

1
2 (10.00 am)
3 (Delay in proceedings)
4 (10.15 am)
5 MRS ANN NOBLE (continued)
6 Questions from MR WOLFE (continued)
7 MR WOLFE: Good morning, Mrs Noble.
8 A. Good morning.
9 Q. I want to take up where we left off yesterday, which is
10 with Raychel coming back from theatre to Ward 6 after
11 her appendicectomy. As I understand the position, you
12 were on your break when Raychel was at theatre.
13 A. Yes.
14 Q. And when you arrived back, you tell us in your witness
15 statement that you were told that Raychel had a mildly
16 congested appendix.
17 A. Yes.
18 Q. Who would have informed you of that?
19 A. I think it was Staff Nurse Patterson.
20 Q. Staff Nurse Patterson was the nurse who had gone to
21 theatre to fetch Raychel back to the ward, if you like.
22 A. Yes.
23 Q. And it was your responsibility, or partly your
24 responsibility, during the early hours of the morning to
25 carry out observations with respect to Raychel.

1

1 entry from the top. That is in fact the first entry
2 made post-operatively; isn't that correct?
3 A. That's correct.
4 Q. And it's made by Staff Nurse Patterson. I can't read
5 her writing. If you can help us perhaps ...
6 A. "Sleeping but easily roused on return to ward. Wound
7 site satisfactory."
8 Q. Yes. And then Nurse Patterson makes the next entry:
9 "Sleeping [again], wound site satisfactory, colour
10 pink."
11 Then you make the rest of the entries up to 5 am;
12 is that correct?
13 A. That's correct.
14 Q. Without going through each of them, if you briefly look
15 at the observations, temperature, pulse, blood pressure,
16 respiratory rate and the comments, is the summary of the
17 position that Raychel is progressing satisfactorily and
18 there's no cause for concern or alarm?
19 A. That's correct.
20 Q. You tell us in your witness statement that you had
21 a brief conversation with the parents at the point of
22 observations.
23 A. Well, I would normally speak to the parents and maybe
24 just reassure them that everything looked okay and
25 everything was fine. I don't recall the exact

3

1 A. Yes.
2 Q. And as we noted from the care plan yesterday, initial
3 observations post-operatively are quite close in time.
4 In other words, there's observations every 15 minutes
5 for the first, I think, two hours, correct me if I'm
6 wrong.
7 A. Yes.
8 Q. And then stretching into half hourly and then hourly,
9 and then for the rest of the day, four-hourly.
10 A. Yes.
11 Q. Perhaps if I could just take a look at those. There's
12 a document at 020-015-029, if we could have that on the
13 screen, please. I think this is the first time we've
14 looked at this document. We can see that at the top of
15 the page it was opened by Staff Nurse Patterson, who
16 made an entry at 9.50, which was preoperatively, and
17 various observations are made: temperature, pulse, blood
18 pressure, respiratory rate, and a pain rating. Then
19 there is an opportunity to make comments in the
20 right-hand margin. As we can see, this was completed
21 throughout the day with the last entry being 9.15, by
22 which time you had come back on to duty; isn't that
23 right, Mrs Noble?
24 A. That's correct.
25 Q. We can see if we pick up on 1.55 am, that's the second

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1 conversation I had with the parents. I think I might
2 have advised one of the parents to go home, as Raychel
3 was so well settled, and I think I remember saying that
4 it might be better if one of them went home to have
5 a sleep because Raychel would probably need them
6 better -- more the next morning when she was awake and
7 mobilising.
8 Q. One of the parents, Mr Ferguson, remembers -- we see
9 this in his witness statement at 021/1, page 3, we
10 needn't bring it up on the screen. He remembers you
11 being quite abrupt and telling the parents that only one
12 of them could stay; is that your recollection?
13 A. I don't recall being abrupt. I would make them aware
14 that it was hospital policy and ward policy that only
15 one parent should stay at night, but I didn't force
16 anybody to leave.
17 Q. In any event, Mrs Ferguson left the hospital in the
18 early hours of the morning; do you remember that?
19 A. I don't remember her leaving, no.
20 THE CHAIRMAN: Do I take it from that that you don't
21 remember her leaving, but that you do recall that she
22 left, so there was only one parent who stayed? Or are
23 you unsure?
24 A. I'm unsure of the exact ...
25 MR WOLFE: Given that we have this document up on the

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1 screen, I want to ask you some questions about the whole
2 issue of record keeping and note making, which is
3 an issue which the inquiry wishes to examine. A concern
4 has been expressed by some of the experts retained on
5 behalf of the inquiry about the absence of note keeping
6 or note making by nurses particularly during the day of
7 8 June. It's suggested by those experts that there
8 might have been an under-recording of Raychel's symptoms
9 and particularly her vomiting. That's obviously
10 something that we will test out as we go along. But
11 I just want to ask you about the importance of note
12 keeping and the facilities available to nurses for note
13 keeping. In your experience and practice, what is the
14 importance of note keeping or recording of a patient's
15 symptoms?
16 A. So that the person -- another person coming on, taking
17 over from that nurse who had been looking after the
18 patient, could see exactly what happened and could see
19 from the observations chart an exact idea of the
20 condition of the child throughout the day.
21 Q. Yes. So, for example, if a nurse comes on duty not
22 having had any experience or exposure to a particular
23 patient, they should be able to pick up --
24 A. Yes.
25 Q. -- the notes and say, "That's what happened to that

5

1 might have with them when you go to see Raychel to make
2 the observation?
3 A. Yes, at that time.
4 THE CHAIRMAN: There's a reference to vomiting in the very
5 last entry at the bottom of the page at 9.15, isn't that
6 right, 21.15?
7 A. Mm-hm.
8 THE CHAIRMAN: Does that mean that there was vomiting at the
9 time of the observation, but from the absence of any
10 reference to vomiting earlier in the day it means that
11 there was no vomiting at the specific time of the
12 observation?
13 A. I can't speak for whoever wrote in the vomiting at that
14 time, whether they had just noted the vomiting at that
15 time or whether they had been informed of the vomiting.
16 THE CHAIRMAN: Okay. So if Claire was vomiting, let's say
17 between 1 pm and 5 pm -- there was certainly some
18 vomiting around 3 o'clock and there's an issue around
19 how often, but do I understand your evidence to be that
20 the reason why that is not on this observation sheet is
21 probably because she was not vomiting at the time of the
22 observation at 1 pm or at the time of the observation at
23 5 pm?
24 A. Yes.
25 THE CHAIRMAN: So we have to look elsewhere to find a record

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1 child or patient in the last five hours", for example?
2 A. Yes.
3 Q. The document that we have in front of us, one can see
4 that -- if we look at the period from 9 am to 5 pm, I'm
5 conscious of course that you aren't on duty during that
6 period, but we don't see any record in that period of
7 the four vomits that are otherwise recorded in the fluid
8 balance chart. Could you tell me whether this document
9 is designed for the purpose of recording features or
10 episodes such as vomiting?
11 A. The fluid balance sheet would be the ideal place to
12 record vomiting, but personally if I had witnessed it,
13 I might have recorded in the comments column that the
14 child had been nauseated and vomited as well, but
15 I wasn't on duty during the day.
16 THE CHAIRMAN: Can I get this clear from you? This sheet is
17 the observations sheet that you're going back at
18 30-minute intervals and then hourly intervals and
19 two-hourly intervals. So does that mean that you only
20 record on that sheet what you actually see at that
21 specific observation?
22 A. Yes, or I would even record if the parents had expressed
23 any concerns or, if I had noted the parents to be overly
24 anxious, I would have also written something like that.
25 THE CHAIRMAN: Yes, but is that from a discussion which you

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1 of vomiting?
2 A. Yes.
3 THE CHAIRMAN: Right.
4 MR WOLFE: If we go to document 020-016-031, and if we could
5 have that up on the screen with the next page, 032.
6 Each of these documents, as is clear, are called
7 observation sheets, same piece of stationery. There's
8 one for 7 June and one for 8 June. The one on the
9 left-hand side records Raychel's condition at about
10 8 o'clock when she first came to the hospital or shortly
11 after coming to the hospital. And then the one on
12 9 June records the particular episode of Raychel's
13 seizure and the nursing events that flowed from that.
14 So for example, as we understand it, Nurse Gilchrist
15 recorded blood pressure on that sheet, but I think -- is
16 the top part of the sheet your entry, "Child found on
17 side"?
18 A. Yes, that's all my writing on that page.
19 Q. My question at this stage is simply limited to: what is
20 the purpose of this kind of observation sheet by
21 contrast with the observations we've just looked at?
22 A. The previous observation sheet was usually used when
23 a child would have come back from theatre and this
24 particular observation sheet on 9 June was a close
25 observation sheet. And the one on 8 June was

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1 discontinued and a four-hourly graph chart had been used
2 because they felt that Raychel's observations had been
3 stable enough to go on to a graph sheet. And then when
4 she fitted, I found it was necessary to start a close
5 observation sheet about her.
6 Q. I'm not sure I picked you up correctly. You said the
7 one for 8 June was discontinued.
8 A. Yes, the one of 8 June, the last entry by Staff
9 Nurse Gilchrist, she had documented at 21.15, and she
10 had mentioned her vomiting. And then whenever the girls
11 went to do their observations again at 2 am, there was
12 a graph sheet that was used.
13 Q. Yes. Sorry, what I am anxious to explore before we go
14 to the graph sheet is: should there not have been
15 a similar observation sheet in place to record
16 significant episodes that occurred during the day of
17 8 June? In other words, we have this observation sheet,
18 one for 7th, one for the 9th. Obviously they record, if
19 you like, significant episodes, Raychel coming into the
20 hospital and her condition at that time, 9 June,
21 Raychel's seizure. But would you not expect to find one
22 for 8 June, for example recording the passage of vomits
23 that occurred during the day?
24 A. Well, the one on 8 June, that was a nurse during the
25 day, she obviously felt that there was enough space to

1 A. In conjunction with, yes.
2 Q. And indeed, looking at this document -- and we'll come
3 on and look at the evening and night of 8 June
4 presently -- if one looks at it towards the bottom, you
5 can see a space for vomiting.
6 THE CHAIRMAN: This is the second line from the bottom?
7 A. Yes.
8 MR WOLFE: So whoever was completing this was not fully
9 completing it.
10 A. That's correct. We wouldn't normally have written about
11 the vomiting in those sheets, we would have concentrated
12 our observations on the fluid balance sheet at that
13 time.
14 Q. So if a doctor came along and decided simply, for
15 convenience or for whatever reason, just to look at this
16 document, thinking he would see all of the relevant
17 data, he would be missing something, wouldn't he?
18 A. Yes.
19 Q. What was the instruction or training from Altnagelvin at
20 that time in relation to the completion of this sheet?
21 A. Mostly, the temperature, pulse and respiration and
22 possibly a blood pressure on admission were filled out
23 on that sheet. We normally did put a weight in, but we
24 concentrated on marking down and taking output on either
25 a feed chart or the fluid balance chart.

1 document Raychel's progress throughout the day.
2 I wasn't there and, as I say, I probably would have
3 continued on the sheet post-operatively.
4 Q. You refer to a graph sheet that was used.
5 A. Yes.
6 Q. And I think that's to be found at 020-015-028. Is that
7 the document you referred to?
8 A. Yes.
9 Q. I think what you told us is that the observation sheet
10 that we looked at earlier was discontinued and you
11 instituted a graph format.
12 A. We had finished the observations, Nurse Gilchrist
13 resumed the observations. We're supposed to keep
14 a graph chart as well to document any spikes in
15 temperature so that you can see if there's any maybe
16 potential for infection. Sometimes the girls would omit
17 to use the graph sheet as well as the observation sheet
18 post-operatively, but Staff Nurse Gilchrist started at
19 10 o'clock to write in her observations, as had the
20 girls during the day, at the specific times, 2 pm and
21 6 pm.
22 Q. Yes, but this was not a replacement for the observation
23 sheet we looked at earlier.
24 A. No.
25 Q. This is a document that had been used throughout.

1 Q. If we go to the next page again --
2 MR STITT: May I interrupt for one moment? I apologise as
3 ever. I think it's only fair, if one is looking at the
4 system which is in force -- and obviously the point is
5 why is there no reference to vomiting because the
6 "vomiting" column horizontally is empty. I think it's
7 only fair, before one moves away from this point, to
8 point out to the inquiry that this is actually entitled,
9 on the top left-hand corner, a "4-hourly TPR chart".
10 This is not a fluid balance chart. I appreciate it says
11 "vomiting" below, but nonetheless, to put into the
12 balance, so to speak, this is actually a four-hourly
13 TPR -- temperature, pulse and respiration -- chart.
14 That's the purpose of this chart.
15 THE CHAIRMAN: Well, I think it must be more than that,
16 Mr Stitt, because if I understood Mrs Noble correctly
17 she said that this graph sheet is to be used with the
18 observations sheet, and the observation sheet isn't
19 restricted -- the observations don't just come every
20 four hours, the observations come every 15 minutes, the
21 half hourly, then hourly, then two hours, then four
22 hours. So there must be more to this sheet than just
23 a four-hourly chart.
24 MR STITT: Well, I have to say, the three sources of the
25 information are: the observation sheet, which we have

1 dealt with; the TPR chart, which we're on at the moment;
2 and the fluid balance sheet at page 37. I think it's
3 only fair to put the three of them together and see what
4 the sum of the knowledge is because unless the case is
5 being made that the doctor would only look at this,
6 because all of these sheets are available to anybody
7 wishing to check the records, then one would see the
8 full parameters of the observations.

