't vomit, but we did not know about it.
12 MR WOLFE: You went off duty at some time between 5.30 and
13 6 o'clock.
14 A. Yes.
15 Q. And as I think we've established this afternoon, you
16 didn't examine Raychel during that late afternoon
17 period.
18 A. No.
19 Q. You saw her at a distance and she was sleeping.
20 A. Yes.
21 MR WOLFE: Very well.
22 Sir, could we leave it now until the morning?
23 We have one segment of evidence to deal with.
24 THE CHAIRMAN: Yes. What I'm now going to give Mrs Millar
25 to look at is the evidence that Mrs Noble gave yesterday

158

1 tomorrow morning and we'll get through his evidence
2 tomorrow. Thank you.
3 (5.00 pm)
4 (The hearing adjourned until 10.00 am the following day)
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160

I N D E X

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3 MRS ELIZABETH MILLAR (called)1
4 Questions from MR WOLFE1
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