Thursday, 28 February 2013

(10.15 am)

(Delay in proceedings)

(10.39 am)

THE CHAIRMAN: Good morning. I'm sorry I'm late. Sorry for keeping you waiting, Mrs Millar. Would you come forward, please?

MRS ELIZABETH MILLAR (called)

Questions from MR WOLFE

MR WOLFE: Good morning. Is it Mrs Millar?

A. Yes.

Q. Mrs Millar, I'm going to ask you some questions about your role in the nursing and care of Raychel Ferguson. Before I begin, can I ask you to confirm that you provided the inquiry with two witness statements? One was dated 30 June 2005; the second, more recently, 20 June 2012.

A. Yes.

Q. Can you confirm for the record that those statements are accurate and that you wish to adopt them as part of your evidence?

A. Yes.

Q. Your evidence will, of course, be supplemented by what you tell us in the course of today.

Can I start by asking you this. You've said in each

of your witness statements, Mrs Millar, that you're confident that Raychel received the highest standard of care from the nursing staff in Ward 6.

A. Yes.

Q. You recall saying that in your statement?

A. Yes.

Q. Do you stand by that assertion?

A. Well, at the time I wrote my statement, I did believe that and I did, at the time, believe we were delivering a high standard of care to Raychel. Raychel received the same care that any other child in the ward would have been given. We did fall down on our documentation, there's no doubt about that, but overall I think we did give a good standard of care.

Q. Are you of the view that nurses have nothing to reproach themselves for in the care that they delivered to Raychel?

A. I think looking back now on what we know now that our documentation could have been better; it was deficient. Also, what we know now, we would have been getting a doctor to see Raychel, if it was me, probably around the 1 o'clock vomit. But at the time I was fully sure and happy with Raychel's progress from the time I came on in the morning until the time I left at 5.30.

I hadn't been there early afternoon, I was in my

office, but I was there all morning up until 1.30/1.45 and I was happy with Raychel's progress at that stage.

Q. Yes. So to summarise this opening explanation, you would say that in two respects nursing care was deficient. Firstly, the records left something to be desired.

A. Yes, I would agree with that. I think our documentation was not adequate and, looking back now, our urinary measurement and the vomit measurement, although at that time we did not measure vomit, it was the practice at that time to document the first passing of urine, which was done at 10 o'clock, and following that we didn't, at that time, routinely document urinary output.

Q. We'll come to the detail of that in a moment. I just want to establish our baseline here. So record keeping, you would accept left something to be desired, and whether --

A. The fluid balance sheet could have been better, yes.

Q. And the second point that you make is that, looking at all things now, you would accept that a doctor should have been brought to Raychel's bedside at an earlier point in time and you point to the time of 1 o'clock.

A. No. At that time, 12 years ago, I was very happy with Raychel during the day.

Q. Yes.

A. No, I would not have got a doctor at 1 o'clock. I did call a doctor at 3 o'clock. But looking back now at that time and what we know now, 12 years later, yes, we know now that we should have called a doctor at 1 o'clock.

THE CHAIRMAN: That's on the basis of knowing what you know now which you didn't know then?

A. Yes.

THE CHAIRMAN: Can I take it that in a way, maybe like Mrs Noble and some others -- in fact, some much more senior people in Altnagelvin -- you feel a bit let down that some lessons which might have been learnt earlier in other parts of Northern Ireland and in the Royal hadn't made their way through to Altnagelvin by June 2001?

A. Yes. If there was something known about the fluid at that stage, we didn't know about it. I had never heard of hyponatraemia in post-surgical children and I had, at that stage, been nursing for 35 years. I had seen hyponatraemia in medical paediatric patients, especially children with -- they would have been brought in with severe gastroenteritis, they would have been in the treatment room being resuscitated and the electrolytes would have been done as an emergency and I would know that the doctor would say the child is hyponatraemic,

low sodium, potassium would probably be abnormal, and the urea would be raised, but the actual scientific side of it I didn't know.

THE CHAIRMAN: We're jumping around a bit and Mr Wolfe will go through these issues in more detail, as I think you'll understand. But if for instance the Royal had stopped using Solution No. 18, that's something that you would have liked to have known --

A. Yes.

THE CHAIRMAN: -- in Altnagelvin.

A. Yes, I would have. I didn't know.

THE CHAIRMAN: And you'd have liked to have known why and what it had been replaced with.

A. Yes, if it had been changed in the Royal, but I wasn't aware it was changed.

THE CHAIRMAN: Going on Mrs Noble's evidence, there seems to have been a very strong adherence to Solution No. 18 on Ward 6.

A. Yes. I came to Altnagelvin in 1976 and I came from the Royal. The solution there, I always -- all my nursing career up until 12 years ago was always Solution No. 18. I had seen Hartmann's used in children with severe burns and I remember back in the 80s, late 80s and early 90s, if we got in a very, very severe child with scalds or burns, those children would be transferred to Belfast,

and very often they were on Hartmann's. That was the only time I had seen Hartmann's being used long-term. Again, I wouldn't have understood the actual reason why the child was getting Hartmann's. I know it was high sodium, but there was no sugar in it.

THE CHAIRMAN: Okay. Well, we'll let Mr Wolfe get back on track.

MR WOLFE: We'll probably be coming back to those issues very shortly in some detail. Picking up on the point I made before the chairman intervened, the point that I was asking you about was what you said about having a doctor come in earlier. Just so that I understand it, before we move off, you say that knowing what you know now you would have probably got a doctor to see Raychel earlier; is that your position?

A. That is my position. I would have -- 1 o'clock, I was ... Even if I knew then what I know now, I still would have been happy up to -- "happy" may be not the word, but satisfied with Raychel up until the 10 o'clock, even though she did vomit at 10 o'clock. The 1 o'clock vomit, if I knew, as I say now, what -- I would call a doctor at that stage, or ask a doctor to see her to give her an anti-emetic.

Q. I will explore that with you in some detail as we go on. In June 2001, you were the sister for Ward 6.

A. Yes.

Q. Does that make you one of a number of sisters or were you the only sister?

A. No, I was the senior sister and there were two junior sisters.

Q. Right.

A. I not only had Ward 6, I also had outpatients department, a day-care unit, and we were in the progress of getting together a transitional care unit for children with life-limiting illnesses, a three-bedded unit.

Q. We're going to look at your various roles just now, but if I could have up on the screen what might serve as your CV at 056/1, please, at page 1. WS056/1. You'll recognise this, Mrs Millar, as the first page of your original witness statement to the inquiry.

A. Yes.

Q. At the top of the page, helpfully set out is really a list of your various posts.

A. Yes.

THE CHAIRMAN: You actually qualified as a children's nurse?

A. Yes, it was a three-year training, January 1968 to January 1971, and it was in the Children's Hospital in Belfast.

MR WOLFE: You're fully qualified and registered as

at January 1971.

A. Yes.

Q. And you took up a staff nurse position in the Royal Children's Hospital.

A. Yes, I stayed there -- I was a staff nurse from January 1971 to September 1974. I got a sister's post in 1974 there on a medical ward until August 1976, when I went to Derry. I started in Altnagelvin in August 1979 to October 1985. Then I was -- oh yes, I was an acting sister then from October 1985 to July 1986 when I got my present post. That post started as a sister's post and then, as I was then what they call a G grade, and an H grade, which -- I had gone up the ladder a bit.

Q. In or about 2004, I think you tell us, you became an H-grade paediatric unit manager --

A. Yes.

Q. -- in Altnagelvin.

A. Yes.

Q. Was that the same as a sister's role or was that a development?

A. My role had developed over the years. I had started out with a 32-bedded ward on the 10th floor and then we were amalgamated with a baby unit, which had been on the fifth floor, and we went from 32 beds to 43 beds. We

also -- the outpatients moved up to the sixth floor as well. It was two wings, it was the full sixth floor and there were two wings. On the other wing there was the outpatient department and the day-care unit.

Q. Just while we have it here on the screen, you set out helpfully a list of all the training that you'd received over the years.

A. Mm-hm, yes.

Q. I think you tell us in your witness statement that you received no formal training in relation to fluid management for children.

A. That's right, I didn't.

Q. You've now retired from practice; is that correct?

A. Yes.

Q. You retired as of?

A. Over two years, two years and three or four months, yes.

Q. If we could have up on the screen WS056/2, please, page 2. You say, Mrs Millar -- it's a point you've made already -- that as of June 2001 you had responsibility for a children's unit and your duties comprised of four specific areas; is that correct?

A. Yes.

Q. So --

A. Well, sorry, three specific areas and we were in the process of developing the transitional care unit.

Q. Okay. So in the middle of the page there --

A. Yes.

Q. -- we can see the description of your various roles. You were responsible for the ward.

A. Yes.

Q. By that, you mean the ward where Raychel was cared for?

A. Yes, that's right. At that time I was moving away very much from the clinical end because my role was developing and becoming much more complex and I had nearly 80 staff. So it was moving away. I had two junior sisters and the clinical side was very much their interest, whereas mine was more managerial and organisational. However, I was still spending the mornings in the ward and the afternoons in my office because at that time I felt I had to have some input into the ward to know what was actually happening, and I felt that -- I just felt I didn't want to move away from it. But a year later, I did have to because I just couldn't do everything, I couldn't manage four areas.

Q. A year later from what?

A. In 2002.

Q. So at the time of Raychel's care in the hospital, which was June 2001, you were juggling these various responsibilities, still keeping your hand on the tiller of the clinical responsibilities?