9 THE CHAIRMAN: I don't think any particular case is being
10 made. What we're exploring is if Mrs Noble has said,
11 undoubtedly correctly, that the point of record keeping
12 is if a new doctor or nurse comes along or is called
13 along, he or she can look at the records and see what
14 has been happening to the patient; right? So what we're
15 looking at then is what information is contained on the
16 different documentation which is then made available to
17 the doctor or nurse.

18 MR STITT: Absolutely, and with respect, sir, you've summed
19 it up absolutely correctly. But the point is, it's not
20 just this one sheet; it's one of at least three sheets.

21 THE CHAIRMAN: Yes, thank you.

22 MR WOLFE: I am proceeding through to each of the sources in
23 fairness to Mrs Noble.

24 Moving to the next page, 029, if we could, we'll be
25 focusing on this whole area of time in actual terms in

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1 Mrs Noble if you look at this page, 029, you signed at
2 2.35, 3 am, 3.30. Are those your initials then at
3 4 o'clock?

4 A. Yes.

5 THE CHAIRMAN: And 5 o'clock?

6 A. Yes.

7 THE CHAIRMAN: And then at 7 am, it's Nurse Hewitt; is that
8 right?

9 A. That's correct.

10 THE CHAIRMAN: And at 9 am it's Nurse Rice. At 1 pm, it's
11 not you; you weren't there at 1 pm.

12 A. No.

13 THE CHAIRMAN: Nor were you there at 5 pm.

14 A. No.

15 THE CHAIRMAN: And then we're back to Mrs Gilchrist at 9.15;
16 is that right?

17 A. That's correct.

18 MR WOLFE: We believe, sir, that the entries at 1 pm and
19 5 pm, for your note, were the entries of Avril Roulston.

20 A. Yes.

21 MR WOLFE: She has confirmed that in her statement to us.

22 THE CHAIRMAN: Thank you.

23 MR WOLFE: Another document I would like to briefly refer
24 you to is a document at 020-015-027. This is a document
25 called a "feed chart". We can see that there's only one

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1 due course. But just for the record, again, Mrs Noble,
2 21.15 is the last entry on that sheet, albeit when we
3 looked at the graph, if anybody was looking at it
4 carefully, you'd have seen a number of entries plotted
5 on that graph for after 21.15. But could you explain to
6 us why there are no actual comments written on this
7 sheet after 21.15?

8 A. Well, I didn't take the observations, I didn't do
9 Raychel's observations, so I can't answer why the nurse
10 didn't fulfil further observations. She obviously was
11 happy enough with Raychel's condition at that time to
12 progress on to the four-hourly graph chart.

13 Q. It's not the case, presumably, that you avoid making
14 these kinds of observations at night, you continue to
15 make these observations at night; would that be your
16 expectation?

17 A. Yes. Usually, this chart would have been used for the
18 first day post-operatively.

19 Q. Are you saying that that perhaps explains why the nurse
20 didn't make a further entry on this sheet at quarter
21 past midnight?

22 A. Possibly.

23 Q. Do you know or are you speculating?

24 A. I'm speculating.

25 THE CHAIRMAN: Sorry, just while we're here, Mr Wolfe:

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1 entry in it for 10.25, reflecting the large vomit at
2 that time. Again, can you help us in terms of the
3 purpose of this document? And, in particular, can you
4 assist us in terms of whether all vomits should have
5 been recorded on this sheet?

6 A. Not while a child was on intravenous fluids. I wouldn't
7 have recorded a vomit on that sheet.

8 THE CHAIRMAN: Would you use this sheet at all for a child
9 who's on intravenous fluids?

10 A. No. But that sheet would have maybe come in the
11 admission pack. We usually would make up an admission
12 pack when a child would come into hospital and a fluid
13 balance sheet or an intravenous fluid balance sheet was
14 only brought out if the child was commenced on IV
15 fluids, and the sheet might have been there and because
16 it was there somebody would have made an entry in it
17 maybe.

18 MR WOLFE: So rather confusingly, this document shouldn't
19 have been opened at all for this child because she
20 was --

21 A. Because she was on intravenous fluids, yes.

22 Q. In terms of your experience and practice in Ward 6, in
23 what document would you have expected to see all of the
24 vomits recorded?

25 A. On the fluid balance sheet.

16

1 Q. Right. If we take a look at the most relevant fluid
2 balance sheet now, that's to be found at 020-018-037.
3 So as I understand you, Mrs Noble, if we were looking
4 for a snapshot of Raychel's vomiting during 8 June, this
5 should be the document we should refer to; is that
6 right?
7 A. Yes.
8 Q. And as we discussed, I think yesterday, in terms of
9 inputting data on to this sheet, a number of things
10 should be recorded. We talked about the need to record
11 urine output --
12 A. Yes.
13 Q. -- the need to record oral fluids --
14 A. Yes.
15 Q. -- and the need to record any vomitus or stool output.
16 A. Yes.
17 Q. In circumstances where a child is mobile and with her
18 parents, I suppose there might be difficulties for
19 a nurse in obtaining the data. So for example, if
20 a child is brought to the toilet by her parents and the
21 nurse isn't present, a system would need to be put in
22 place to ensure that if a child passed urine, that that
23 made its way to the nurse, that information made its way
24 to the nurse.
25 A. Yes.

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1 point when you're checking the fluids?
2 A. Yes.
3 Q. If we could return to the post-operative situation,
4 could I raise the following concern with you? Mr and
5 Mrs Ferguson have told the inquiry, through their
6 witness statements, that they had been advised that
7 it would be likely that Raychel would return to the ward
8 within the hour and the fact that she didn't return
9 until close to 2 o'clock caused them concern. Are you
10 aware as to who would have advised the Fergusons of
11 that?
12 A. No.
13 Q. It does appear to be the case that Raychel's return to
14 the ward was delayed in the sense that there was
15 a prolonged period before she came out of the
16 anaesthesia because of the administration of opioids.
17 That seems to be the explanation that was available and
18 I think Nurse McGrath talked about that to some extent
19 yesterday. Was there a system in place at that time
20 whereby the ward could make contact with the theatre
21 recovery area?
22 A. Yes. We could have telephoned them.
23 Q. And in your experience, is that something that is done,
24 that checks are made when parents are anxiously waiting
25 for their child to come back?

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1 Q. And in order to perfect that system, the parents would
2 need to be told that if they were aware of any urine
3 being passed or vomiting occurring, they should report
4 that to the nurse?
5 A. Yes.
6 Q. Or, alternatively, the nurse should check with the
7 parents periodically --
8 A. Yes.
9 Q. -- to ensure that that information was imparted?
10 A. That's correct.
11 Q. Which of those two options was the practice in
12 Altnagelvin? Were parents encouraged to report or did
13 nurses get themselves into a system of going and seeking
14 the information?
15 A. Well, I can only speak for myself and I would always
16 have asked the parents had the child been to the toilet
17 and whether their bowels had moved, whether they had
18 passed urine when I was checking their IV fluids, and we
19 checked their IV fluids every hour. And when I would be
20 checking, I would say, "Have they been to the toilet?".
21 The night of Raychel coming back from theatre, she would
22 be sleeping and she normally wouldn't be out to the
23 toilet during the night.
24 Q. So your practice, which may not be universal across your
25 colleagues, would be to ask at that convenient hourly

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1 A. If a parent had approached me, I would have rung theatre
2 and asked what the delay was so that I could try and
3 allay anxiety and give the parents an explanation as to
4 what the delay was and when they could expect to find
5 their child back on the ward.
6 Q. So that could have been easily done?
7 A. It could, yes.
8 Q. At or about 8 o'clock, you were responsible for
9 delivering a nursing handover to the day shift coming on
10 duty; is that correct?
11 A. That's correct.
12 Q. And at or about that time, Raychel suffered her first
13 vomit. Conveniently, we have the document which records
14 that on the screen in front of us. So this is the
15 second fluid balance sheet, the one from the night
16 before ends at or about the entry at 7 o'clock. And
17 this is the new sheet for the day; isn't that right?
18 A. That's correct.
19 Q. And there's an entry just over halfway across. It says,
20 "vomit", and there appears to be a signature. The
21 signature needn't necessarily correlate to the person
22 who has identified or witnessed the vomit; do you know
23 whose signature that is?
24 A. I think that's Nurse Patterson's.
25 Q. Yes. If you can remember, you will, of course, help us.

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1 But you were delivering the handover at or about 7.50,
2 something like that.
3 A. That's correct.
4 Q. And do the night nurses remain on duty really until that
5 handover is completed?
6 A. Yes.
7 Q. And the day nurses can emerge from the office or
8 wherever the handover is being done and take over the
9 reins; is that the way it works?
10 A. Yes. Usually one nurse would have stayed behind to keep
11 an eye on the children while the other nurses were
12 receiving handover. There was always somebody left
13 behind.
14 Q. As I understand it, you weren't aware of that first
15 vomit when you left for the day?
16 A. No.
17 Q. It wasn't discussed at the handover?
18 A. No.
19 Q. The purpose of the handover, Mrs Noble, is presumably to
20 inform the nurses coming on duty about the condition,
21 progress, issues, in relation to all of the patients on
22 the ward, of course, not just Raychel.
23 A. That's right.
24 Q. But in Raychel's case, you delivered a handover which
25 would have told the nurses that Raychel was an appendix

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1 THE CHAIRMAN: Can I add to that? Even if you had known
2 about the vomit at about 8 am, that wouldn't really have
3 altered the picture, would it?
4 A. Possibly not. Occasionally patients would maybe have
5 a vomit in the morning before they would start maybe
6 just to clear their stomach, and once their stomach was
7 cleared possibly have a rest, settle down, and try and
8 start oral rehydration later.
9 THE CHAIRMAN: So a single vomit is something that is noted
10 but it is not in itself a --
11 A. Concerning, no. No.
12 THE CHAIRMAN: Thank you.
13 MR WOLFE: However, as we have observed from the documents
14 that have recently been up on the screen, such as the
15 fluid balance chart, Raychel had subsequent vomits
16 within reasonably short periods of time. So there was
17 one recorded on the feed chart, 10.25, and another entry
18 at or about 1 o'clock on the fluid balance chart. We
19 needn't bring them up on the screen.
20 In those circumstances, would you have expected your
21 nursing colleagues to be seeking medical assistance to
22 intervene in that situation?
23 A. Yes, to administer an anti-emetic to see if the nausea
24 and vomiting could be stopped, yes.
25 Q. It's obviously difficult for you to put your feet into

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1 patient.
2 A. Yes.
3 Q. You've told us in your witness statement that you
4 advised the nurses at the handover that Raychel hadn't
5 micturated, hadn't passed urine --
6 A. Yes.
7 Q. -- that she had received an antibiotic and Voltarol for
8 pain relief --
9 A. That's correct.
10 Q. -- and that she appeared to be comfortable.
11 A. That's correct.
12 Q. The experts retained by the inquiry have examined
13 Raychel's condition coming out of surgery, mildly
14 congested appendix, reasonable if not good overnight
15 progress, and Ms Ramsay, for example -- the reference is
16 224-004-011 -- has concluded that the operation was
17 straightforward and she says that it could therefore
18 have been expected:
19 "She could therefore be expected to increase her
20 drinking during the day, walk a short distance and
21 possibly eat something light later in the day."
22 Based on your observations with Raychel overnight,
23 broadly speaking, is that how you anticipated Raychel
24 would have progressed, all things being equal?
25 A. Yes.

22

1 the shoes of the --
2 A. Yes.
3 Q. -- nurses who were on duty at that time. But the answer
4 that you've just given me accords with, for example, the
5 opinion expressed by Mr Orr, the expert retained on
6 behalf of the Trust. He says in his statement at
7 WS320/1, page 10, within (g), the last four lines:
8 "It would be normal practice for the surgical team
9 to be alerted if a patient had recurring episodes of
10 vomiting in order that she could be assessed and any
11 changes made to fluid therapy as required."
12 In your experience of working in Altnagelvin, first
13 of all, if a child has two or three vomits in, say, the
14 period of a morning, you would have got a doctor?
15 A. Yes.
16 Q. And you would have provided the doctor with a full
17 history of what had occurred?
18 A. Yes.
19 THE CHAIRMAN: Would you want to be there with the doctor
20 or --
21 A. I would have been there to explain to him what had gone
22 on, yes, and how many times she had vomited.
23 THE CHAIRMAN: Sorry, your answers seem to take it for
24 granted that you would be there, but I'm not sure, as we
25 go on to look through that day, that there was

24

1 necessarily a nurse present with the doctor when the
2 doctor arrived. So if you called for the doctor, then
3 it'd be much preferable that instead of the doctor just
4 looking at the notes, that there would be a nurse like
5 yourself or somebody else there to explain why he was
6 being called and what the extent of your concern was?
7 isn't that right?
8 A. But you mightn't always accompany the doctor to the
9 bedside with the child.
10 THE CHAIRMAN: No, because you might be doing something
11 else.
12 A. Yes.
13 THE CHAIRMAN: But you would at least want to grab a few
14 words with the doctor to explain why he or she was being
15 called?
16 A. Yes.
17 MR WOLFE: So by that exchange I understand you're saying
18 that whether you're with the doctor as he attends the
19 child or not, you would be, in your practice, looking to
20 give the doctor as much information about the recent
21 history as possible?
22 A. Yes.
23 Q. And then clearly, it's a medical decision what action to
24 take in light of that.
25 A. Yes.

25

1 Q. Of course, but you seem to be reflecting an experience
2 there whereby the consultant, presumably the consultant
3 under whose care the patient had been admitted, would
4 make it his or her business to come to see the child.
5 It may not be in the morning, it might even run into the
6 afternoon.
7 A. Or they may not have seen the children at all.
8 Q. Right, okay. So what you're saying is that in your
9 experience, a consultant may or may not see the child.
10 A. That's correct.
11 Q. In terms of the purpose of the ward round, whether it's
12 an SHO or whether it's a registrar conducting it, on
13 a child who has had overnight surgery, what was your
14 understanding of its purpose?
15 A. For the doctors to come and see how the child had
16 progressed during the night, how her observations were,
17 and for them to make a plan of progress for her
18 throughout the day.
19 Q. And as part of that plan, would you expect the doctor to
20 be thinking about what fluids the child would need?
21 A. Yes.
22 Q. In Raychel's specific case, given her sound progress
23 overnight, did you anticipate or could you have
24 anticipated how her fluids would have been dealt with
25 during the day if she'd continued on that smooth

27

1 Q. We touched briefly yesterday on the issue of ward rounds
2 and plainly, at or about that time, after you'd finished
3 your handover, you would have expected a surgical ward
4 round to have taken place.
5 A. Yes.
6 Q. I think you told us yesterday that, in your experience,
7 a registrar is more likely to attend that ward round
8 than, as compared to a consultant.
9 A. Yes. It could also have been a senior house officer who
10 could have done the ward round that morning. When the
11 surgeons could come, they usually did try to come first
12 thing in the morning to review their children, but it
13 could have been lunchtime or after before sometimes they
14 would be able to be available on the ward.
15 Q. Yes.
16 A. There was no specific time for surgeons to come.
17 Q. Yes. So as I understand it, there would typically be an
18 early morning ward round, which, in your description, is
19 possibly unlikely to have been conducted by
20 a consultant, but are you saying that a consultant in
21 your experience would generally make it his business to
22 come to see the child at some point during the day?
23 A. I didn't work day duty so I couldn't give a full answer
24 to that. The girls on day duty or whatever would be
25 better equipped to tell you that.

26

1 progress?
2 A. I would have expected that if Raychel had tolerated her
3 fluids initially, there may well have been -- she may
4 well have tried a bit of light diet later on, having
5 tolerated oral fluids, and then her IV fluids would have
6 come down later on in the day.
7 Q. Is there a plan put in place around that or is it
8 a wait-and-see approach?
9 A. It's a wait-and-see approach.
10 THE CHAIRMAN: Sorry. I might be stupid, but when you say,
11 "I would have expected that if Raychel had tolerated her
12 fluids initially", that's fluid that she takes orally
13 herself?
14 A. Yes, oral fluid.
15 THE CHAIRMAN: Yes. Does that mean you would expect that
16 oral fluids would be tried?
17 A. Yes.
18 THE CHAIRMAN: And I know that every child is different, but
19 if there was anything wrong with Raychel's appendix, it
20 was on the mild side, not the serious side. And all
21 being well, as it seemed to be well after the operation,
22 would you have expected oral fluids to be tried, if you
23 can help me, late in the morning or at some point in the
24 afternoon or when perhaps?
25 A. Maybe first thing in the morning if the child was

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1 thirsty.
2 THE CHAIRMAN: Okay. Thank you. If that went well,
3 effectively, you wound down the intravenous fluids and
4 she moves back towards something like a normal diet?
5 A. Yes, a light diet first of all.
6 THE CHAIRMAN: Thank you.
7 MR WOLFE: I'm struck by an answer you gave earlier, where
8 you said you didn't work day shift, you worked night
9 shift.
10 A. Yes.
11 Q. And so what was your experience of ward rounds or seeing
12 them in action?
13 A. Well, when I worked nights we didn't stay for the
14 morning ward rounds, but I had worked for just about
15 a year and a half when I first came to Ward 6 and had
16 experienced ward rounds and sister mostly took the ward
17 round or a senior staff nurse, but you were in the
18 peripheries and a staff nurse communicated to the nurse
19 in that area, the named nurse, what the doctor had said
20 and what had been decided of the plan of care for the
21 day.
22 Q. Can you help us with this: would there be a surgical
23 ward round for surgical patients and a separate ward
24 round run by paediatricians for medical patients?
25 A. Yes.

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1 less admissions than there were over the winter period.
2 Q. You've told us in your witness statement -- we needn't
3 bring it up on the screen -- that Nurse McAuley, who was
4 formerly Nurse Rice, Rice being her maiden name, she
5 delivered a handover to the nurses coming on duty;
6 is that right?
7 A. I don't remember if Nurse McAuley actually handed over,
8 but the nurse who would have been handing over would
9 have read out what Nurse McAuley had written in the
10 DM Nurse system as her care of Raychel during the day.
11 Q. You've obviously had the benefit of reading
12 Nurse McAuley's statement.
13 A. I actually haven't read her statement.
14 Q. You haven't?
15 A. No.
16 Q. Let me bring your statement up on the screen then,
17 WS049/1, at page 2, please. The penultimate paragraph,
18 if that could be highlighted for me, please. You say
19 here:
20 "I returned to night duty Friday, 8 June, and took
21 charge of the main ward for the duration of my shift.
22 As I was in charge, I did not fill in any observations
23 on Raychel. At handover, Staff Nurse Michaela McAuley
24 reported that Raychel had micturated, but had vomited
25 a few times during the day, the latter requiring

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1 Q. As we know, you returned to duty on the evening of
2 8 June --
3 A. Yes.
4 Q. -- to start the night shift.
5 A. Yes.
6 Q. You were the nurse in charge, again, on Ward 6.
7 A. Yes.
8 Q. We've been advised by the DLS in correspondence that,
9 working backwards a little from the start of your night
10 shift, but at the start of that day of 8 June, there
11 were 23 patients within Ward 6. There were two more
12 admissions during the day and one discharge.
13 A. Yes.
14 Q. This was a 42, 43-bed unit.
15 A. Yes.
16 Q. So is it right to say it was just a little over half
17 full?
18 A. Yes.
19 Q. Would that be your recollection?
20 A. Yes.
21 Q. Was that a typical complement of patients? Obviously,
22 there can be peaks and troughs.
23 A. Yes, it was quite variable.
24 Q. Is that about average?
25 A. Yes. Usually, in the summer months there was usually

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1 parenteral Zofran, 2 milligrams, at around 17.30 hours.
2 Parenteral Solution No. 18 was infusing at 80 ml an hour
3 and her parents were present."
4 So on the face of that, you received a report from
5 nurse --
6 A. From her nursing handover.
7 Q. Sorry?
8 A. From her nursing handover.
9 Q. What does that mean?
10 A. Well, the nurse in charge or whoever was handing over
11 that night would record -- the nurse in charge wouldn't
12 be able to maybe see everybody that day and know exactly
13 what was going on, and this was her report of the events
14 of that day. And Nurse McAuley, that was her report of
15 what had happened to Raychel. I didn't say that she had
16 reported personally, but that was her communication from
17 her care plan.
18 THE CHAIRMAN: Does that mean it might have been her
19 personally --
20 A. Yes, I don't recall.
21 THE CHAIRMAN: -- or if it wasn't, it was somebody telling
22 you from her notes ...
23 A. What Nurse McAuley -- yes, uh-uh.
24 MR WOLFE: We know that Nurse McAuley denies being involved
25 in a verbal handover.

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1 A. Well, I can't recall.
2 THE CHAIRMAN: Can I take it, Mrs Noble, that it actually
3 shouldn't matter?
4 A. Exactly.
5 THE CHAIRMAN: Because if the condition of each child is
6 being passed on accurately, then that condition should
7 be apparent from the notes?
8 A. That's correct.
9 THE CHAIRMAN: For instance, if you did a handover at about
10 a bit before 8 o'clock that morning, you might not have
11 seen every child on a regular basis through the night,
12 but it's still your job to do a handover for each child.
13 A. That's correct.
14 THE CHAIRMAN: So you did that handover as best you can from
15 talking to the nurses who were on duty with you and from
16 what they've written in the notes?
17 A. That's correct.
18 THE CHAIRMAN: And the same thing applies coming up to
19 8 o'clock in the evening?
20 A. That's correct.
21 MR WOLFE: As I've said, Nurse McAuley denies being involved
22 in a verbal handover, but she simply updated her
23 patients on what she refers to as DM Nurse. I've been
24 calling that the episodic care plan; is that the same
25 document?

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1 A. Yes.
2 Q. We have a number of other documents, most importantly
3 perhaps we have the DM Nurse or episodic care plan,
4 which, as we can see here, is updated by Staff
5 Nurse McAuley at 5 o'clock, a couple of hours before her
6 shift concludes.
7 A. Yes.
8 Q. But you seem to have mentioned a number of other
9 documents that are perhaps put together for the purposes
10 of the handover; did I interpret you correctly?
11 A. No, it was just a printout off the computer that we had.
12 Q. Right. So the person delivering the handover might have
13 printed out relevant extracts from the DM Nurse --
14 A. Yes.
15 Q. -- for the purposes of delivering that handover --
16 A. Yes.
17 Q. -- in respect of each patient?
18 A. Yes.
19 Q. And in respect of Raychel, obviously there are other
20 entries made under the various other headings.
21 A. Yes.
22 Q. But in terms of Raychel's state of wellness, I stand
23 corrected if anybody wants to put something else
24 forward, but this seems to be the entry which attempts
25 to summarise her condition, if you like --

35

1 A. Yes, that's right.
2 Q. Let me turn up a page from that document, which records
3 what Nurse McAuley was communicating towards the end of
4 her shift. If I could have 020-027-064. Could we
5 highlight the middle section?
6 Just before we look at that, Mrs Noble, when you
7 receive a handover, presumably from the nurse in charge
8 and she's going through a list of patients, what
9 documents does she have access to when she's making the
10 report or what documents would she typically turn to
11 when she's making the report?
12 A. We have an assessment sheet, which gives you the details
13 of the patient and any previous history of note, any
14 conditions, what medications they're on, and maybe any
15 social history as well. Then we would have had an
16 evaluation booklet and the evaluation booklet -- well,
17 back then it was our DM Nurse -- and the care plan was
18 updated daily and the summary of care was printed off.
19 Q. Yes, so --
20 A. And that's the only documents that we would have had.
21 We printed off what we wrote on to the computer until
22 the children were discharged.
23 Q. Yes, but what we know is that we have a fluid balance
24 chart, which sets out the vomits as observed by the
25 nurses during the day.

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1 A. Yes.
2 Q. -- at 5 o'clock. And it says:
3 "Observations appear satisfactory. Continues on PR
4 Flaygl [which is an antibiotic]. Vomit x3 this AM, but
5 tolerating small amounts of water this evening."
6 That report says nothing at all about vomiting
7 in the afternoon; isn't that right?
8 A. No.
9 Q. If Raychel had been vomiting in the afternoon, would
10 you have expected to see a report to that effect?
11 A. Yes.
12 Q. It says nothing at all about the need to bring a doctor
13 to Raychel's bed and to administer an anti-emetic.
14 THE CHAIRMAN: Sorry, can we just confirm something before
15 you go through this? Piecing things together as best
16 you can, is this likely to be the printout that you saw
17 or that the handover was done from?
18 A. Yes.
19 THE CHAIRMAN: So the handover in effect is these four
20 lines?
21 A. There were different parts of the care plan, but that
22 was what obviously Nurse McAuley wanted to communicate
23 in relation to her "post surgery, at risk of
24 complications". There was obviously other parts to the
25 care plan.