A. Yes. When I came on duty in the mornings, if the ward wasn't busy and it was well staffed, I would have spent the day in my office. But sometimes I came on, there may have been a staff nurse sick, there could have been -- the day Raychel ... On 8 June, there were two staff went off sick that morning and I had to reallocate the nurses. So I stayed that morning to do the ward round and so release up a nurse that she could deliver hands on care.

Q. Yes. It might be convenient to deal with the specifics of that. On the morning of 8 June when Raychel came under your care, you had two nurses responsible generally for the care of Raychel on Ward 6.

A. Yes.

Q. That was Nurse Roulston and Nurse McAuley.

A. Yes. There was a nursing auxiliary as well, Nurse O'Kane.

Q. In the morning of that day, you were available on the ward for clinical care, clinical issues.

A. Yes.

Q. But in the afternoon, from in or about 2 o'clock, you retired to your office to carry out administrative type duties --

A. Yes.

Q. -- returning to the ward at or about 5 o'clock --

A. Yes.

Q. -- for the purposes of seeing patients and then finishing your shift at about 6 o'clock.

A. Yes. I went off some time before 6 o'clock. Half five was my finishing time and I definitely was gone by six, but I can't remember the exact time. I was gone by six.

Q. If we could have up on the screen your job description. It's WS056/2 at page 30.

THE CHAIRMAN: Can I take it that if, because you were in the office, which was in essence part of Ward 6, there was anything of real concern or any type of emergency, that the nurses would be free to come and speak to you to bring you out?

A. Yes, they would. There were three very senior nurses on the ward that day. Avril Roulston was in the nursery. She originally had been looking after Raychel but then she had to go and cover the nursery because Nurse Gibson went off. Nurse Wilson, who was allocated to medicines that day, who would substitute for me in my absence, she was a very senior nurse, and Michelle Bryson was also a very senior nurse. If they wanted to speak to me to ask me anything, I was available, and as Nurse McAuley rang me to say that Raychel had vomited again --

THE CHAIRMAN: Yes.

A. So I'm always available.

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

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

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

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

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

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

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

A. Yes.

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. No, I didn't. I was at the reception desk when Mr Ferguson passed me with Raychel. It was around -- the first lunch breaks had left ... There's two lunch breaks, two teams of nurses, and I was at the desk. I can't remember what I was doing. But I noticed Mr Ferguson and Raychel walking past. I said, "Mr Ferguson, I can bring a bedpan, Raychel doesn't need to walk to the toilet". He said, "No, she wants to go like this". Because I was concerned that she was actually fit to go to the toilet, I thought after having her surgery, that perhaps she wouldn't be able to walk, but she was walking, albeit holding her tummy. They

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

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

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

Q. Yes.

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

Q. Okay.

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

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

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

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

A. Yes.

Q. Next one:

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

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

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

with them and then allocated them again a senior staff nurse to work alongside, usually for a period of six weeks, and ...

Q. Could I ask you this question about training as a general point? In many of the statements which the inquiry has received to date, and indeed in the evidence that the inquiry's heard over the past day or so from an experienced nurse, Mrs Noble, there appears, on the face of those statements, to have been a confusion between what was meant by maintenance fluids and replacement fluids. First of all, before I ask you about that sense of apparent confusion, would you have known the difference between a maintenance regime and a replacement regime?

A. No. I didn't know anything about a replacement regime. I had never had any training on IV fluid administration. Solution No. 18 was the fluid that I understood to be a safe fluid because it had a little sugar in it.

Q. I'm sorry, I'm not talking about the type of fluid, I'm talking about the aim of the regime.

A. No, I didn't understand the replacement, no.

THE CHAIRMAN: Just to be more specific, if a child is repeatedly vomiting, then there is material leaving her body, which alters the make-up of her body and her blood; is that right?

A. Yes.

THE CHAIRMAN: In Raychel's case she's given a fluid which, as you now know, does not replace the losses which she's suffering, the sodium losses. Do I understand your answers to Mr Wolfe to indicate that what you were aware of was the need to keep the child hydrated rather than the need to keep her levels of sodium at an appropriate level?

A. Yes. I think that Raychel was on IV fluids and I believed -- I was reassured by those IV fluids. I did not recognise that her vomiting could dehydrate her because I thought her loss was being replaced by the fluid.

THE CHAIRMAN: Right. And you knew, in a general way, that it was regarded as a safe fluid, so whatever she was losing, she was having that replaced with something which you thought was safe?

A. Yes.

THE CHAIRMAN: And that happened not just in Raychel's case, but on the evidence we have heard from Mrs Noble and others, this would be the sort of fluid which is given to other children who had a bad reaction to surgery or to anaesthetic and who vomited a lot afterwards. They all got Solution No. 18.

A. Well, to my -- yes. Well, my experience was that they

did unless a child who was very, very ill and was losing a huge amount of fluid through a naso-gastric tube or maybe a child that had severe intussusception or obstruction, although those children went to Belfast, but they may need stabilisation before they go. They may have got other fluids, but they would have been resuscitation fluids. I very, very rarely saw that in the surgical side. Those children were extremely ill and were being transferred to Belfast.

THE CHAIRMAN: There seems, on the evidence, to have been a very strict line taken that only Solution No. 18 was given on Ward 6.

A. Yes.

THE CHAIRMAN: Where did that come from?

A. I don't know where it came from. That was the practice when I came in 1976.

THE CHAIRMAN: You know I've heard evidence over the last few days that doctors who wanted to prescribe Hartmann's were being told in terms that you have to justify that because the position on Ward 6 is that we give Solution No. 18. As it turns out, the doctors here didn't feel strongly enough to say, "No, it must be Hartmann's", but it seems to me to be rather curious that, for instance, an anaesthetist or a surgeon who wanted to give Hartmann's was being required to justify

himself because that wasn't the practice.

A. All I can say is that Solution No. 18 was the fluid that was used. As a nurse, we were told that -- or it was the general opinion that Hartmann's was a dangerous fluid for children because it didn't have any sugar.

THE CHAIRMAN: Sorry, where were you told that? Were you told that in Altnagelvin or the Royal?

A. No, no, that was my understanding.

THE CHAIRMAN: Is that your understanding from training in the Royal in the late 1960s and then from working in the Royal over the next five or six years?

A. I didn't get any training on IV fluids in the Royal. Those were the fluids that were being used in the Royal, Solution No. 18. I didn't -- I don't remember seeing Hartmann's used in the Royal except, as I say, on severe burns.

THE CHAIRMAN: Thank you.

MR WOLFE: Just finally on this segment, on 4.10 on the screen in front of us, it states that with one of your responsibilities was:

"[To] cooperate with medical staff in a problem-solving approach to treatment, investigation and general care of patients."

Again, I would assume, Mrs Millar, that that is a principle or an approach which all nurses would have

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

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

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

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

albeit we knew the child was vomiting. Yes, I would expect that. Very often, if a doctor is busy, very busy, and covering a lot of wards, it may be difficult to have a very in-depth conversation.

Q. Would you expect the nurse to attend a doctor at the patient's bedside where, for example, an invasive procedure such as an injection is being administered to a child?

A. Yes. Well, we always endeavour to go with the doctor when they came on the ward or even the doctors that are on the ward, the paediatric doctors. But there are times, especially during tea breaks and lunch breaks, if -- I mean, three or four doctors could come on the ward at one time. I've actually known five or six to come on the ward. You would not be able to free up a nurse to go with every doctor. Some doctors will wait and they won't go to a patient until a nurse comes, but there are other doctors who are happy to see a patient without a nurse. But the usual thing would be for a nurse to go with a doctor.

Q. Moving on, Mrs Millar, your awareness of hyponatraemia by June 2001 appears to be more developed than some of your nursing colleagues who have given evidence or are about to give evidence to the inquiry. You had heard of hyponatraemia.

A. Yes.

Q. Without getting into the complexity of it, you had heard it was consistent with low serum sodium in blood --

A. Yes.

Q. -- and you had direct experience of seeing it in non-surgical patients.

A. Yes, I had very few, but I had seen it. During my years of nursing, maybe three or four children. There may well have been more, but I cannot remember. It was not a big issue in medical paediatrics. We very, very rarely got a child in with hyponatraemia and certainly in recent years -- I mean, we may get a child in with a low sodium, but just maybe 130 or a low potassium and urea would be raised. Those electrolytes would be corrected with Solution No. 18, usually. These were only mildly dehydrated children, but I have seen children with hyponatraemia and these were mostly severe gastroenteritis children who had to be resuscitated.

Q. Did I just hear you say that there were times when you might have had:

" ... a child in with low sodium, maybe 130 [it says on the transcript]. These electrolytes would be corrected with Solution No. 18"?

A. Solution No. 18 plus normal saline.

Q. Yes. In combination?

A. In combination.

Q. Because the Solution No. 18, self-evidently, wouldn't correct the sodium deficit.

A. No. It was too low in sodium.

THE CHAIRMAN: Of course, the point there is that you knew what the sodium level was because the electrolyte tests had been done --

A. Yes.

THE CHAIRMAN: -- and the critical omission in Raychel's case was that there was no electrolyte test done all day Friday; isn't that right?

A. Yes.

MR WOLFE: We'll come back to this in a second, but just in passing we note from your statement that after Raychel's death, you found yourself in possession of some information in relation to Lucy Crawford. One of the paediatric consultants told you about her death.

A. No, he didn't tell me. I heard it in conversation with consultants. I didn't know anything about Lucy Crawford until after Raychel died. I think I heard a conversation between consultants that maybe there was a link between the two children. But it was some time after Raychel died. I hadn't heard about Lucy Crawford, I didn't know anything about her.

Q. So you obviously didn't know about Lucy until after

Raychel had died.

A. Mm-hm.

Q. In what context did this conversation take place that you heard about?

A. Well, I think there was a discussion. It wasn't at a meeting, it was just an informal discussion. I think Dr Nesbitt had been in contact with the Department of Health and I think it had come down through the medical staff that maybe there was a link. I mean, I wasn't actually told it directly, I just overheard it in conversation and I was wondering, you know, if this child had died in Enniskillen, I didn't hear anything about it. But that's really all I knew at that time.

Q. Let me see if you can help us with trying to pinpoint this a little further. Lucy died in or about April 2000. Raychel died 14 months later in June 2001. Between those two deaths, a consultant paediatrician based at Altnagelvin, Dr Murray Quinn, had carried out some work on behalf of the Sperrin Lakeland Trust in assessing or analysing issues around Lucy's death. And then of course, as I say, we have Raychel's death.

First of all, did you know Dr Quinn?

A. I did, yes.

Q. Clearly, you are reflecting a conversation that was

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

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

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

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

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

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

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

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

to the police. He says at the 12 June meeting that there was a discussion about the amount of fluid she got and it was too much. So that would have been information, since you were at the meeting on the 12 June --

A. I was, yes.

THE CHAIRMAN: Whether you remember it now, that's information you would have had at June 2001.

A. I have no recollection of that.

MR WOLFE: You go on to say at (b) that:

"The Lucy/Raychel link was also discussed with the risk management department after Raychel died."

Do you see that?

A. Yes.

Q. Were they formal risk management meetings?

A. They were formal risk management meetings. I'm not sure when we commenced those meetings. I think they were commenced before Raychel died. I cannot remember the dates, but they would have involved the consultants, myself and risk management, Therese Brown, and some senior staff, and it was really incidents that would have occurred, anything to do with medications. It could have been anything that we regarded as being a risk that we would discuss. Maybe even the simple thing of children tripping in the corridor, you know.

So it was really to try and look at these and reduce the risk.

Q. Yes. In any event, those were formal meetings and one would expect them to have been minuted.

A. Yes.

Q. Moving on then, could I ask you about the issue of your awareness or knowledge of the kinds of circumstances in which electrolyte imbalances could occur in children.

Did I pick you up correctly when you said earlier that you had experience of seeing children with sodium depletion? Whether it was called hyponatraemia perhaps doesn't matter. But you had experience of seeing such patients in hospital and observing their treatment?

A. Very, very few of these patients I saw. As I say, they would usually have been very sick babies with gastroenteritis. I don't recall seeing it in any other children.

Q. But you would have been aware, therefore, that --

A. Yes --

Q. Some of the causes --

A. These children would have come in, they wouldn't be up on IV fluids, but the initial electrolytes would have shown that they were hyponatraemic, and that would be corrected then with IV fluids. These were all on the paediatric side, the medical side.

Q. Yes. And therefore, in terms of the causes of electrolyte imbalance in such children, you're pointing to gastroenteritis, in other words vomiting and diarrhoea, and the excretion of sodium-rich fluids.

You were asked in your witness statement whether you were aware of the factors that could cause an electrolyte imbalance in a child following surgery. Were you aware of the kinds of problems that could follow from surgery, such as post-operative vomiting?

A. Yes. Well, I had seen ... I mean, post-operative vomiting wasn't unusual in surgical children.

Q. Yes.

A. Of course, they didn't all vomit, and in my younger days of nursing, you could say they nearly all did vomit because anaesthetics in those days were ...

THE CHAIRMAN: Crude?

A. Yes. They've improved. So post-operative vomiting, we would see -- you know, we wouldn't see it every day, but you would have seen a child maybe once a fortnight, maybe once a week, that may have had prolonged vomiting. So you asked me was I aware ...

MR WOLFE: I'm asking you this, just to move on: were you aware that, with prolonged and severe vomiting, a child could be at risk of electrolyte imbalance?

A. No. I wasn't aware with Raychel.

Q. No, no, I'm not dealing specifically with the case of Raychel.

A. No, I wasn't.

Q. I'm dealing with the case more generally.

A. No.

Q. Are you saying that, simply put --

A. I was aware --

Q. You'll have to wait for the question, Mrs Millar.

The question is this: in circumstances where a child has severe and prolonged vomiting, are you telling the inquiry that you would not be concerned for the risk of electrolyte imbalance?

A. Yes. I would be, if that child didn't have IV fluids, I would. I would be calling a doctor to do an electrolytes and put up IV fluids. In a child who has IV fluids up and who is vomiting, I would not have recognised that the child could become dehydrated and needed replacement fluids. I did not know at that time. I was aware of the opinion that the fluids were up and even though the child was vomiting and they weren't large vomits, that the fluid was being replaced. Obviously I was -- what I know now is different, but at that time I didn't know. I was reassured with the IV fluids.

Q. So you now know that the IV fluids that were in place

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

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

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

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

of post-surgery, the common denominator, if you like, is the fact that the patient is losing sodium-rich fluids from his or her body; isn't that right?

A. Yes, well, I know that now, but at the time I didn't know --

Q. You didn't --

A. -- for the post-surgical children.

Q. Hold on, what's the difference between a child who has gastroenteritis and is vomiting and the child who is post-surgery and is vomiting in relation to the issue of sodium depletion?

A. Well, there's very little. But I did not make that link at that time.

Q. The point is, Mrs Millar, that you had the knowledge to be able to make the link; would you agree with me?

A. No, no.

Q. Explain to me why you weren't in a position to make the link.

A. I had seen hyponatraemia in very, very few children in my time, and these were mostly children who were brought in, resuscitated, and very often transferred to Belfast. They were extremely ill children. I probably had two or three in my lifetime of nursing, maybe half a dozen, but I had never seen hyponatraemia in post-surgical children.

Q. Again, Mrs Millar, that is not the point. The point is this: you have two categories of patient. One has got gastroenteritis, the other is vomiting post surgery. They're suffering from a similar problem, both of them are releasing from their body vomit, maybe in gastroenteritis you have diarrhoea as well. Do you not accept the similarity in the cases in that if both are losing fluids from their body, they're also losing sodium?

A. Yes. Well, I have to accept that now, yes.

Q. And indeed you'll have considered the report of Sally Ramsay, who says that, at a minimum, she would expect a registered nurse to be aware that fluid loss from vomiting, if not replaced intravenously, can result in dehydration and electrolyte imbalance. You've seen that?

A. Yes, I have.

Q. And do you accept that?

A. Well, I do accept that, yes.

Q. What surprises her, Mrs Millar, is that all of the nurses, with the possible exception of Nurse McGrath, who have given statements to the inquiry, have articulated the view that they thought Raychel was safe because she was in receipt of an intravenous fluid. And what she says is that she is surprised that experienced

nurses think that, regardless of the child's output, the simple fact that she's getting an intravenous fluid rendered her safe.

A. Yes.

Q. Whereas in fact, what nurses and the medical staff ought to have been thinking about is what was the composition of that fluid. You're nodding your head. You seem to agree with that, that nurses and medical staff ought to have been thinking about the composition of the fluid that Raychel was receiving.

A. Well, as nurses at that time we did not know -- we had no training -- I had no training in IV fluids, neither did my nurses. So I didn't know anything about replacement fluid. I had seen, as I say, children getting different fluids over a short period in resuscitation and being transferred to Belfast. But I did not think that Raychel that day was -- she had vomited a number of times, but because her general appearance -- her observations, her colour, she was bright and alert during the time I was on -- I did not warrant that she was in a deteriorating condition.

Q. Again, we're drifting back into Raychel's specific case.

THE CHAIRMAN: I think you've taken it as far as you can, Mr Wolfe.

MR WOLFE: In terms of post-operative management of fluids

in Altnagelvin at that time, who had the responsibility for initial post-operative fluids?

A. It could have been the anaesthetist or the surgical JHO or SHO. Usually when a child went to theatre, their preoperative fluids were written up by the admitting doctor, then in theatre the anaesthetist would look after the fluids. Sometimes the child came back with -- the anaesthetist may have written up fluids, very often there were no fluids written up. And we would have had to get a surgical doctor to rewrite the fluids. But usually, the Solution No. 18 was continued -- it was usually Solution No. 18 was the fluid -- and that was continued after the child came back to the ward.

THE CHAIRMAN: Sorry, it was continued from when? If we take Raychel as an example, it wasn't continued from the surgery. When you say that, "Usually the Solution No. 18 was continued", do you mean continued from pre-surgery or during surgery?

A. No, pre-surgery.

THE CHAIRMAN: So a child comes in and is given Solution No. 18, goes into surgery, and is given whatever the anaesthetist decides, and after surgery goes back to Solution No. 18?

A. When the child came back to the ward, it goes back, the child went back on Solution No. 18. That was the

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

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

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

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

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

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

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

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

post-operative fluid management arrangements at 2001. In answer (c) you're asked:

"In any event, how were the arrangements for post-operative fluid management communicated to nursing and medical staff?"

And you say:

"Written practice that Solution No. 18 was the default solution to be used for all children."

A. No, that's not right. It wasn't a written practice, so that's wrong.

Q. You wish to correct that?

A. It wasn't a written practice, it was a known practice, but not written.

Q. Okay.

A. That's wrong.

THE CHAIRMAN: You say, in fact, it even preceded your arrival in the mid-1970s.

A. Sorry?

THE CHAIRMAN: When you arrived in the mid-70s at Altnagelvin, that was already the practice?

A. Yes.

MR WOLFE: That was simply an error, you're telling us?