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1 THE CHAIRMAN: Okay. Thank you.
2 MR WOLFE: As I say, I think you've accepted that if there
3 had been vomiting in the afternoon, as we know there was
4 from the fluid balance sheet, you would have expected it
5 to have been recorded.
6 A. Yes.
7 Q. Indeed, the message that's contained there that Raychel
8 was tolerating small amounts of water this evening, that
9 sends out the impression that the vomiting that had
10 occurred in the morning had settled and Raychel was able
11 to take in fluids, tolerate them and not release them
12 again in the form of vomit.
13 A. Yes.
14 Q. Is that the impression that you would form from reading
15 that --
16 A. It's the impression that I would form from reading that,
17 yes.
18 Q. In other words, she had suffered a dip or deterioration
19 leading to vomiting, but had rallied and was now
20 tolerating --
21 A. Sips of water, yes.
22 Q. -- fluids.
23 THE CHAIRMAN: Would that then give you the impression that
24 while she hadn't progressed in the way that you had
25 expected when you left the shift in the morning, she was

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1 suggesting that if amendments were needed for the
2 purposes of a handover, nurses would add the extra
3 details in the way you described?
4 A. Yes. Uh-huh.
5 Q. I'll bring you to this document: 063-032-076. We can
6 see an entry in handwriting at the bottom of the page.
7 Perhaps this is the kind of thing you describe.
8 A. Yes.
9 Q. I'm obliged to my colleague for bringing that to my
10 attention.
11 So you are told that by way of an amendment in this
12 form that there had been vomiting this afternoon --
13 A. Yes.
14 Q. -- and that "Zofran had been given with fair effect".
15 How would you interpret the phrase "fair effect"?
16 A. It maybe would have stopped it initially and possibly
17 she may vomit after that.
18 Q. Because if it said "with good effect" --
19 A. It would have stopped her vomiting completely.
20 Q. It would have stopped her vomiting altogether?
21 A. Yes.
22 Q. Whereas in fact -- and we needn't put it up on the
23 screen -- as you presumably correctly say, "fair effect"
24 implies that there had been further vomiting. But the
25 fluid balance chart, which we've looked at, doesn't

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1 now back on track?
2 A. Yes.
3 MR WOLFE: Although returning to your statement, if I could
4 have it up, at 049/1 at page 2, down to the bottom
5 again, please, what you go on to say there in the
6 penultimate paragraph is:
7 "At the handover, it had been reported that Raychel
8 had received Zofran at around 17.30 hours."
9 And clearly, if she did receive it at 17.30, that
10 fact couldn't have made it into the episodic care plan,
11 which was drawn up at 5 o'clock. So although the
12 episodic care plan gives a particular impression of
13 improvement following earlier vomiting, you're telling
14 us that in fact, although it doesn't appear in the care
15 plan, that you were told verbally --
16 A. Yes.
17 Q. -- that Zofran had been administered?
18 A. At half five, yes. Sometimes it wasn't always possible
19 due to the situation in the ward for nurses to get back
20 to a computer to update and on a lot of occasions there
21 would have been pen put to paper to add in these little
22 extra bits, and those documents that had written
23 material on them would have been kept in the patient's
24 notes.
25 Q. That's not something the inquiry has seen. Are you

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1 record any further vomiting between 3 o'clock and about
2 9 o'clock, when the coffee-ground vomiting starts.
3 Again, if there had been vomiting after the
4 administration of the anti-emetic, you would have
5 expected that to have been recorded, presumably.
6 A. Yes.
7 Q. On the basis of what you were told at the handover,
8 you've told us in your witness statement that you formed
9 the impression that Raychel was suffering from
10 post-operative nausea and vomiting and this wasn't
11 unusual.
12 A. That's correct.
13 Q. You weren't suspicious about any underlying cause?
14 A. No. Raychel, in my impression, had been a fit and
15 healthy child up until this episode.
16 Q. Yes.
17 A. And I had, in my experience, seen children who had
18 vomited maybe all day post-operatively and even into the
19 evening and had come to no ill effect.
20 Q. Of course, Mrs Noble, you've got to nurse the patient
21 that's in front of you --
22 A. Yes.
23 Q. -- and every patient is different.
24 A. Yes.
25 Q. But can I ask you whether you got yourself in a mindset

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1 which contained the following ingredients: patients
2 don't generally die after an appendectomy, some of
3 them vomit and Raychel's just another one of these
4 patients who will be okay?
5 A. Well, I was reassured that she was still on IV fluids,
6 that her fluids hadn't been reduced or cut down, that
7 she was still on maintenance fluids and wouldn't
8 dehydrate as a result of her vomiting.
9 Q. Of course, dehydration is only one part of the equation,
10 isn't it?
11 A. Yes.
12 Q. And electrolytes and the loss of electrolytes is the
13 other part of the equation; isn't that right?
14 A. Yes.
15 Q. And as we saw yesterday in your evidence, as you told
16 me, that if you'd thought about it, you were aware that
17 the loss of electrolytes from vomiting, from severe
18 vomiting, would be a cause for concern or ought to have
19 been a cause for concern.
20 A. Yes.
21 Q. We'll look at the particular features of Raychel's
22 condition at that time as we move along, but just
23 dealing with your duties when you moved beyond the
24 handover. We know that broadly speaking you had 20, 25
25 patients on that night and you had three members of

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1 Q. Was it an allocation that you could have countermanded?
2 A. We have an allocation book and the nurses were told what
3 area they were working in that night. Depending on the
4 night, on events happening, as the nurse in charge, you
5 could make a change to that if you felt it necessary.
6 But it wasn't uncommon for you to be in the infant unit
7 one night or maybe two nights if you were working maybe
8 three nights in a row and maybe end up having to come
9 out to the ward on the third night, according to skill
10 mix.
11 Q. In terms of your responsibilities that night, you
12 weren't carrying out observations; is that correct?
13 A. That's correct.
14 Q. You were responsible for distributing medicines to
15 patients --
16 A. Yes.
17 Q. -- leaving the other two nurses to carry out
18 observations --
19 A. That's correct.
20 Q. -- and report any difficulties to you --
21 A. Yes.
22 Q. -- and presumably to each other.
23 A. Yes.
24 Q. In terms of making yourself aware of Raychel's condition
25 when you came on duty, you obviously received the

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1 staff, that is Staff Nurse Gilchrist; is that correct?
2 A. Correct.
3 Q. Staff Nurse Bryce?
4 A. Yes.
5 Q. And an auxiliary nurse, Lynch?
6 A. That's right.
7 Q. You also had Staff Nurse Patterson back on duty that
8 night, but she was allocated to the infants' unit;
9 is that correct?
10 A. That's correct.
11 Q. She had previously been Raychel's named nurse when she
12 was first admitted and had drafted the care plan; isn't
13 that correct?
14 A. Yes.
15 Q. And clearly had some familiarity with Raychel's
16 situation overnight?
17 A. Yes.
18 Q. Why did it make sense to allocate her to the infants'
19 unit when she was Raychel's named nurse or had been
20 Raychel's named nurse?
21 A. It was the duty of the senior nurse or sister during the
22 day to make allocation for the nurses on night duty to
23 what area they were going to work in.
24 Q. So that wasn't your duty?
25 A. That wasn't my duty, no.

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1 handover report and we've seen the amended document with
2 the annotated notes, so you were aware that Raychel had
3 been vomiting during the day, had received an
4 anti-emetic with fair effect. Did you or was it the
5 practice at that time to, if you like, delve into the
6 notes further to obtain a fuller appreciation of
7 Raychel's condition?
8 A. It wouldn't have been normal practice to do that. The
9 idea being that you needed to get the medicines given
10 out to the children while they were awake.
11 Q. And given how you had left Raychel on the morning,
12 making good progress, were you in any sense surprised
13 at the description that you were receiving of her at the
14 other end of the day at 8 o'clock? Did that come as
15 a surprise to you?
16 A. No.
17 Q. Well --
18 A. Because again, in my experience, I had noted some
19 children would do that.
20 Q. Yes.
21 A. Obviously, as you say, each case is individual, but
22 it wouldn't have been uncommon for children to not
23 progress after a period of maybe appearing fine. That
24 wouldn't have been unusual. I mean, the anti-emetic
25 given in theatre can sometimes prevent the nausea in the

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1 first instance and vomiting.
2 Q. Well, was it an unusual feature of Raychel's case that
3 she had a good initial post-operative period, no
4 vomiting, no nausea, when you left, presumably just
5 before 8 o'clock, but then to suffer this dip? I don't
6 call it a significant dip. That's a matter for the
7 chairman to rule upon. But was that an uncommon feature
8 in your experience?
9 A. Not uncommon, no. Sometimes mobilising would maybe make
10 the children nauseated, maybe trying to take fluids
11 would initially start them ...
12 THE CHAIRMAN: Would you help me with this? While I'm sure
13 everyone can understand that not every child recovers
14 at the same rate, are the complications not likely to be
15 greater the sicker the child is --
16 A. Yes.
17 THE CHAIRMAN: -- so that a child who has what is described
18 to you as a mildly inflamed appendix removed is more
19 likely to make a smooth recovery than a child who had
20 a more severe problem with appendicitis?
21 A. Yes, but maybe the anaesthetic would have made the
22 children more nauseated. Some children recover better
23 from an anaesthetic than other children do.
24 THE CHAIRMAN: But an element in is it how ill the child was
25 in the first place?

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1 description suggests, not the most serious form of
2 appendicitis.
3 A. That's correct.
4 Q. And you perhaps would have had experience of receiving
5 reports back following appendicectomies with patients
6 who had significantly inflamed appendix with areas of
7 infection, which required a prolonged period of surgery?
8 A. Yes.
9 Q. And Raychel's case fell into the mild category than what
10 I've described as a much more serious category?
11 A. Yes.
12 Q. Arising out of your interaction with the chairman just
13 now, while every case is different and we do point that
14 out, a child falling into the mild appendix category is
15 likely to have a much easier and smoother post-operative
16 course than the child falling into the more severe
17 category.
18 A. That's correct.
19 Q. On the evening of 8 June when you started duty, Raychel
20 had a number of people around her who were in a position
21 to observe how she was at that time. As I understand
22 it, you didn't see Raychel face-to-face until you
23 attended with her at or about 9.25 to give --
24 A. That's correct.
25 Q. -- her her medication.

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1 A. Yes.
2 THE CHAIRMAN: So we have here a girl who wasn't all that
3 ill.
4 A. Yes.
5 THE CHAIRMAN: So she might have a reaction to the
6 anaesthetic.
7 A. Yes.
8 THE CHAIRMAN: Something else might go wrong, but in the
9 general scheme of things, you would expect her recovery
10 to be smoother and easier than that of other children.
11 A. Yes.
12 MR STITT: Can I just make one observation, if I may? Would
13 it be important to establish from the nurse just what
14 she knew of the actual results of the operation at any
15 given time? We know the operation --
16 THE CHAIRMAN: Mrs Noble told us when she was told that.
17 When Raychel came back down to the ward after the
18 operation, the information which she got from Staff
19 Nurse Patterson, who'd been given it in the theatre, was
20 that Raychel had had a mildly inflamed appendix.
21 A. That's correct.
22 MR STITT: I'm grateful.
23 MR WOLFE: Maybe because it has been raised, we can just
24 unpack that a little? A mildly inflamed appendix, in
25 terms of your understanding, would be, as the

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1 A. That's correct.
2 Q. If we could, just so we can contextualise this, reflect
3 for you some of the observations that were made by
4 visitors to Raychel at or about the time of the
5 handover, just before it and just after it, so that
6 we can understand the scene into which you were walking
7 as the charge nurse on that occasion.
8 Could we have up on the screen Mr Ferguson's account
9 to the police, 095-005-017? This is a statement made by
10 Mr Raymond Ferguson, father of Raychel, in or about
11 2005, in the context of a PSNI investigation. About
12 halfway down the page he says:
13 "I returned to the hospital along with my sons,
14 Jason and Jamie, and the girl next door, Lisa McColgan,
15 who was Raychel's best friend. This was at
16 approximately quarter to seven. We came into the ward
17 and Marie [that's Raychel's mother] said to Raychel,
18 'Look who is here, Jamie, Jason and Lisa'. Raychel
19 didn't even acknowledge us, she was still lying in bed.
20 Teresa and Sarah McCullagh arrived a short time later.
21 She had brought Raychel a video and book. I showed
22 these to Raychel and she was unresponsive. Teresa and
23 Sarah didn't stay for very long and she thought Raychel
24 was only out of her operation. At around 8 o'clock or
25 thereafter, Marie left the hospital to take the two boys

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1 and Lisa home."
2 So that was the situation just at or about the time
3 of the handover, as Mr Ferguson recalls it. He then
4 goes on in this statement -- and we'll deal with this
5 sequentially in a moment -- about the situation in the
6 next hour or two after the handover, but could I put to
7 you another recollection of a visitor, Mrs McCullagh,
8 who was alluded to there in Mr Ferguson's statement? If
9 we could have on the screen 095-009-029, please.