A. Yes, it must be because there's no written practice.

Q. You wrote it, that's why I'm asking, Mrs Millar.

A. No, that's wrong.

Q. You did write it?

A. I did write that, yes, but it's a mistake.

Q. It's a mistake?

A. Yes.

Q. Okay. Could we then turn to the nursing handover that took place at or about 8 o'clock on 8 June. You commenced duty at 7.50 in the morning; is that correct?

A. I was usually on about 7.30, but the handover report starts at 7.50.

Q. As we know from earlier, the nurses who you allocated to Raychel's care on that day were Rice -- we call her McAuley for the purposes of the record -- and Staff Nurse Roulston.

A. Yes, and a nursing auxiliary.

Q. Staff Nurse Roulston, as you have said, was the experienced member of staff --

A. Yes.

Q. -- whereas Nurse McAuley had one year's experience before coming to Altnagelvin.

A. She had done her paediatric training through Altnagelvin and I think she was 18 months, maybe, at that stage, after qualification. So she would have done her placements in Ward 6.

Q. And Raychel's condition and, indeed all of the patients on the ward, their condition, was reported to you at

a handover provided by Nurse Noble.

A. Yes.

Q. Can you recall how Nurse Noble described Raychel's overnight condition?

A. I think she reported that Raychel was progressing well following her post-operative surgery. She was on IV fluids and I recall that she hadn't passed urine at that time and that her observations were within normal limits.

Q. Were you aware that the record of the surgeon had established that Raychel's appendix was mildly congested?

A. Yes.

Q. And we've heard from Mrs Noble yesterday about, if you like, a straightforward appendicitis and a more serious, severe appendicitis. She would have Raychel falling into the former category, that this was a mild case of appendicitis and she had had a good overnight recovery.

A. Yes.

Q. It was her expectation -- and perhaps you could comment on this -- that Raychel, she anticipated, would continue on IV fluids during the day, taking sips of water, decreasing the need for IV fluids, would become increasingly mobile and would perhaps be eating by the end of the day. Was that a reasonable anticipation at

that point?

A. Yes, that would have been the expected pathway for Raychel to have followed, that she would be seen by the doctor post-operatively in the morning, oral fluids would be introduced slowly if she wasn't vomiting, and once she was established on the oral fluids, we would hope to reduce the IV fluid to maybe half at lunchtime or pre-lunchtime, and you would hope by the evening, 5 or 6 o'clock, the IV fluid would be discontinued.

Q. Yes. In terms of the specific allocation of nursing care to Raychel, you were a nurse down that day; is that right?

A. I was two nurses down that day.

Q. And so Staff Nurse Roulston was specifically allocated at some point, according to her, to the infant unit.

A. Yes.

Q. The infant unit was a distinct unit separate from the ward; is that right?

A. No, it was within the ward. It would have been the -- Raychel's room was room I and the two rooms -- nearer the entrance there were two larger --

Q. Sorry to cut across you. Let me try and assist you with that. There's a plan available to us and I want to ask you some questions in relation to the plan. At 316-016b-001. Just take a moment to orientate yourself.

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

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

I see it's just in the corner.
A. It would be the first room as you come through the middle doors.
THE CHAIRMAN: Okay thank you.
MR WOLFE: In terms of the toilet facilities, we can see a number of them on the screen. You have said, and we'll deal with this presently, that you observed Raychel's father bringing her to the toilet on two occasions, I think you've said.
A. That's right, yes.
Q. Which toilets are they? Which toilet was Raychel brought to?
A. It was next to the treatment room, just below the treatment room.
Q. Above --
A. You see the treatment room on the left.
Q. Yes, I can see a toilet.
A. There's a toilet below that. It would have been that one.
Q. So just above the words "zone 4"?
A. Yes.
Q. On each of the occasions you say you saw her father bringing her to the toilet, was that the toilet that he went to?
A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

THE CHAIRMAN: In fact, if you feed in some information here like the child's name and so on, you're going to get an automatic printout of things to do. On this pro forma, one of the requirements is to observe and record urinary output. That's what the package that Altnagelvin had for the care plan required, but it was not Altnagelvin's practice to do that, to follow that particular aspect of the printout; is that fair?

A. Yes, that's fair, yes.

MR WOLFE: Mrs Ramsay, in her report, cites various nursing texts, and in particular she cites Hubbard & Trig. She explains that:

"Where a child has surgery and her hydration needs are being met by IV fluids, as in Raychel's case, a fluid balance chart is crucial to monitor all input and output. All intake and output to be recorded."

She concludes that:

"In Raychel's case there was a failure to record fluid balance accurately."

Do you accept that that --

A. I do accept that, yes.

THE CHAIRMAN: When you retired, was this sort of pro forma printout being used, the care plan?

A. Yes, I think they were. They had reverted to the evaluation by free text, I think around the time that

I left, but I think the core care plans are still in use.

THE CHAIRMAN: Okay.

MR WOLFE: Another aspect of recording, perhaps a very important aspect of recording that ought to have been supplied with, was vomiting. Any vomiting should have been recorded. There is a dispute on the facts of Raychel's situation with regard to how much vomiting there was in terms of both volume and incidence of vomiting. Could I ask you, Mrs Millar, did you actually physically see any of the vomit, any of the vomiting?

A. Yes, I saw the vomit at 10 o'clock. Well, it was between 10 and 11 o'clock, I was in the room with the paediatricians doing the ward round. I happened to notice that there was a vomit bowl on Raychel's bed table. There was some vomit in it and initially I thought, "Why is that there? Who has left it?". So I gave it to Nurse McAuley to dispose of.

Q. Who recorded that in the note?

A. I think it was Nurse McAuley.

Q. And that's the vomit that was identified as a large vomit?

A. Yes.

Q. Could I have up on the screen, please, 012-041-203? Just to orientate you, Mrs Millar, this is a record of

your deposition to the coroner at Raychel's inquest. If we go back a page, just so that the witness can familiarise herself with it. Take your time to identify that and read it if you need to. (Pause).

I want to draw your attention to the section starting "Mr Foster". Mr Foster was counsel representing the Ferguson family at the time of the coroner's inquest. The coroner would have recorded your evidence in answer to Mr Foster's questions. He has recorded:

"I was the most senior nurse. Nurse Wright [that must have been Nurse Rice, I would suggest, but leaving that] was a junior staff nurse at the time. Nurse Roulston was also involved with the care of Raychel. It was not routine to note each passage of urine or the quantity on each occasion. It may be important to note if a patient actually passed urine. I did not personally see any of the vomits. The 10.30 am was slightly larger than the other. The nurses described the vomits for me. I cannot recall which nurse I handed over to."

That's into a different issue.

Has the coroner recorded your evidence correctly where you say --

A. I saw the 10.30, the 10/10.30 vomit.

THE CHAIRMAN: Sorry, do I understand it that you didn't see Raychel vomiting --

A. No.

THE CHAIRMAN: -- at any time, but you saw what she had vomited at one point?

A. Yes.

THE CHAIRMAN: Okay.

A. Yes, that's probably what -- yes, I ... I didn't see Raychel vomit at any time during the day, but I did -- and the only vomit I saw was the vomit between 10 and 11 or 10.30. That was sitting in a bowl on her bed table during the paediatric ward round.

MR WOLFE: Where you say, "the nurses described the vomit for me", that doesn't apply to the 10.30 vomit?

A. No, it applies to the 1 o'clock vomit. The 8 o'clock vomit in the morning, I actually didn't know she had vomited until I went with the doctor to look at her, when he came to see her post-operatively. That vomit, I think, happened during the handover report, and it was documented by one of the night staff.

Q. Dealing with that, what we call the 8 o'clock vomit, it's recorded in that slot between 8 o'clock and 9 o'clock on the fluid balance chart; did you see that vomit?

A. No.

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

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

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

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

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

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

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

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

Therese Brown, which provides an explanation of a treatment book, which you tell us you had with you at the time of Dr Zafar's visit and Therese Brown provided this explanation to the PSNI during their investigation:

"The treatment book is something held on the ward, which provides a guide to patient layout and allocation. It details the age of the child, the consultant, and the provisional diagnosis. It is used as general information for all staff on the ward and is used as a prompt for required action. If a patient is seen by medical staff, a brief summary is recorded in the treatment book. The book is used by nursing staff during the consultant ward round when a brief summary of action and the treatment plan is recorded. The book is not used in isolation from the medical notes or nursing notes. Generally something is written in the treatment book about all patients in the ward on a daily basis unless the patient is a 'long stay' patient."

Is that a description which you concur with?

A. Yes.

Q. And in terms of the treatment book itself, we can find the relevant extract from it at WS056/2, at page 29. The inquiry, Mr Chairman, has received as an addendum or an appendix to Mrs Millar's statement a rather fuller sheet containing the treatment for various patients, but

for obvious reasons it has been redacted --

THE CHAIRMAN: Yes.

MR WOLFE: -- and that's why you see it in this form.

Mrs Millar, you can confirm perhaps that this is the entry relevant to Raychel?

A. Yes. The line underneath is not relevant to Raychel. "Regular nebs", that must be another child.

Q. Just read out the words which are applicable to Raychel.

A. "Allowed sips later. Seen by surgical doctor. Analgesia. And if drinking, reduce IV fluids."

Q. Yes. Let me translate that. The "SB" on the first line is "seen by"?

A. Yes.

Q. "Surgical doctor." And then it goes along, "if drinking", and then you go below the line, there's an arrow down.

A. Yes.

Q. "Reduce IV fluids."

A. Yes. That would be, "Reduce IV fluids according to the tolerating of oral fluids".

Q. Yes. Could you paint the scene for us? When are you writing this down?

A. I write that straight after the doctor. I had the book with me and I just often put it on the bed table and write it.

THE CHAIRMAN: Because if you don't write it then, you won't remember it?

A. Yes, if I don't write it, then I won't remember. It's certainly written before I leave the room.

MR WOLFE: Yes. That appears to be the only note that you record in relation to Dr Zafar's visit.

A. That's right.

Q. Would it be practice to write a fuller note in the nursing notes?

A. No. What I would have done was, I conveyed this to Michaela McAuley and as far as I remember, Avril Roulston was with her just outside the door, that Raychel was allowed sips later because, when I told Mr Zafar that Raychel vomited at 8, he had said to start oral fluids and reduce IV fluids accordingly, which would be -- mid-morning, the IV fluids you would hope would be down to half because Raychel would be tolerating oral fluids and you would hope by evening time, 5, 6 o'clock, the IV fluids could come away. But because Raychel had vomited at 8, I said to Mr Makar [sic], "Can we delay giving the oral fluids?", and therefore -- he said yes. I mean, I can't remember him agreeing, but as far as I know he agreed with that.

MR CAMPBELL: Just for the record --

A. He didn't really just say anything.

MR CAMPBELL: I think the witness there meant to refer to Mr Zafar.

THE CHAIRMAN: And not Mr Makar, thank you.

A. No, Mr Zafar, yes.

THE CHAIRMAN: Page 95, line 2 of the draft transcript should read "Mr Zafar". Thank you.

MR WOLFE: Have you appraised yourself of Mr Zafar's account of your interaction with him?

A. Yes.

Q. And do you know that he recalls this event rather differently?

A. Yes.

Q. Could I have up on the screen, please, Mr Zafar's first statement for the inquiry, WS025/1 at page 2, please? Maybe go to the next page. I've got a rogue reference in my note.

You see at paragraph 1, Mrs Millar, that Mr Zafar recalls that, on 8 June, he conducted a morning ward round and he saw Raychel:

"She did not complain about nausea or vomit and the ward staff did not mention any vomiting earlier that morning. I have no recollection or knowledge of any vomit at 8 am."

What do you say to that?

A. My recollection is I did tell him that Raychel had

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

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

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

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

fluid because I had advised that the rate of fluid should be reduced. Verbal advice on the ward round would not always be recorded in the medical notes."

THE CHAIRMAN: Mr Zafar's problem is that he hasn't made a record; is that right?

MR WOLFE: That's right. He's made a record, but it doesn't refer to the fluids. He goes on at (iii) to say:

"I advised that IV fluids should be stopped when Raychel tolerated oral fluids."

If we could have the page open in full, please, or zoom out. He goes on to say -- I'm not sure if I can find it on that page -- that he reached the conclusion that Raychel could manage with less IV fluids.

A. No.

Q. Sorry, it's at (d). I'm obliged to my colleague. Raychel could manage with less IV fluids.

A. No, the plan was to start oral fluids. I said, "Raychel's vomited at 8, can we delay for an hour to let her recover?". He agreed to that. The IV fluids were to be reduced, when Raychel was tolerating small amounts, to half around lunchtime, late morning, and to stop them, if all was well, by late afternoon. If he had told me to reduce the fluids, I would have reduced the volume on the Imed pump which we always did when given instructions by the doctors, and I would have

written in my treatment book, communication book, "IV fluids reduced to 40", or whatever they were reduced to.

I have never been given specific instructions on reducing fluids by the surgical medical team. It starts oral fluids and reduce the IV fluids accordingly.

Q. Yes. Well, let me ask you this: Raychel had been prescribed 80 ml per hour preoperatively. She was now out of theatre by the time of this ward round by something in the order of eight or nine hours. Her fluids were continuing at 80 ml per hour. Was it the practice in Altnagelvin at that time to continue the fluids at the same rate post-operatively as was the case preoperatively?

A. Yes, to continue the fluids until the patient was taking adequate oral fluids.

Q. At the same rate as the preoperative rate?

A. Yes. I have never got instructions about reducing IV fluids in children, specifically reduction in IV fluids, in other words to say: reduce the fluid to 30 ml or reduce the fluid to 40 ml. I have never got that.

Q. I'm not talking about any type of oral instruction, I'm -- let me approach it in this way. You will have read perhaps the reports of Mr Orr and Mr Foster, the expert surgeons who have been retained by the DLS/Trust and the inquiry respectively. And you will have read

that they are of the view that fluids post-operatively should be reduced because of the risks of fluid retention. As a general approach within Altnagelvin at that time, were fluids ever reduced post-operatively in your experience?

A. No. It was always once the patient had started to take oral fluids and was tolerating that we would reduce to half, hopefully by lunchtime, and then they would be discontinued by the evening time.

Q. At this stage we were, as I say, eight or nine hours after surgery, Raychel had had a strong overnight recovery, there was no pain, there was no nausea, no vomiting. Everything seemed to be on a even keel; isn't that right?

A. Except for the vomit at 8 o'clock.

THE CHAIRMAN: A single vomit wouldn't overly concern you?

A. No. It wasn't unusual for children to vomit.

THE CHAIRMAN: So there was no real issue of concern?

A. At that point, no.

MR WOLFE: Mr Zafar's thinking is that in light of this smooth overnight recovery, it was appropriate to reduce the fluids, he seems to suggest, immediately, gradually reduce the fluids, introduce sips of water, and gradually stop the IV as oral fluid is tolerated. In what respects do you say that wasn't the plan as you

understood it?

A. He didn't tell me to reduce the fluids immediately. If he had, I would have reduced it on the pump, on the Imed pump, and I would have written it in the nursing notes.

Q. Are you familiar with any of the methods or formulae for calculating paediatric IV fluids?

A. No.

Q. At that time --

A. At that time, no.

Q. So you would never yourself have had --

A. No. But if a child was getting excessive fluid, I mean if Raychel had been written up or getting 100 ml an hour, I would know that that was excessive or if she had been getting 30, 40 ml an hour, I would know that that was too little. But for her age, she was 9, I know it's a guess, but it was through experience over the years that I had seen different age groups get different amounts of fluid, but I did not know how to calculate IV fluids. I was never shown or never educated in that, but certainly, if a child was getting excessive fluids, I would know and I would be very quick to say.

THE CHAIRMAN: So you would know from your experience what was obviously too much or obviously too little?

A. I would, yes.

THE CHAIRMAN: Okay.

MR WOLFE: Mr Foster for the inquiry suggests that maintenance rate for Raychel should have been 65 ml per hour and then that figure should have been reduced by 20 per cent more post-operatively, bringing it down to something in or around 52. Would you have appreciated that that difference, something in the order of 30 ml an hour, was the situation in Raychel's case? I didn't ask that question very well, I'll ask it again.

Would you have appreciated that Raychel's fluids after an operation should be reduced?

A. After, sorry?

Q. After an operation, after surgery?

A. No, that was not the practice at that time and I did not know -- I had never seen it. I had never seen IV fluids reduced. It was always half the fluids around lunchtime if the patient was tolerating, and hopefully they would be gone, they'd be out 5, 6 o'clock, but I had never seen IV fluids reduced immediately on a surgical ward round. Never.

Q. So in terms of the plan, as you understood it, which was to introduce sips of oral fluids, it was your understanding that that should be done after some delay?

A. Yes, because I had said to Mr Zafar, "Raychel has vomited, can we delay?". That was a usual practice that we would delay giving the oral sips, maybe for an hour,

until the child had settled and was able to tolerate.

Q. And that's what was done in Raychel's case?

A. Well, Raychel had vomited at 10 or 10.30, and we didn't at that stage get introducing the fluid until late morning. I think she got some sips and they -- yes, she got some sips before lunchtime.

Q. And did she tolerate them?

A. Well, she vomited again at 1 o'clock.

Q. Was there ever a period when she did tolerate oral fluids?

A. No, she got very little oral fluids during the day because of her vomiting, the vomit at 10 and 1. And I'm not sure if she got any during the afternoon. But I understand she did get some late afternoon.

Q. After Dr Zafar had seen Raychel or perhaps at or about the same time, Mr Makar was present in Ward 6.

A. Yes.

Q. And he came to see Raychel; is that right?

A. Yes.

Q. He made no change to her treatment?

A. No. He came -- as Mr Zafar and I were leaving, he came in the door of the room and I said -- he said he was here to say Raychel. I said, "Raychel's just been seen by Mr Zafar". I didn't go with him, but he did go over to Raychel and he did speak to Mr Ferguson. I wasn't

with him, I had gone out, just outside the door at that stage with Mr Zafar. But they spoke to each other, Mr Zafar and Mr Makar, in passing. They did speak to each other.

Q. In terms of the conduct of ward rounds, did paediatricians have ward rounds as well as surgical staff. Do they broadly follow the same pattern or do paediatric ward rounds take longer or shorter? Are they more involved?

A. They are more involved and take longer, yes.

Q. Is that because the patients have different needs in your experience or is it because surgeons perhaps are in rather more of a hurry to get off to theatre?

A. Well, some of the paediatric patients would have been complex cases, not always, but there could be maybe two owe three children who would have complex needs and those children would take quite a long time to examine, talk to parents, give advice. There may be a child there with prolonged asthma or a child that has been fitting over a number of hours on and off. So those children would need a lot of input. And the consultants or the doctor would be looking at observation sheets, fluid balance sheets and medication and deleting or adding as needed.

Q. In terms of the personnel who attend upon a surgical

ward round, it's notable in the eyes of the surgical expert retained by the inquiry, Mr Foster, that nobody more senior than a senior house officer saw Raychel and nobody more senior than a senior house officer saw Raychel throughout her stay. So it was a senior house officer who attended the ward round and subsequently she was attended by junior house officers until the point of her collapse when the paediatricians came to her assistance.