10 This is another visitor to Raychel's bedside. Maybe
11 I could have the page back as well, please, set
12 alongside that. Again, this is a statement of
13 Teresa McCullagh made to the PSNI. You can see the date
14 at the top of the page, Mrs McCullagh being a visitor to
15 Raychel. What she says is, taking it from halfway down
16 the first page:

17 "Sarah and I went to the shop at the hospital, where
18 Sarah bought a tape and a magazine to bring up to
19 Raychel. We went up to the ward to see Raychel. We
20 arrived in her ward some time between 6.30 and 7 pm.
21 When we went into the ward, Raychel was lying on the
22 bed, on top of the bed clothes. I did not notice a drip
23 line attached. Raychel's mother, Marie, was also there.
24 Her father was sitting down at the bottom of the bed and
25 a little girl, who I learned was Raychel's best friend

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1 in Altnagelvin Hospital on 8 June at around 8 pm. My
2 wife, Elaine, had been there during the day with Emma.
3 I noticed that Raychel Ferguson was being very sick when
4 I arrived. I went out to the corridor and got
5 a papier-mache sick bowl. I told one of the nurses that
6 Raychel was still being very sick. I do not recall the
7 name of the nurse I told. I remember pulling the
8 curtain around Emma's bed to give some privacy to
9 Raychel and her family."

10 Then he goes on to deal with events later in that
11 evening.

12 Those descriptions, Mrs Noble, perhaps very
13 graphically, describe the impressions of three visitors
14 or observers of Raychel just before the handover or just
15 after the handover on 8 June. In circumstances of
16 a mild appendix situation, as befell Raychel, Raychel's
17 state at that time is not at all what anybody would have
18 expected to see; isn't that right?

19 A. That's correct.

20 Q. Everybody would have expected to see Raychel up and
21 about, taking oral fluids, perhaps eating something
22 light; isn't that right?

23 A. Yes.

24 Q. And plainly, for whatever reason, she and her condition
25 had departed from that recovery plan or that recovery

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1 from her street, was also there. I could see that
2 Raychel looked very ill and I spoke to Mrs Ferguson,
3 saying I hoped we had not come at a bad time. She said
4 no and thanked us for coming. Sarah went up to the bed
5 and Marie said, 'Look, Raychel, here's Sarah to see
6 you'. Sarah left the present on the side of the bed and
7 Raychel did not speak at all. She just seemed to be
8 that sick and was not in any form for anybody. I knew
9 Raychel and that was not like her. She was very
10 restless and fidgety and very unsettled. Raychel's
11 mother tried to persuade her to speak, but she did not
12 respond in any way. Raychel turned from one side to the
13 other and at one stage I even said to her, 'Raychel,
14 don't turn on that side or you might hurt your wound'.
15 She didn't even seem to hear me."

16 And so on:

17 "Marie told me that Raychel had been very sick,
18 vomiting."

19 Finally, on this sequence, if I could. Mr Duffy,
20 whose daughter was a patient in the same room as
21 Raychel, he came to the hospital at about 8 o'clock. If
22 I could have up on the screen 095-008-025. Again,
23 a statement made to the PSNI, 26 October 2005.

24 If we take it from the top:

25 "I arrived at the ward where my daughter, Emma, was

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1 process --

2 A. Yes.

3 Q. -- and yet you didn't regard it as unusual or abnormal?

4 A. I wasn't aware of this.

5 Q. Well --

6 A. This had happened, obviously, around 8 o'clock while
7 we were in handover and that scenario was not
8 communicated to me. When we went out to the ward, there
9 was nothing drawn to our attention to say that had
10 happened or communicated to me, and we normally just
11 started the -- I normally just started the medicines at
12 that time and the nurses started at either end of the
13 ward to do the observations.

14 Q. Yes. Well, what was communicated to you was the
15 description provided by Nurse Gilchrist --

16 A. Yes.

17 Q. -- shortly after the period of time reflected in the
18 statements which I've just opened to you.

19 A. Yes.

20 Q. Let's just pause now and look at what Mrs Gilchrist was
21 able to observe at or about that time. If I could have
22 up on the screen, please, the witness statement of
23 Mrs Gilchrist at 053/1, at page 3. If we could
24 highlight the top half of the page to start with. What
25 we have then is, just orientating ourselves,

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1 Nurse Gilchrist recording that:
2 "After the handover report, some time after 8 pm,
3 Mr Ferguson, Raychel's father, asked me to change her
4 bed linen as she had vomited on it. Elizabeth Lynch, as
5 far as I can recall, and myself changed the bed. At
6 this time, Raychel was sitting on a chair at the side of
7 the bed. I don't recall what conversation took place at
8 this time."

9 So the first part of that statement records an
10 event, vomiting on to the bed, vomiting plainly that the
11 child hadn't been able to control, and it happened
12 shortly after 8 o'clock, and we know that there is no
13 vomiting recorded just at that time. There's vomiting
14 recorded at or about 9 o'clock and we'll look at that in
15 a moment. But let's move down:

16 "At approximately 21.15, [Nurse Gilchrist] took and
17 recorded Raychel's observations, her pulse, respiratory
18 rate and temperature. They were unremarkable. At this
19 time, she was nauseated and had vomited coffee grounds
20 into a vomit bowl, approximately 150 ml. Her nausea and
21 vomiting subsided shortly after this, but about 20 to 25
22 minutes later she became nauseated and vomited three
23 small amounts. I spoke to Mr Ferguson and told him that
24 I would contact the surgical doctor on call. I also
25 spoke to Staff Nurse Ann Noble about contacting the

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1 Raychel was still nauseated and had vomited coffee
2 ground material and that she informed the surgical JHO
3 that an anti-emetic could be prescribed and
4 administered.

5 You reached Raychel's bed with the medicine trolley
6 at 2115 hours, informed her father that Raychel was due
7 to receive rectal Flagyl. He informed you that Raychel
8 had had a headache and that, although she was asleep,
9 was not settled.

10 So you're then asked, arising out of that, what you
11 did discuss with Nurse Gilchrist. And you discussed
12 that Raychel needed to be examined by a doctor and it
13 appears to be, by that time, the nurse had already
14 called the doctor.

15 A. Yes.

16 Q. You personally felt that Raychel had had a Mallory-Weiss
17 tear and that that could have accounted for the
18 coffee-ground vomit.

19 A. Yes.

20 Q. A Mallory-Weiss tear is a tear of the distal oesophageal
21 mucosa at the back of the throat; isn't that right?

22 A. Yes, that's correct.

23 Q. That's a rare condition, isn't it?

24 A. We would have seen it quite a bit on the children's
25 ward.

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1 doctor so that he could administer an anti-emetic to see
2 if it could give Raychel some relief."

3 So here we have a situation, Mrs Noble, taking it
4 from the point of time of handover, you've been advised
5 of Raychel's progress during the day, leading to
6 a situation where a doctor had to come and give her an
7 anti-emetic. Plainly, at this stage you haven't had an
8 opportunity to go and see Raychel.

9 A. Yes.

10 Q. But your nurse is reporting to you coffee-ground vomits,
11 two separate episodes of them, on the back of the child
12 having vomited on to her bed.

13 A. Yes.

14 Q. This was becoming a serious situation, wasn't it?

15 A. Yes. And Staff Nurse Gilchrist told me she was going to
16 contact the doctor and I agreed, yes, that was the right
17 thing to do, to get a doctor to come and see Raychel.

18 Q. You've reflected in a witness statement to the inquiry
19 that -- if I could have it up on the screen at 049/2,
20 page 8. You've reflected here your recollection of the
21 discussion with Staff Nurse Gilchrist. On this page,
22 we can see what you say in your first witness statement
23 in the form of the question at the top and then the
24 questions that arise out of that. So what you recall
25 for the inquiry is that Nurse Gilchrist reported that

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1 Q. Ms Ramsay, who has reported on this matter for the
2 inquiry, has described it as quite a rare condition.

3 A. Well that's her experience and this is my experience.

4 Q. You've seen it commonly?

5 A. Yes.

6 Q. Is it indicative of severe vomiting in your experience?

7 A. Yes, yes. Or that the vomiting is very intense, even
8 that they mightn't be vomiting a lot, but that the
9 retching was very severe.

10 Q. And it's a matter that would require medical input?

11 A. Yes.

12 Q. And is it a matter that you brought to the doctor's
13 attention?

14 A. Nurse Gilchrist brought it to the doctor's attention.

15 Q. Nurse Gilchrist brought to the doctor's attention that
16 you suspected a Mallory-Weiss tear?

17 A. No, she had told the doctor that Raychel had vomited
18 a coffee-ground vomit.

19 Q. We'll come to what she reported in a moment. But in
20 terms of you asking Nurse Gilchrist to report
21 a Mallory-Weiss tear, that didn't happen?

22 A. No.

23 Q. So you believe that the child had suffered one of these
24 tears, leading to the kind of vomits that was being
25 produced?

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1 A. Yes.
2 Q. And this wasn't brought to the doctor's attention so
3 that he could suggest a treatment plan?
4 A. Well, the doctor was told that she had vomited
5 a coffee-ground vomit.
6 Q. But he wasn't told that the nurse in charge of the ward
7 suspected a tear?
8 A. Well, the doctor ... I mean, he was informed that she
9 had a coffee-ground vomit and I don't know ... I mean,
10 what was he ... It was his job to investigate why she
11 had vomited coffee grounds. It was for him to assess
12 Raychel.
13 THE CHAIRMAN: But if you have an idea about what might be
14 causing this, isn't that why nurses and doctors work
15 together? So if you have an idea about what might have
16 brought this about, you give that idea to the doctor,
17 the doctor may accept it or reject it, but he's not
18 going to discard what an experienced nurse in charge
19 says, is he?
20 A. Yes. But he was made aware that her vomit was coffee
21 ground and I thought that was adequate at that time.
22 I didn't want to -- it wasn't my job to diagnose, but
23 that's what I felt that she had had.
24 MR WOLFE: But it is your job, and we'll look at this in an
25 expanded form in a moment, as the nurse -- or your

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1 screen, during your discussion with Nurse Gilchrist, you
2 concluded that the Zofran hadn't worked and that another
3 anti-emetic might be more beneficial.
4 A. Yes.
5 Q. So at this stage, you're still thinking about this
6 simply in terms of vomiting, you're not suspecting
7 anything more serious.
8 A. No.
9 Q. You're simply thinking about stopping the vomiting.
10 A. Yes.
11 THE CHAIRMAN: Just explain to me one thing: the
12 Mallory-Weiss tear, is that something that sometimes
13 happens because a child has been vomiting?
14 A. Yes.
15 THE CHAIRMAN: That causes a strain or a stretch, which
16 leads to a tear?
17 A. Yes.
18 THE CHAIRMAN: Would that typically be associated with
19 severe vomiting?
20 A. Severe vomiting or retching.
21 THE CHAIRMAN: Right. So that in itself indicates -- even
22 if the tear isn't as rare as Ms Ramsay seems to think,
23 or you disagree with her on that, but that in itself is
24 a sign of how much vomiting and retching there has been?
25 A. Yes.

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1 fellow nurses' job, given that you're the continuity on
2 the ward -- you have the opportunity to observe
3 a patient for longer periods of time than a doctor who's
4 coming from somewhere else in the hospital; do you agree
5 with that?
6 A. Yes.
7 Q. So does it not become the function of the nurse to give
8 the doctor all of the relevant material which is in the
9 hands of the nurse so that he can make an accurate
10 diagnosis?
11 A. I personally didn't have a discussion with that doctor
12 myself.
13 Q. No, I'm conscious of that.
14 A. Yes.
15 Q. I'm talking about nursing duties or nursing obligations.
16 It is a nursing obligation, is it not, to put a doctor
17 in the best position possible so that he can make an
18 accurate diagnosis so that he can build a treatment plan
19 around that?
20 A. Yes.
21 Q. And not telling the doctor that you suspected
22 a Mallory-Weiss tear was an omission in nursing care.
23 A. Well, I thought that the doctor would make that
24 assessment for himself.
25 Q. And just looking at the page in front of us on the

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1 THE CHAIRMAN: Because a Mallory-Weiss tear wouldn't occur
2 to you unless you had a child who had been doing a lot
3 of vomiting and retching.
4 A. Yes.
5 THE CHAIRMAN: In your experience of it, what is the way to
6 cure that? I guess it must be to stop the --
7 A. To stop the vomiting.
8 THE CHAIRMAN: And does the tear heal itself?
9 A. It resolves itself, usually spontaneously.
10 THE CHAIRMAN: But as a starting point, it is an indication
11 of how severe the vomiting and retching has been?
12 A. Yes.
13 THE CHAIRMAN: We're going to need to take a break in a few
14 minutes, Mr Wolfe, so if you just pick whatever time is
15 appropriate.
16 MR WOLFE: Just finishing with this page. You deal at (v)
17 with some of the issues just posed to you by the
18 chairman. Moving down the page to (vi), you're asked:
19 "Did you give any consideration to whether the
20 conditions existed which placed Raychel at the risk of
21 suffering an electrolyte imbalance?"
22 You said:
23 "No, not a this time as Raychel was receiving IV
24 fluids, replacing her fluid losses from vomiting, and
25 I did not suspect that an electrolyte imbalance was

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1 contributing to her symptoms as these could have been
2 due to the reaction to the anaesthetic medication or
3 post-operative nausea and vomiting that some children
4 had experienced in the past."
5 So we're back, in a way, to an issue which we dealt
6 with in general terms yesterday and let's just apply it
7 to Raychel. You were aware now, arising out of this
8 report from Staff Nurse Gilchrist, that this child had
9 been vomiting for various episodes since 8 o'clock. So
10 she's coming up on 14 hours since this vomiting had
11 started. Starting at 8 o'clock in the morning, she's
12 still vomiting at 9 o'clock at night and later; isn't
13 that right?
14 A. That's correct.
15 Q. And would you agree with the suggestion of the experts
16 that have looked at this that this vomiting must now
17 fall into the severe and prolonged category?
18 A. Yes.
19 Q. You have accepted, I think, that with vomiting develops
20 a risk of sodium depletion, that electrolytes are being
21 lost through vomiting and there's a risk of depletion.
22 A. Yes, but because her fluids were in progress, I wasn't
23 unduly concerned at that time. Had she not been on
24 fluids, then I would have been concerned.
25 Q. But you --

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1 I think, was -- yes, the fluid that was given to Raychel
2 all day Friday was the rate of fluid that had been
3 prescribed for her on Thursday night before she went
4 into the operation --
5 A. Yes.
6 THE CHAIRMAN: -- which is precisely one of the problems.
7 A. Yes.
8 MR QUINN: There's one point that I want to raise before
9 this point finishes. I would like through you, Mr
10 Chairman, to ask: could they describe Raychel as giving
11 no cause for concern? I use those words cautiously
12 because those are the words that seem to appear
13 throughout the nurses' statements. There are three, at
14 least, of the nurses who have used those words,
15 including Nurse Millar at WS056/2, if that could be
16 brought up. Page 7. You'll see under (e), second
17 paragraph:
18 "Raychel was on four-hourly observations. Raychel
19 was bright and alert despite the vomits. She was giving
20 no other cause for concern."
21 I want to know if that could be an accurate
22 description of how Raychel was during this nurse's
23 shift. And I want to ask a second question following
24 from that.
25 MR CAMPBELL: Mr Chairman, is that a fair question, because

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1 A. More concerned.
2 Q. You must have known, Mrs Noble, that the fluids that she
3 was getting, the aim of those fluids or the objective of
4 those fluids was maintenance. Nobody had come to see
5 her to prescribe replacement fluids.
6 A. Well, the children that usually had vomiting, even as
7 excessive as Raychel's, in my experience, were only ever
8 treated with their maintenance fluids and anti-emetics.
9 And Solution No. 18 was always the solution that had
10 been in use up until then in my practice.
11 THE CHAIRMAN: Do you know if they were children who also
12 got the right rate of fluid?
13 A. I couldn't comment.
14 THE CHAIRMAN: Because there's a major issue here about
15 Raychel getting too much fluid. So it's not just the
16 type of fluid she was getting, in other words
17 Solution No. 18 as against Hartmann's or something else;
18 it's the rate of fluid she was getting, which was
19 arguably higher than required before the operation, but
20 I think the view of all of the experts is that it was
21 too much after the operation.
22 A. Yes, well, I can't comment on the other rates of fluids
23 because the doctors prescribe the rates of fluids.
24 THE CHAIRMAN: Of course, the problem is that the rate of
25 fluid which was being given to Raychel all day Friday,

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1 the statement from Sister Millar was made during the day
2 shift? We're now talking upwards of maybe 6, 8 or
3 12 hours later.
4 THE CHAIRMAN: Can I ask you it this way, Mrs Noble? Can
5 I take it from the fact that there had been so much
6 vomiting around 8, 9, and then up towards 10 o'clock
7 that that was a cause of concern?
8 A. Yes, and we had communicated that to a doctor.
9 THE CHAIRMAN: This might ease the way for later questioning
10 for you and others: does the fact that a doctor is
11 brought in in itself mean there's a cause for concern?
12 A. Yes.
13 THE CHAIRMAN: Right. The only question is how great the
14 cause of concern is, but a doctor would not be called
15 unless you were concerned about a patient?
16 A. Exactly, yes.
17 THE CHAIRMAN: Okay.
18 MR QUINN: The second point I want to make is -- quite
19 rightly, my learned friend has, as it were, pointed out
20 that that was on the day shift. But could this nurse
21 have given any doctor information after midnight, for
22 example, that Raychel had been reasonably well? And
23 I want to make that point because I want brought up
24 012-040-200. This is a statement by Dr Johnson, who
25 came along at the latter stages after 3 o'clock in the

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1 morning. You'll see in the handwritten notes a question
2 by Mr Foster five lines down. It says:
3 "I had been told Raychel had been reasonably well.
4 I may have been told that she vomited once or twice."
5 Where did that information come from? Because this
6 was the nurse in charge on that shift when Dr Johnson
7 was brought in.
8 THE CHAIRMAN: Okay. Dr Johnson will give evidence, I think
9 he's scheduled for next week, Mrs Noble. On the face of
10 this answer which he gave to the coroner, if he told
11 the coroner that he had been told that Raychel had been
12 reasonably well, is that something that you could have
13 told him?
14 A. I don't recall. I don't recall.
15 THE CHAIRMAN: Well, was it your view that when you were --
16 I think at the handover you were not -- [OVERSPEAKING]
17 at the time of the handover at about 8 pm you were not
18 particularly concerned about Raychel, but after the
19 events of around 9 o'clock, 10 o'clock, you had become
20 concerned about Raychel.
21 A. Yes. And we had got a doctor to come and see her, who
22 had given her another anti-emetic.
23 THE CHAIRMAN: Even to the extent that you thought that that
24 might have worked, would you have told any doctor that
25 Raychel had been reasonably well?

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1 Mrs Noble can say she can't remember saying this, but on
2 that interpretation, "I had been told Raychel had been
3 reasonably well (since the events but from 9 to 10 or 9
4 to 11), but after that she had settled". We'll hear
5 from Dr Johnson more about that.
6 The second point that Mr Quinn raised, Mrs Noble,
7 was that Dr Johnson says, "I may have been told that she
8 vomited once or twice". Well, she had certainly
9 vomited -- this again depends on timescale. But
10 Dr Johnson does not appear to have known that she had
11 been vomiting on a fairly regular basis from about 8 am
12 and had particularly been vomiting in the evening, so
13 that at around about 8 o'clock -- to the extent she
14 needed her bed changed, then after 9 o'clock, and then
15 25 minutes later she had vomited again. That doesn't
16 appear to be what Dr Johnson had picked up if that
17 statement is right.
18 A. All I know is that I probably would have told him about
19 the vomits that I had been aware of on my shift.
20 THE CHAIRMAN: Okay, thank you. We'll take a break for ten
21 minutes.
22 (12.06 pm)
23 (A short break)
24 (12.26 pm)
25 MR WOLFE: Mrs Noble, just a very brief point, which

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1 A. Well, I can't recall what I said to the doctor. But at
2 that time Raychel had appeared to settle after the
3 second dose of anti-emetic and appeared to settle to
4 sleep and appeared settled enough that her parents were
5 happy enough to go home. I think that might have been
6 what I was trying to imply to Dr Johnson at that time.
7 MR QUINN: Mr Chairman, she had a Mallory-Weiss tear.
8 Something has to be put to this nurse that in view of
9 her own view that she had a Mallory-Weiss tear that was
10 not communicated to the first doctor who came on duty to
11 give her the drugs required, how can anybody get
12 information from whoever it was received from that she
13 had been reasonably well? How could that occur?
14 THE CHAIRMAN: Well, it depends how it's read, Mr Quinn. If
15 it's read that Raychel -- it could not be said that
16 Raychel had been reasonably well, for instance, for the
17 duration of Mrs Noble's night shift.
18 MR QUINN: That's correct. But these are the night shift
19 nurses who were telling the doctor that information.
20 THE CHAIRMAN: We'll explore this more, but it depends at
21 what point the "had been reasonably well" refers to.
22 Does it refer to after the arrival of the doctor, about
23 10-ish, and there's another anti-emetic given. She
24 seems to settle, she seems to go to sleep. If you can
25 find the time frame to that point, it may be that

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1 Mr Campbell has asked me to raise with you. Just going
2 back some distance to the issue about whether there was
3 a delay in Raychel coming back from theatre. He's
4 invited me to ask you would there have been a typical
5 time or an expectation of how long surgery would take in
6 this kind of case?
7 A. Well, usually I would have told the parents at that time
8 to expect their children back on the ward after about
9 an hour and a half or two hours. That would have been
10 generally my experience of how long it would take and
11 I usually would have told the parents that the children
12 would have spent longer in the recovery area than they
13 would actually in the theatre itself.
14 Q. Very well.
15 THE CHAIRMAN: It's not one of the fundamental points,
16 Mrs Noble, but if Mr and Mrs Ferguson got the impression
17 or were told that Raychel might only be away from the
18 ward for an hour, that was certainly too short, wasn't
19 it?
20 A. Yes.
21 THE CHAIRMAN: Because even though the operation going well
22 will take less than an hour --
23 A. Yes.
24 THE CHAIRMAN: -- Raychel or any other child, for that
25 matter, has to be taken up to surgery, has to be

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1 anaesthetised, then the operation, the time for
2 recovery, and then she's brought down again.
3 A. Yes.
4 THE CHAIRMAN: So it was never going to be an hour.
5 A. Never, no.
6 MR WOLFE: Going back to the evening of 8 June, you got to
7 see Raychel for the purposes of the medications round at
8 about 25 past, half past 9; is that correct?
9 A. Yes.
10 Q. And you administered Flagyl --
11 A. Yes.
12 Q. -- which is the antibiotic, rectally, and the father
13 raised with you -- that is Mr Ferguson raised with
14 you -- a complaint that Raychel was suffering
15 a headache --
16 A. Yes.
17 Q. -- and you suggested the administration of rectal
18 paracetamol --
19 A. Yes.
20 Q. -- to address the headache.
21 A. Yes. And to help her to settle.
22 Q. And you recalled that she had been asleep at that time,
23 but was unsettled and easily roused.
24 A. Yes.
25 Q. At that time, you would have known that Raychel had

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1 hadn't had any pain relief all day, which I thought
2 could have accounted for her condition of being
3 unsettled and in pain, and the vomiting I thought maybe
4 was giving her a headache as well -- maybe the amount of
5 times she had vomited, she had had a sore head. So I
6 thought if we could relieve her headache, get her an
7 anti-emetic while the fluids were being administered,
8 that Raychel would hopefully settle to sleep and wake in
9 the morning ready to try and start oral rehydration
10 again.
11 Q. You had dealings with Mr Ferguson at that time --
12 A. Yes.
13 Q. -- at the time of doing the medical rounds. You've told
14 us in your witness statement that he had concerns about
15 the vomit and the headache.
16 A. Yes.
17 Q. But you sought to reassure him by explaining that this
18 was not uncommon.
19 A. And it wasn't.
20 Q. His concerns weren't recorded by you in the care plan,
21 were they?
22 A. Not at that time.
23 Q. Not at all.
24 A. Not at that time or at all because of the events that
25 unfolded later on.

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1 suffered these coffee-ground vomits?
2 A. Yes.
3 Q. And at that time, would you have known that the plan was
4 to get a doctor to come to the ward.
5 A. I think she had received her cyclizine prior to me
6 coming.
7 Q. Well, is that right?
8 A. Yes.
9 Q. Because Dr Curran, we can look at this in a moment,
10 seemed to have a recollection that the anti-emetic was
11 administered by him at 10.15.
12 A. I'm not sure of that. I'm not sure of that. I didn't
13 read Dr Curran's statement. But my impression was that
14 at that time that the anti-emetic had been given and
15 that the paracetamol would help her to settle and help
16 relieve her headache.
17 Q. Maybe we'll come back to that point. At that time, as
18 I've said, you have this headache in addition to the
19 coffee-ground vomits, and the child is unsettled on your
20 description. What was your impression of her condition,
21 taking those factors into account?
22 A. My impression was that Raychel had had a difficult
23 post-operative day and that she had vomited and,
24 obviously, the latter had been a coffee-ground vomit,
25 that she required a second dose of anti-emetic, that she

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1 Q. Mr Ferguson, in his account which he gave to the police
2 in 2005, he described Raychel as being in a very poor
3 state at that point in time. She was bright red in the
4 face, she told her father that her head was "wild sore",
5 then she vomited blood, as he describes it, on to the
6 bed. The nurses came in and made Raychel stand while
7 they changed the bed, yet she could hardly stand, given
8 her state at that time. And she subsequently vomited
9 again and thereafter he phoned his wife and told his
10 wife the nurses weren't listening to him, weren't
11 listening to his expressions of concern.
12 You had direct dealings with him; were you taking
13 his concerns seriously?
14 A. From what I recall, I knew Raychel had vomited and
15 I knew that she'd had a headache and Mr Ferguson had
16 said that she wasn't settled and she was easily roused.
17 I felt that if Raychel was given some pain relief, that
18 she wouldn't vomit, that maybe she would settle. And
19 when I assessed Raychel myself, she was able to
20 communicate with me, she was coherent, and she was fully
21 cooperative whenever I tried to get her to assume the
22 position to receive a rectal suppository. So I felt
23 Raychel was actually cooperative at that time.
24 Q. But did you get the impression that Mr Ferguson was very
25 agitated about his daughter's condition?