In terms of the ward round specifically, in your experience, did the consultant attend at that?

A. Did they come that day?

Q. Generally to the ward round, the morning ward round, if we call it that.

A. Not every day.

THE CHAIRMAN: Does that mean that they were as likely or not to be there, or were they even -- I've begun to get the impression that they were there relatively infrequently.

A. Yes, that would be correct.

MR WOLFE: If a consultant under whose care a child is admitted can't see a child at the ward round, would you expect him or her to make arrangements to see the child at a later stage in the day?

A. Well, usually the registrar came. It would usually be

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

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

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

MR WOLFE: Senior house officer.

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

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

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

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

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

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

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

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

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

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

A. During the morning period?

Q. Yes.

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

Q. Post ward round?

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

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

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

A. Yes.

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

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

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

A. Yes.

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

A. Yes.

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

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

slightly stooped over ..."

Mr Ferguson is clear in his witness statement that he wasn't at the hospital at that time, Mrs Millar.

A. No, I am absolutely clear that I saw Mr Ferguson walking with Sarah [sic] to the toilet on two occasions between 12 and 1.45.

THE CHAIRMAN: Raychel.

MR WOLFE: You used the name Sarah there to describe her.

A. I'm sorry, Raychel, I'm sorry. I apologise.

Q. And by contrast with your account again, Mrs Millar, Mrs Ferguson recalls that she in fact carried her child to the toilet at midday because the child had become increasingly unwell during the morning, needed to go to the bathroom, and as she was about to leave the bathroom, she produced a large vomit of undigested food into the sink, and she reported that incident to -- I think she describes "a small nurse with dark hair".

Clearly, both versions of events cannot be correct. Either Mr Ferguson was in the hospital or he wasn't.

A. No, I saw Mr Ferguson with Raychel on two occasions between those times.

Q. If we move the time parameters, could you be mistaken in terms of the time?

A. No. No, because I -- it was definitely over the lunchtime period. And usually, the nurses are divided

into two groups for lunch and the first group go about 12/12.15. I would have stayed back, I didn't go to early lunch because I would cover for their absence in answering the telephone and dealing with parents, and I'm absolutely sure that I saw Mr Ferguson twice with Raychel going to the toilet.

Mrs Ferguson, I saw her -- when I came in in the morning at 7.30, and went into the room to collect the chair, Mrs Ferguson was there. When I came back after the handover report, she wasn't in the room.

Q. On Mrs Ferguson's account, again, I don't have the precise timing my head --

A. Well, about the precise timing ... But I didn't see Mrs Ferguson from approximately 9 o'clock until I came back over to the ward, around 5, and Mrs Ferguson was sitting at the bed with Raychel.

Q. Of course, Mrs Millar, if you'd been complying with the requirements of the episodic care plan to record Raychel's urine output, you would have engaged with whoever brought Raychel to the toilet to discover whether there was anything to report for the purposes of the fluid balance chart.

A. Yes.

Q. Given that that was an obligation and given that you say you knew Raychel was going to the toilet, can you

explain why you didn't complete the record if it is the case that you did see her going to the toilet?

A. I did see her go to the toilet and I should have either documented it myself or I should have asked somebody else to document it. I didn't.

Q. So if Mrs Ferguson was there during the morning from 9.30 to 3 o'clock, you couldn't have failed to see her; is that what you're saying?

A. Yes, if she was there, I would have seen her. I didn't see Mrs Ferguson from 9/9.30 until I came over to the ward at 5 o'clock. I'm not saying she wasn't there, but I didn't see her, and I was in the room on several occasions before 11 o'clock that morning.

THE CHAIRMAN: If she was there in Altnagelvin, the place where she was most likely to be was at Raychel's bedside.

A. Yes, or --

THE CHAIRMAN: She might go off to the toilet or she might go off to get a coffee or something.

A. She may have gone for a coffee or to the canteen.

THE CHAIRMAN: That's right. So although she's in the hospital because she's worried about Raychel, she wants to be at Raychel's bedside, parents don't automatically sit there non-stop for three or four hours.

A. No, mostly they come and go.

THE CHAIRMAN: And in a sense that's the easy bit. But the more difficult bit is the suggestion that you saw Mr Ferguson, who says he wasn't there. That's the more difficult bit to sort out, isn't it?

A. No, I saw Mr Ferguson, yes.

THE CHAIRMAN: Thank you.

MR WOLFE: So if we can turn to just examining your view of Raychel's condition through that morning. You've told us that during the morning Raychel became more mobile and was able to walk to the bathroom with her father, she was sitting at the table colouring in, she was generally bright and happy, albeit that you note that she vomited at 10.30 and again at 1 o'clock. You say that you weren't concerned because vomiting was not an unusual feature in children post-operatively.

A. Yes.

Q. Whereas by contrast, Mrs Ferguson would say that when she arrived at the hospital she found a happy, content child at or about 9.30, colouring in, with materials that her father had brought up from the hospital shop, but that from in or around 11 o'clock she began to become increasingly unwell, producing a slime-like vomit, and then at 12 o'clock she had what Mrs Ferguson describes as a large or significant vomit, which she reported. Moreover, a Mrs Duffy, who was the mother of

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

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

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

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

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

with me --

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

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

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

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

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

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

A. Yes.

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

got the call during the afternoon from Nurse McAuley?

A. No, there was a 1 o'clock vomit, and I was aware of that through Nurse Roulston.

THE CHAIRMAN: Okay.

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

A. No.

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

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

Q. Yes.

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

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

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

THE CHAIRMAN: Review?

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

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

He says:

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

And it seems to be his view that:

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

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

the toilet -- I saw her on two occasions -- but knowing now what I didn't know then, at that stage, I would have called a doctor.

THE CHAIRMAN: I think the difference is that the experts who are saying this, they're not saying, looking back on it with hindsight, that's what should have happened. They're saying, by the standards of 2001, that's what should have happened. But that's not your experience?

A. No, it wasn't.

THE CHAIRMAN: Sorry, can I ask you it this way -- and if you can't answer this, just tell me -- how many vomits would it take for you to call in a doctor?

A. Well, when she vomited at 3 o'clock -- it would depend on the volume of the vomits and the frequency.

THE CHAIRMAN: So what swung it for you was when Nurse McAuley told you, at some time after 3, that Raychel had vomited again, that went from three vomits in five hours to four vomits in seven hours and, for you, that was time to get the doctor?

A. Yes.

THE CHAIRMAN: Okay.

MR WOLFE: If we look at the fluid balance chart, please, at 020-018-037, you can see the vomits documented there. You've said on a number of occasions that the vomits weren't large, but of course Nurse McAuley documented

a large vomit, and you also saw that vomit. Presumably, you had a discussion about it, if both of yous are seeing the vomit at or about the same time.

A. I can't remember. I did ask Nurse McAuley to dispose of the vomit. I can't remember if we had any discussion on it.

Q. You say you asked her to dispose of it. Why didn't you dispose of it yourself if you saw it?

A. Because I was on the ward round with the paediatricians --

Q. Right.

A. -- so I asked her to do it.

Q. Okay. So she saw it and formed her view that it was large.

A. Yes.

Q. But if you had been writing up the notes, you wouldn't have written "large"?

A. Well, that particular vomit, I would have said, "Small to medium", or two pluses.

Q. What's one plus?

A. Small.

Q. What's two pluses?

A. Medium, approximate.

Q. And three pluses is large?

A. Would be large or -- yes.

Q. So you have two medium vomits here. One at 3 o'clock, one at 1 o'clock, and a vomit that was described as large that you are now calling small.

THE CHAIRMAN: Small to medium.

MR WOLFE: Small to medium. Was the fact that you were of the view that that was a small-to-medium vomit a factor in you deciding not to call the doctor in at about 1 o'clock?

A. Yes. I didn't see the vomit at 1 o'clock, but Nurse Roulston informed me that it was not a large vomit. And Raychel was not appearing to be in any distress or in any difficulty. So I was still happy with her condition at that time.

Q. So just to be clear, the one at 10 o'clock is small to medium?

A. Yes.

Q. Is that what you told the coroner?

A. I'd say it was more small than medium.

Q. Could we have up on the screen, please, 098-018-044, please? This is a note composed by counsel or solicitor for the Trust at the inquest. Perhaps it's on the page before, 043. If we could have 043 and 044 up together, please.

We need to start at the bottom of the left-hand page:

"It was put that at 10.30 am there was a large vomit, which the sister [that's yourself] described as medium to large."

Do you see that?

A. Yes.

Q. Trusting to the accuracy of this note, do you think that's what you said?

A. I presume I must have said that if it's documented. But the vomit was no more than a small to medium vomit.

THE CHAIRMAN: I'm not sure where -- frankly, Mrs Millar, I'm not sure how I can accept that. The hospital note at the time says, "Large". You are asked at the inquest and you say, "Medium to large", and you now say "small". How can it get smaller as the years go on?

A. The vomit that I saw at 10.25/10.30 was not a large vomit.

THE CHAIRMAN: Okay.

MR WOLFE: You see, in order to explain the fact that a doctor wasn't involved much before 6 pm in the evening, you justify your position by suggesting that the vomits were small or medium.

A. Yes.

Q. Whereas in fact, you didn't know how much was produced in the 8 o'clock vomit; is that right?

A. No, I didn't see that, no.

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

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

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

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

of the documents and on what Mrs Noble says between what was discussed and faced up to internally and what the Fergusons were told when they met the Altnagelvin. I think, since you're going to be asked to cover some of the same ground as a person who was at both meetings, it would help you because you say your memory's a bit short on that area. Okay?