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1 A. I didn't get that impression at that time.
2 Q. His impression, which he has communicated to the inquiry
3 in his witness statement, is that your approach made him
4 feel angry. You were, to his mind, laid-back and not at
5 all concerned about Raychel. That was his impression.
6 You've seen that in his witness statement.
7 A. I didn't read Mr Ferguson's --
8 Q. Maybe we'll bring it up. WS021/1, page 9. At
9 question 17, you can see a quotation from his police
10 witness statement, reference 095-005-019:
11 "I told Nurse Noble that Raychel was complaining of
12 a sore head and was bright red in the face. Nurse Noble
13 said she would come and give Raychel a paracetamol and
14 did so a short time later. I remember feeling very
15 angry at the way Nurse Noble dealt with that situation."
16 Then he's asked to explain his sense of anger:
17 "She appeared to me to be laid-back and not
18 concerned at all about my daughter."
19 "Did you explain your concern to Nurse Noble or any
20 other member of nursing staff?"
21 "I was just dealing with the situation as it
22 developed and I did not get into any debate with the
23 nurses. I thought they knew best."
24 So the impression conveyed by Mr Ferguson, if I can
25 put it in this way, seems to be of a deteriorating

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1 THE CHAIRMAN: Would it be fair to say from your
2 perspective, Mrs Noble, that -- we never quite know how
3 we come across to each other. I don't know how I come
4 across to you, you maybe don't know how you come across
5 to Mr Ferguson, but looking at the answer (a), which is
6 on the screen, you were concerned about Raychel and
7 that's why when he spoke to you about her headache, you
8 were talking about rectal paracetamol.
9 A. Yes.
10 THE CHAIRMAN: You shared the concern which had been
11 expressed to the extent that a doctor was going to be
12 brought in to check what Raychel needed or what was
13 wrong with her. So you would say, I presume, that it's
14 not fair to say that you weren't concerned at all?
15 A. No, it's not. I felt I was being professional.
16 THE CHAIRMAN: Yes. But you were not concerned that
17 Raychel's life was in any way in danger?
18 A. Because I had never encountered anything like
19 hyponatraemia before.
20 THE CHAIRMAN: Okay. Thank you.
21 MR WOLFE: Well, as you say, you were sufficiently concerned
22 to get a doctor to come to Raychel.
23 A. Yes.
24 Q. It appears from the extracts from your statement we
25 looked at earlier that you wanted to get a doctor there

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1 situation for his daughter. The normal recovery path
2 was now a distant memory, she had been vomiting during
3 the day and now the vomiting appeared to be getting
4 worse. She was bright red in the face, she had
5 a headache, and yet the nurses, according to him -- and
6 in particular, yourself -- didn't seem to be giving him
7 the reassurance that it was being taken seriously.
8 A. Well, I had never experienced a child deteriorating with
9 hyponatraemia. I had experienced children being
10 nauseated and vomiting throughout the day
11 post-operatively, first day post-operatively. I noted
12 that she had had no pain relief from early morning and
13 all I wanted to do was to try and make Raychel
14 comfortable at that time. I treated Raychel the way
15 I would have treated any child, and Mr Ferguson did not
16 express to me at that time how much he was concerned.
17 He told me the facts, yes, but with the knowledge that
18 I had at that time, I just felt Raychel had had
19 a particularly poor post-operative first day and that
20 I would try and relieve the symptoms that I would see.
21 We had contacted a doctor, who was going to come and
22 assess Raychel and make an assessment should anything
23 else be required, and as I say, I'm sorry that
24 Mr Ferguson felt angry at that because I certainly
25 didn't ...

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1 in order to provide an anti-emetic --
2 A. Yes.
3 Q. -- to Raychel.
4 A. Yes.
5 Q. The doctor that was contacted was a junior house
6 officer.
7 A. Yes.
8 Q. In the nature of things, a junior house officer is
9 relatively inexperienced; isn't that right?
10 A. Yes.
11 Q. You would know that, essentially, he's a non-qualified
12 member of the medical staff in training.
13 A. Yes. That was the practice at that time, to contact the
14 junior house officer initially, and if he felt he had
15 any concerns, then he ascended the line of seniority to
16 express his concerns and take advice from his seniors.
17 Q. Would you agree with me that there were other options,
18 had you sought to trigger them that night? You could
19 have, for example, approached a paediatrician on the
20 ward if you were sufficiently concerned?
21 A. That was not common practice.
22 Q. Well, we know, for example, that a paediatrician was
23 contacted earlier in the day for the most basic of
24 tasks, of writing a prescription --
25 A. Yes.

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1 Q. -- in respect of Raychel's fluids. So presumably, if
2 you felt the situation had deserved it, you could have
3 contacted a paediatrician.
4 A. Yes, but the first port of call was to ring the surgeon.
5 She was a surgical patient, therefore you contacted the
6 surgical doctors about her, and due to the surgical
7 doctors not being present on the ward at all times --
8 paediatricians were there at all times and it probably
9 was easier for a paediatrician to prescribe the fluids
10 rather than to take a surgical doctor away from the
11 surgical ward.
12 Q. Yes. Do you mean a paediatric doctor away from the
13 surgical ward?
14 A. Sorry? I beg your pardon?
15 Q. Just explain your logic again.
16 THE CHAIRMAN: You said:
17 "It was probably easier for a paediatrician to
18 prescribe the fluids rather than to take a surgical
19 doctor away from the surgical ward."
20 A. Yes. That's what I'm saying.
21 MR WOLFE: In terms of the interaction between your nurse
22 colleague, Ms Gilchrist, and the doctor who came,
23 Dr Curran, would you agree with Ms Ramsay's analysis
24 that the responsibility of the nurse is to monitor
25 a patient's progress and to advise medical staff of any

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1 patient and they decide then what investigations should
2 be carried out as a result of that assessment.
3 Q. Yes, but I thought I had you agreeing with me that what
4 you and Nurse Gilchrist intended and in fact asked for
5 was for the doctor to come to prescribe an anti-emetic.
6 A. Yes, but a doctor must see the patient and make his own
7 assessment. I mean, I wouldn't advise a doctor to do
8 anything without making a full assessment of the patient
9 before doing so.
10 Q. Yes. So as I understand it, you didn't see Dr Curran
11 when he came?
12 A. No.
13 Q. It appears from the entry in the drug kardex that he
14 administered Valoid. The reference for that -- and I'm
15 not sure we need it up on the screen -- is 020-017-034,
16 which appears to be some 45 minutes or so after you were
17 carrying out your medication round. Let's just take
18 stock, if we can, to reflect upon all of the factors
19 that made up Raychel's condition at that time. What
20 I want to ask you when I set these out for you,
21 Mrs Noble, is whether you or your nurse colleague,
22 Mrs Gilchrist, ought to have communicated these factors
23 to the doctor.
24 The relevant factors seem to be, and you can correct
25 me if I'm wrong, are: this is a child who had a mildly

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1 changes or variations from the expected recovery
2 pathway?
3 A. Yes.
4 Q. And does that imply that when Dr Curran arrived on the
5 ward, he should have been given all of the relevant
6 information necessary for him to make a, if you like,
7 a diagnosis or to decide on what investigations were
8 required?
9 A. Yes, that will be ...
10 Q. Arising out of your conversation with Nurse Gilchrist,
11 am I right in saying that, between the two of you, you
12 simply reached a conclusion that the doctor should come
13 to prescribe an anti-emetic?
14 A. Well, at that time we felt that Raychel's vomiting was
15 the biggest problem and that if the vomiting was
16 stopped, that Raychel would recover and begin to feel
17 better.
18 Q. Do I infer from that then that when the doctor came,
19 he was going to be asked to prescribe an anti-emetic --
20 A. Yes.
21 Q. -- as opposed to carrying out investigations to
22 determine what might underlie Raychel's deteriorating
23 condition?
24 A. Well, as nurses we don't ask doctors to carry out
25 investigations, they make their own assessment of the

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1 congested appendix; isn't that right?
2 A. Yes.
3 Q. The expectation was that she would have a fairly smooth
4 recovery and be up and about and eating light snacks
5 during the course of that day; isn't that right?
6 A. That's correct.
7 Q. And in fact, the recovery path was, for a short period
8 of time into mid-morning at least, just like that. She
9 had experienced that recovery pathway.
10 A. Yes.
11 Q. But she had been vomiting at various points during the
12 day; isn't that right?
13 A. Yes.
14 Q. Moreover, if one looked at the fluid balance chart --
15 and if we could have that up on the screen, please, it's
16 020-018-037 -- we can see that in terms of passing
17 urine, the child had only passed urine, according to
18 this record, on one occasion; isn't that right?
19 A. Yes.
20 Q. And, according to this record, she hadn't taken any oral
21 fluids, albeit that is to be contrasted to some extent
22 with what is recorded in the episodic care plan.
23 A. Yes.
24 Q. All of those factors that I've listed, should they have
25 been brought to the attention of the doctor?

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1 A. Yes.
2 Q. And then we get into a situation in the early evening
3 where Raychel's had an anti-emetic for the first time at
4 6 o'clock or thereabouts. That's only had fair effect,
5 in other words she's had nausea or vomiting
6 notwithstanding the administration of that drug.
7 Is that a factor that should have been brought to the
8 attention of the doctor coming in at 10 o'clock?
9 A. Yes.
10 Q. And moreover, she's now in a situation where she is
11 described as being bright red in the face by her father,
12 albeit the nursing observation -- and we'll look at that
13 in a minute -- says she's "moving from being pale to too
14 red", I think that is the expression. Her complexion or
15 appearance is varied. Should that factor have been
16 brought to the attention of the doctor?
17 A. Yes.
18 Q. And these coffee-ground vomits, which, in the view of
19 some, are indicative of severe retching or vomiting and
20 may be consistent with prolonged vomiting as well,
21 should the coffee-ground vomits have been brought to the
22 attention of the doctor?
23 A. Yes, and it was written on the fluid balance sheet.
24 Q. Yes.
25 A. And the doctor had access to those sheets.

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1 quite bad again from 8 o'clock onwards.
2 A. Yes. I wasn't aware of what the relatives had witnessed
3 or had experienced at that time. I wasn't aware of
4 that.
5 THE CHAIRMAN: But you were aware that there had been
6 vomiting at, I think, 9.25 and then 25 minutes or so
7 later.
8 A. Yes.
9 THE CHAIRMAN: Whatever you individually knew, the
10 collective knowledge of the nursing team was that the
11 vomiting was bad enough at one point for her bed to have
12 to be changed --
13 A. Yes.
14 THE CHAIRMAN: -- which suggests something more than a small
15 vomit of retching. It suggests something more than
16 that.
17 A. The bed would have been changed if there was a small
18 vomit or even a mouthful. It didn't quantify --
19 THE CHAIRMAN: It depends where it hit?
20 A. It depends where it hit. We would have changed every
21 child's bed who had vomited, whether it be a spot or
22 a lot.
23 THE CHAIRMAN: So the hours from 8 o'clock onwards, but
24 particularly from 9 o'clock onwards, were a clearly a
25 very bad time.