MR CAMPBELL: I think that would be helpful too.

THE CHAIRMAN: If we do that, that means that when we get up to the stage this evening of the critical incident review and the later meeting, we can stop at that point and give Mrs Millar the transcript.

MR CAMPBELL: Is the plan to start with Mrs Millar tomorrow?

THE CHAIRMAN: Yes, we'll start with Mrs Millar tomorrow so she's finished tomorrow morning.

MR CAMPBELL: Very good.

MR WOLFE: Mrs Millar, just before we enter the afternoon phase of Raychel's care on 8 June 2001, you've said repeatedly that, with the benefit of hindsight perhaps, that by 1 o'clock, when you think about it, knowing what you know now, a doctor should have been brought to Raychel. Do you agree with me that really if you had thought about it and thought about the issues at that time, applying the standards of that time, the three vomits in the morning ought to have led you to encourage

a doctor to attend Raychel?

A. Well, if I had known what I know now at that time, 12 years ago, I think as I said earlier, I would have called a doctor at that time. But I was still content with Raychel's progress at that time and up until I had left for lunch, I still -- but looking back and with hindsight, it would have been maybe prudent to have called a doctor, but at that time I was still happy with her progress.

Q. You would accept that when a child is vomiting, producing three sets of vomits, that's very likely to be uncomfortable for a child?

A. That's right, it would be.

Q. It would be stressful for a young child?

A. Yes, but as I say, Raychel's condition appeared to me to be -- she wasn't complaining of pain. Staff Nurse Roulston had -- I think it was 1 o'clock her observations were done, as far as I can recall.

Q. Yes.

A. And she had said, as far as I know, at that time, "not complaining of pain". I hadn't seen Raychel vomit. It's not a pleasant experience, I accept that. But she didn't give me -- her general demeanour, her appearance, and what the nurses were telling me, I wasn't alarmed at that stage.

Now, I didn't see Raychel at 1 o'clock in between the time her dad took her to the toilet, between -- I saw her walking, but I didn't see her in her room. I hadn't been in the room.

Q. Yes. A doctor attended to deal with the prescription of fluids at 12.10, Dr Butler --

A. Yes.

Q. -- who was the senior house officer on the paediatric side. Did you have any dealings with her when she attended?

A. No.

Q. By this stage, Raychel's fluids had been running for some 14 hours or so, and Dr Butler was being asked to write up a second bag of Solution No. 18, by which stage Raychel had vomited at least twice on the record, if not more, according to her mother. Should that doctor have been advised of the vomiting prior to writing up a further bag of Solution No. 18?

A. Well, I'm not sure what the nurse said to Dr Butler, but at that stage she would have told Dr Butler that Raychel had vomited --

Q. Sorry, I am not asking that question. I'm asking: should the doctor have been advised of the vomits?

A. Well, I presumed she did know about the vomits.

I wasn't with her when she came, but I'm sure when -- the nurse who was with her probably informed her. I cannot be sure on that point.

Q. That's why I'm asking the question in the way I am. Should she have been informed of the vomits?

A. Yes, she should.

Q. You can't say whether she was informed?

A. No.

Q. The issue of vomiting is clearly a key issue in determining the need for or the type of intravenous fluids. Moreover, here was an opportunity to appraise a doctor of vomiting and ask her to review the child; isn't that right?

A. Yes. Well, I understood that -- I didn't see Dr Butler, I didn't have any dealings with her. But I understood she was asked to write up the prescription.

Q. Yes.

A. I'm not -- I cannot -- I do not know what was said to her, but I would expect that she was asked to write up the IV fluids.

Q. Yes.

A. And I cannot say whether she was informed of the vomit, of her vomiting.

Q. Dr Butler was an SHO on the paediatric side of the house. Would it be common practice at that time to, if

you like, simply grab any doctor coming through the ward to write up a further bag of fluids, or should the surgical team have been contacted for that purpose?

A. Well, it was mostly the surgical team who wrote up the surgical patients, but if we were unable to get them, we would ask one of the paediatric staff.

Q. And should efforts be made to obtain the attendance of somebody from the surgical team?

A. The usual thing was to contact one of the surgeons. That was the usual procedure.

Q. And do you know whether any attempt was made in this case at 12 noon or thereabouts to do so?

A. I'm not -- I cannot say. I don't know. I don't know.

Q. You see, the expectation at ward round was that sips of fluid would be introduced slowly perhaps and then gradually reduce the need for intravenous fluids.

A. Yes.

Q. But clearly, by 12 noon, that wasn't happening.

A. No, we had made several attempts, I think, to introduce later in the morning, but Raychel had vomited at 1 o'clock.

Q. So the plan that Dr Zafar articulated wasn't going to plan, if you like, wasn't working as expected.

A. Raychel wasn't following the plan that we had hoped for her.

Q. And the surgical team had not been advised of that?

A. No, not at that stage.

Q. Into the afternoon of 8 June, you go to your office from after your lunch break, your lunch break starting at 1.45 --

A. Yes, I probably went to my office before 2.30.

Q. And prior to that, you were aware of Raychel's condition, the fact that there had been three vomits, a decision, it would appear, had not been taken to contact a doctor to assess that. Had you any plan to have Raychel's progress monitored as the day went on, or was she still on the four-hourly observations?

A. Yes, well, she was still on her four-hourly observations. I know that Nurse Roulston had no concerns about her. Of course there was concern about -- there's concern about every child on the ward, but no significant concerns. Raychel was still mobilising and she had started to take some little drinks, but obviously had vomited at 1 o'clock. So up until then, I didn't have any worries about her, and as I say, I saw her walking to the toilet twice before I went off to my lunchtime.

Q. So the last physical sight that you had of Raychel prior to going off at lunchtime, you say, was seeing her father bringing her to the toilet at some time between

1 o'clock and 2 o'clock?

A. Yes. And before I went off duty at half five, I saw her in her bed. In between times, I didn't see her.

Q. We'll come to that. Mr Ferguson returned to the hospital between 1 and 1.30. He tells the inquiry in a witness statement that Raychel seemed to be going downhill. She was not speaking properly, she was in bed, and he took three kidney trays of vomit out to the nurses during that period of time.

Those vomits, on his account, occurred before he left the hospital at 3 o'clock. They don't appear to have been recorded, unless one of them is the 1 o'clock vomit in the fluid balance sheet. Could I ask you this: when a child vomits and perhaps vomits repeatedly within a short period of time of, say, an hour or so, are nurses expected to record each single episode, for example each single kidney tray, or might they take an abbreviated approach and record all vomits in a period as being one vomit?

A. No. Raychel was on her four-hourly observations and if we had seen Raychel to be copiously vomiting, vomiting continually, increasing drowsiness, we would have done her vital signs more regularly, maybe every two hours. But we did not see any vomits other than what are documented in the fluid balance sheet.

Q. Sorry, my question was a specific one, Mrs Millar. Do you need me to repeat it?

A. Yes.

Q. The question is this: if a child vomits more than once within a confined period of time, say up to one hour, say a child vomits three times into three separate kidney trays within that period, would the nurse be expected to record three separate episodes, or, alternatively, because it's within a period of time, would that be regarded as one vomit?

A. No, the episodes should be recorded.

Q. Mrs Ferguson recalls, by contrast with Mr Ferguson, who recalls three kidney trays being brought out to nurses, she recalls two kidney trays full of vomit being brought out to the nurses before 3 o'clock in the afternoon. She was being told by nurses that Raychel's stomach was empty and she wouldn't vomit any more.

If Raychel was vomiting into the early afternoon, as is described, on top of a vomit at 1 o'clock, that would have been an indicator for bringing a doctor in; isn't that right?

A. Yes, if she was, yes.

Q. During this period of the early afternoon, I suppose you were reliant on your nursing staff to make reports to you of what was going on in the ward --

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

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

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

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

and there were other people around her bed; I'm not sure who they were. There was maybe one other person. But Mrs Ferguson was there. I didn't see Mr Ferguson. I hadn't got any information from the nurses on return to the ward that Raychel was in great difficulty. I had asked for the doctors to see her, to give her an anti-emetic, and I had hoped that when she got that, she would settle. But I didn't speak with Dr Devlin.

Q. Mrs Ferguson has described her child as being listless during that period of the afternoon. That was an issue that was raised with you during the coroner's inquest; do you recall?

A. Yes.

Q. And you are recorded as having agreed with the description that Raychel was listless.

A. Well, it was put to me --

Q. Isn't that correct?

A. That is correct, but it was put to me that Mrs Ferguson had thought or said that Raychel was listless and, in my answer, I was saying that children's parents know them very well and we would always work alongside parents in caring for children and we would listen to parents and their concerns. But in my opinion -- and this was my opinion and the nurses who I had spoken to -- I would not have said that Raychel was listless.

Q. Could I just put on the screen, please, the record of what is recorded in respect of the coroner's inquest, 098-018-044? Again, allowing for the fact that these are notes made by counsel or solicitor, the note says at the end of the first paragraph:

"It was further put to her [that is yourself] that Mrs Ferguson had thought the child was unwell during the period. The sister had no concerns. The sister said she would be prepared to agree with the description of Raychel as being listless."

And then we see in your witness statement to the inquiry that you deny that Raychel was listless, in fact. Are you saying that what has been recorded here hasn't captured the answer that you gave to the coroner correctly?

A. Yes. It was put to me, as I say, at the coroner's inquest that Mrs Ferguson felt that Raychel was listless. And being her mother, I would have to -- I wouldn't argue with that, I can't argue with that. That was her opinion and I wouldn't argue with a mother who said her child was listless. But in my opinion, and in the nurses that I spoke to about Raychel and the observations and the communications that I got from nurses, I could not say that -- I would not agree that she was listless.

Q. Well, one can -- sorry, Mr Campbell.

MR CAMPBELL: Mr Chairman, there is also the handwritten note at the end of her deposition, which has appeared earlier before us, which might be useful to consider at this stage in this context.

MR WOLFE: 012-041-204.

THE CHAIRMAN: She says, "I would not agree that Raychel was listless that day".

MR WOLFE: So there's a dispute between the records. But just to be clear, you would say that if it's counsel -- I think we have written, sir, to the DLS to seek to establish the origin of the note that I earlier referred to. It's got a Brangam Bagnall facsimile record at the top of the page, the last record we just looked at.

THE CHAIRMAN: I'm rather compelled, Mr Wolfe, aren't I, to go with the note that's signed by Mrs Millar?

MR WOLFE: Of course.

You, of course, were dependent upon communications to you from your nursing colleagues during the afternoon because, while you arrived at the ward at 5 o'clock, you hadn't seen Raychel for three hours.

A. Yes.

Q. And as I understand the position, while you saw her through the glass door of the room, you didn't go and examine her at or after 5 o'clock in the afternoon.

A. No, that's true.

Q. Was she lying on the bed when you saw her at 5 o'clock?

A. Yes, she was lying on the bed, yes, and she appeared to be sleeping. And her mother was with her.

Q. So in terms of your independent personal observations, you couldn't personally gainsay what Mrs Ferguson has said in description of her daughter.

A. Well, I wasn't there, as you know, in the afternoon. But during the morning I could not describe Raychel as listless. And when I returned to the ward in the afternoon, around 5 o'clock, if there had been concerns about Raychel, I would have expected the nursing staff to tell me that, you know, she was not well and that things were ...

Q. Yes. You would also expect nursing staff to be making records of all relevant vomits; isn't that right?

A. Yes.

Q. And if the fluid balance chart is to be accepted, there were no further vomits between 3 o'clock and 9 o'clock; isn't that correct?

A. Yes.

Q. Maybe if we get that up on the screen. The fluid balance chart is ...

THE CHAIRMAN: 020-018-037.

MR WOLFE: That's it, yes.

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

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

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

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

sending out was that the anti-emetic was no longer having an effect, it had ceased to have an effect, presumably because Raychel had become nauseous again or was, in fact, actually vomiting.

A. Well, as far as I know, Raychel didn't vomit again during that period to Nurse McAuley going off.

Q. Mrs Ferguson --

THE CHAIRMAN: Sorry. When you say didn't vomit again, what is your starting point from when she didn't vomit?

A. From 3 o'clock. I know there was the vomit that Dr Devlin said he saw. That was not reported to us or Nurse McAuley didn't see it.

THE CHAIRMAN: But then, so far as you know, she did vomit again.

A. No.

THE CHAIRMAN: Well, unless we disbelieve Dr Devlin, and frankly there's no reason to accept that Dr Devlin saw her vomit at 6 o'clock and say the Fergusons are wrong and that she vomited at 5 o'clock, is there? I mean, we don't believe Dr Devlin because he's a doctor and disbelieve Mrs Ferguson because she's a parent.

A. I thought he saw her at 5 o'clock --

THE CHAIRMAN: Dr Devlin saw her at 6 and Mrs Ferguson says that Raychel vomited at 5 or about 5.

A. Right.

THE CHAIRMAN: None of that ends up in the fluid balance sheet. But we're assuming that Dr Devlin is right, that he might remember when a child he has been called to see vomits, but we'd also assume that Mrs Ferguson is right. So after your attention, on your recollection, is drawn to this by Nurse McAuley at about 3-ish, and you say, "Get a doctor", there are at least two more vomits, one at about 5 and one at about 6.

A. Well, as I say, they weren't reported to Nurse McAuley and I have no --

THE CHAIRMAN: Is Dr Devlin capable of making an entry about vomit?

A. He is, yes. He would have reported that vomit to one of the nurses or certainly would have mentioned it before he left the ward. I would have thought he would.

MR WOLFE: If there was no vomiting between 3 and 6 o'clock, can I suggest to you that the need for an anti-emetic by 6 o'clock perhaps could have been reconsidered? Whereas if Dr Devlin is right, that in fact there's active vomiting, if Mrs Ferguson is right that there was vomiting at 5 o'clock, that explains why there was a continued need for an anti-emetic.

A. Well, I think what happened was that we had tried to get a doctor from 3.30 or whatever time I had asked Nurse McAuley, and we were unable to get one of the

surgical doctors. And maybe the situation could have been reviewed when Dr Devlin came. But I was still anxious that Raychel should have her anti-emetic. I did not know if Raychel was going to vomit again. That was something I didn't know. I hoped she wouldn't, but I still felt that it would be prudent to give her the anti-emetic, and I would probably expect Dr Devlin to ask Mrs Ferguson how Raychel was and assess her as to whether there was a need for her to have the anti-emetic at that stage.

Q. Assuming that there was an ongoing need for Raychel to have the anti-emetic -- and that appears to be the view that you reached -- was it acceptable that somewhere between two hours and three hours passed by before the doctor's actually brought to the bedside to administer an anti-emetic?

A. No, that was too long.

Q. And it would appear that the approach that was adopted by Staff Nurse McAuley was using the bleeping system to try to attract a junior house officer on the surgical side. You have said that your understanding of why you couldn't get a JHO there was because the JHOs were in surgery.

A. Yes.

Q. Who told you that?

A. No, I assumed that. I wasn't told that. When I rang and asked Nurse McAuley had she got a doctor, she said no. But I didn't know at that stage they actually hadn't answered their bleeps. When I went over to the ward, as I say, I saw Dr Devlin, but I had assumed that she had either contacted the junior house officer or even maybe Mr Zafar, and that they were in theatre, because the usual thing was that they would answer the bleep via a nurse in a clinic or in theatre, and that's what I thought had happened. But that was my assumption; I didn't ask if she had contacted anybody specifically.

Q. You assumed that Nurse McAuley had attempted to contact Dr Zafar or Dr Makar, according to your statement to the inquiry.

A. Yes. That's who I assumed she had contacted.

Q. They were the senior house officers.

A. Yes. They were the two doctors that saw Raychel in the morning.

Q. Yes.

A. It would have been prudent to have got them back, if we could, to see her because they had seen her in the morning.

Q. Were your instructions for her to contact a junior house officer or a senior house officer?

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

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

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

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

afternoon, it ended up later than you thought because it didn't come until about 6 o'clock. But if that didn't work --

A. Then after that, when Raychel vomited, I think again at 9 o'clock -- I think it was 9 o'clock --

MR WOLFE: Just to be clear, Mrs Ferguson has the child vomiting within one hour of the anti-emetic being administered.

Then a visitor to the hospital at 8 o'clock -- I'll come to the name tomorrow perhaps -- observed the child vomiting when he arrived to visit his daughter in the same room.

THE CHAIRMAN: Mr Duffy?

MR WOLFE: Mr Duffy.

A. Yes.

Q. If I can put it in these terms: the characterisation of the anti-emetic having fair effect, which was written by Staff Nurse McAuley before she went off duty at 7.30, we understand, that's consistent with the child becoming nauseous again.

A. Yes, well, I wasn't on duty at that time.

Q. No. We can ask her about that.

A. It's difficult to say. But I understand that there were no recorded vomits between the 3 o'clock and the 9 o'clock, I think.

Q. Yes. And clearly, if Dr Devlin is to be believed, if Mrs Ferguson is to be believed, and Mr Duffy is to be believed, that note --

A. Well, from what I understand, the staff or the nurses were not informed of these vomits, they were not aware of them.

THE CHAIRMAN: Sorry, Dr Devlin is a member of staff. A member of staff was aware of the vomit at 6 o'clock because he had witnessed it.

A. Yes. Yes, I'm not saying that he didn't see it or that Raychel didn't vomit, but we did not know about it.

MR WOLFE: You went off duty at some time between 5.30 and 6 o'clock.

A. Yes.

Q. And as I think we've established this afternoon, you didn't examine Raychel during that late afternoon period.

A. No.

Q. You saw her at a distance and she was sleeping.

A. Yes.

MR WOLFE: Very well.

Sir, could we leave it now until the morning? We have one segment of evidence to deal with.

THE CHAIRMAN: Yes. What I'm now going to give Mrs Millar to look at is the evidence that Mrs Noble gave yesterday

afternoon, on 27 February. It has been printed out from page 167 onwards. It runs through to page 201. There's probably stuff towards the end which is some legal exchanges, but it starts at page 167. The full transcript is on the inquiry website, but that's for your convenience, Mrs Millar. If you could take a while to look at that tonight, it might help your evidence tomorrow morning.

MR CAMPBELL: Chairman, can you just confirm that I have permission to speak about those notes with the witness tomorrow morning, as opposed to her evidence?

THE CHAIRMAN: Sorry, about which note?

MR CAMPBELL: The transcript from yesterday.

THE CHAIRMAN: I'm doing this in ease of your client in order to facilitate her giving evidence tomorrow morning. I'm making available to her in hard copy a document which she would have access to anyway if she had turned on the inquiry website. I don't really think it's appropriate for you to consult with her about that portion of the evidence before she gives it.

MR CAMPBELL: Very well.

THE CHAIRMAN: Unless there is anything further, we'll resume tomorrow morning at 10 o'clock.

Mrs Millar, we'll finish your evidence tomorrow morning and then we'll get Mr Zafar's -- he is flying in

tomorrow morning and we'll get through his evidence tomorrow. Thank you.

(5.00 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X