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1 Q. So all of these factors should have been brought to the
2 attention of the doctor. And indeed, when you take them
3 all together, Mrs Noble, all of these factors taken
4 together point to a situation where this child is not
5 behaving in a manner consistent with the expected
6 recovery pathway; isn't that right?
7 A. Yes.
8 Q. Her body is reacting in a way which is a departure from
9 the normal recovery pathway?
10 A. Yes.
11 Q. And --
12 A. But it was not something that was rare. We had
13 experienced children who had behaved similarly and, in
14 my experience, I felt that Raychel just was having
15 a very bad post-op day and her fluids were in progress.
16 THE CHAIRMAN: Sorry, let me add to this. At the 8 o'clock
17 handover, the note which you saw gave you the impression
18 that she had been sick earlier, but that things had
19 improved.
20 A. Yes, but then obviously she had required the Zofran at
21 5.30 because she had vomited again.
22 THE CHAIRMAN: Yes. And then did things seem to improve but
23 then they had got quite bad again?
24 A. Yes.
25 THE CHAIRMAN: To try and put it neutrally, they had got

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1 A. She had vomited the coffee-ground vomit and we had got
2 the doctor to come and see her.
3 MR WOLFE: You would have reasonably anticipated the doctor
4 coming to see her would have been a young, inexperienced
5 doctor with much less exposure to treating children than
6 you as nurses would have had.
7 A. Well, it would have been normal practice for us to ring
8 the junior surgical house officer and they would have
9 administered anti-emetics to children who had had
10 vomiting.
11 Q. The point I'm directing that question at is: was there
12 not an onus on yourselves as nurses to bring all of the
13 material which I've just described to the attention of
14 the doctor and make it clear to him that, in terms of
15 your monitoring of the child, she was not doing as well
16 as you would have expected and that you were now
17 concerned?
18 A. Yes, but when we were working night duty, it wasn't
19 always possible for a nurse to go with the doctor, but
20 we would have given them the reason for calling him.
21 THE CHAIRMAN: I understand that, that you don't always have
22 the luxury of a nurse free to go and accompany the
23 doctor to see the child. But fairly early this morning,
24 what you said was if that wasn't possible, you would
25 make a point of speaking to the doctor so that the

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1 doctor would know what the concerns are, so that even if
2 you're with another child, the doctor who then goes to
3 see Raychel has the information that you have. It
4 doesn't have to be you, it could be --
5 A. It could be somebody else.
6 THE CHAIRMAN: It could be Nurse Gilchrist, and in this case
7 it was Nurse Gilchrist who called the doctor and told
8 you she was doing that and you thought that was entirely
9 the right thing to do.
10 A. Yes.
11 THE CHAIRMAN: Whether either of you accompanied Dr Curran
12 to see Raychel, wasn't it relevant or helpful for one of
13 you to speak to Dr Curran?
14 A. Yes, it would have been.
15 THE CHAIRMAN: Right.
16 A. But I was continuing the rest of the medications at that
17 time and Nurse Gilchrist and Nurse Bryce were on the
18 ward and it would have been normal practice for one of
19 those nurses to, if they had seen the doctor, either go
20 with them or at least to speak with them after he had
21 been to assess Raychel.
22 THE CHAIRMAN: Okay. Would it also have been normal for the
23 doctor to come to speak to the nurse?
24 A. Yes.
25 THE CHAIRMAN: He comes along and he goes to see Raychel and

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1 A. Well, I would hope that the doctor would make a full and
2 frank assessment of the child when he would come to see
3 her.
4 Q. But this is a doctor, just so that we understand the
5 context here, who is a junior house officer, so he's
6 very inexperienced; isn't that right?
7 A. This was in June and Dr Curran would have been there,
8 I'm sure, from --
9 Q. The previous August?
10 A. The previous August. He would have been used or au fait
11 with assessing patients.
12 Q. He has not had the opportunity that you and your
13 colleagues have had to observe this child over a period
14 of time; isn't that right?
15 A. Yes.
16 Q. So the duty, as Ms Ramsay describes it, is for you as
17 the nurse or your colleagues as nurses to put the doctor
18 in the picture, to make him understand all of the things
19 that have happened so that he can then apply his medical
20 mind to the appropriate treatment plan or diagnosis?
21 A. Yes.
22 Q. But can I suggest to you that all that you and your
23 colleagues did as nurses was to ask Dr Curran to come to
24 prescribe an anti-emetic without reflecting to him the
25 difficulties that this child had had over a longer

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1 there isn't a nurse immediately to hand, then it's also
2 fair to say that in the same way that you want to speak
3 to the doctor, the doctor would want to speak to you.
4 A. I would expect that, yes.
5 MR WOLFE: It is the case that Staff Nurse Gilchrist
6 contacted this doctor.
7 A. Yes.
8 Q. She has told the inquiry in her statement that she
9 wasn't present when he attended because she was
10 attending to other children.
11 A. Yes.
12 Q. If she didn't attend him and you didn't attend him, the
13 only other option is Nurse Bryce, and there's no
14 suggestion that she attended him.
15 A. Or he had gone on his own.
16 Q. He obviously then came on to the ward, administered the
17 anti-emetic, and it appears that his only point of
18 contact was the telephone call from Nurse Gilchrist to
19 him, asking him to come; is that right?
20 A. Well, as far as I'm aware, yes.
21 Q. And what Nurse Gilchrist tells us is that she contacted
22 Dr Curran, explained to him about Raychel's nausea and
23 vomiting, and he said he would come to see her. If
24 that's all he was told, Mrs Noble, that wasn't enough,
25 was it?

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1 period of time, which were inconsistent with all of the
2 expectations for her?
3 A. Well, basically I just felt that ... We had never
4 encountered anything like hyponatraemia before and that
5 the vomiting wasn't unusual, that the first anti-emetic
6 hadn't been effective, that hopefully by the second
7 anti-emetic that Raychel would respond, the vomiting
8 would stop and her fluids were in progress, and the
9 doctor would make a full assessment of Raychel. On
10 night duty, it wasn't uncommon that the doctors didn't
11 go to the patient's bedside themselves and they knew
12 who -- they were advised of who they were going to have
13 to see. Doctors normally would have taken the patient's
14 notes, read through them and gone and made an assessment
15 of the patient before administering anything. And
16 usually, they would come and tell the nurses what they
17 had done and what their opinion was and what the plan
18 would be. But I don't recall Dr Curran coming to speak
19 to either me after he had given Raychel her
20 anti-emetic ...
21 Q. Let me ask you about that. I think you've agreed with
22 me that if the doctor was simply told "this child has
23 been vomiting, please give her an anti-emetic", that was
24 insufficient, wasn't it --
25 A. Yes.

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1 Q. -- if that is all he was told?
2 A. If that is all he was told, then yes.
3 THE CHAIRMAN: Even if that's all he's told, your point
4 is that this isn't a one-way street, he should come
5 looking for --
6 A. Yes.
7 THE CHAIRMAN: -- and he should be looking for the notes?
8 A. Yes, and he should be making a full assessment of the
9 child when he would go to see her.
10 THE CHAIRMAN: And if he doesn't think the notes are clear
11 enough or don't give him all the information he wants,
12 all the more reason for him to speak to you or Mrs
13 Gilchrist.
14 A. Yes, and the parents, to get a full assessment of how
15 Raychel was.
16 THE CHAIRMAN: So for instance, if Mr Ferguson's still
17 there, Mr Ferguson gets the chance to tell Dr Curran
18 exactly what he thinks is wrong and why he is so
19 worried?
20 A. Yes.
21 MR WOLFE: It's of course accepted by the experts who have
22 looked at this, that this is not just a one-way street,
23 but in terms of nursing responsibility you thought the
24 issue demanded the attention of a doctor, didn't you?
25 A. Yes.

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1 THE CHAIRMAN: Sorry. The reason I'm saying that is that
2 I don't think there's any evidence from Dr Curran that
3 he went looking for a nurse and couldn't find anybody.
4 MR WOLFE: I don't think he's saying that. In fact, his
5 memory is quite vague on it. He does seem to have
6 a recollection of telling a nurse that if the vomiting
7 didn't settle, he would come back to review the patient,
8 but you can't recall any dealings with this doctor?
9 A. No.
10 Q. And indeed Nurse Gilchrist has denied any dealings with
11 the doctor. It would, of course, have been important,
12 whether it's the doctor's responsibility or the nursing
13 responsibility, to put yourselves in a position where
14 there was communication in terms of diagnosis and
15 treatment plan.
16 A. Yes, but, as I say, we obviously felt that Raychel's
17 major problem was her vomiting at that time. And
18 because her fluids were going, that the doctor would
19 hopefully administer an anti-emetic, that her vomiting
20 would subside. We had experienced the same situation
21 with similar children and would have hoped that she
22 would have recovered, and as Dr Curran has said, he
23 would have come back, to whoever he said it to, he was
24 going to come back and review her if the vomiting hadn't
25 settled, but the vomiting did appear to settle after

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1 Q. No doubt there are other demands on nursing time on this
2 ward.
3 A. Yes.
4 Q. But here is a child who, I think you've agreed with me,
5 whose situation is now serious in the sense of now
6 producing coffee-ground vomits.
7 A. Yes.
8 Q. A Mallory-Weiss tear suspected, the previous anti-emetic
9 hadn't worked, vomiting most part of the day on and off.
10 A. Yes.
11 Q. Why didn't you or your colleagues make it your business
12 to be there when the doctor arrived and to attend him
13 at the bedside of Raychel?
14 THE CHAIRMAN: I'm not sure that's entirely fair because I'm
15 not sure the nurses were off anywhere else. I think the
16 nurses were on the ward. It's not as if they weren't on
17 the ward. Maybe put it slightly differently: if you or
18 Nurse Gilchrist had seen Dr Curran coming in, would it
19 have been right for one of you to do everything you can
20 to get over to him?
21 A. Yes.
22 THE CHAIRMAN: And vice versa for him to make a point of
23 speaking to you?
24 A. Yes.
25 MR WOLFE: Is it the case that the --

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1 that.
2 Q. We'll come to that in a moment, but the mindset appears
3 to be, and correct me if I'm wrong, that this was normal
4 vomiting, not uncommon, and that the doctor should
5 simply get on with providing an anti-emetic; is that
6 a fair description --
7 A. That's fair at that time, yes.
8 Q. -- of how the nurses viewed this?
9 A. At that time, yes.
10 Q. And do you think it's fair to suggest that this was the
11 mindset that was communicated to this inexperienced
12 doctor?
13 A. I didn't communicate with him, so I can't answer that.
14 Q. In terms of your dealings with the person who was going
15 to communicate with him, that's the mindset that you
16 were of and that Nurse Gilchrist was of?
17 A. Yes.
18 Q. Did you put a plan in place in respect of Raychel after
19 the departure of Dr Curran?
20 A. No.
21 Q. Or to put it another way, Raychel was on four-hourly
22 observations, isn't that correct --
23 A. Yes.
24 Q. -- albeit that her fluids were checked every hour?
25 A. Yes.

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1 Q. Was any special arrangement put in place for her when
2 Dr Curran left?
3 A. There was no special plan put in place, but I was aware
4 that the nurses would be checking Raychel's IV fluids
5 hourly, so that they would be seeing the child every
6 hour and that if she had vomited further, the parents
7 with Raychel would have communicated that to us, and
8 that if there had been any other concerns we would have
9 been aware of them and if there would have been any
10 deterioration that we would have then contacted the
11 doctor.
12 Q. Could I have up on the screen an answer that you gave in
13 a witness statement, 049/2, page 9? Could I have
14 alongside that page 10, please? After a doctor's
15 administered an anti-emetic, somebody should be checking
16 the patient or the child to determine whether that
17 anti-emetic has had an effect; isn't that right?
18 A. That's correct.
19 Q. And you're asked at (e) at the bottom of the left-hand
20 page:
21 "Even if you did not speak to the surgical junior
22 house officer, please explain the following. What was
23 your understanding of Raychel's condition after the
24 surgical junior house officer had seen Raychel?"
25 You say:

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1 A. Yes.
2 Q. Then you're asked:
3 "What was the treatment plan for Raychel after she
4 had been seen by the surgical junior house officer?"
5 And it was to:
6 "Monitor the effects of medication which had been
7 administered and report any change in condition."
8 A. Yes.
9 Q. And you were asked:
10 "What notes or records, if any, were made
11 in relation to the attendance of the surgical junior
12 house officer and the steps taken by him?"
13 You say:
14 "No notes were made and I only realised this
15 retrospectively."
16 A. Yes.
17 Q. So there was, it suggests here, a plan to monitor the
18 effects of the medication --
19 A. Yes.
20 Q. -- which had been administered. Was anybody given the
21 specific task of doing that?
22 A. No, but obviously we were all aware that Raychel had
23 been given a second anti-emetic and we would have been
24 noting the effect that it would have had, whether it
25 would have ceased her vomiting.

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1 "That Raychel would hopefully settle, having had her
2 IV cyclizine and rectal paracetamol."
3 So that's what you were anticipating would hopefully
4 happen?
5 A. Yes.
6 Q. But what was your understanding of her condition at that
7 time, after the administration of the cyclizine?
8 A. Again, I just thought it was post-operative nausea and
9 vomiting that had gone beyond requiring a second --
10 a first anti-emetic, she required a second one that
11 probably and hopefully would have been more effective
12 for her.
13 THE CHAIRMAN: Just before you go on, does Mr Ferguson
14 remember Dr Curran attending Raychel? Could you find
15 out?
16 MR QUINN: We'll take instructions on that.
17 THE CHAIRMAN: You can come back after lunch.
18 MR WOLFE: At (ii) there, at the bottom of the left-hand
19 page:
20 "Was there any plan to monitor Raychel after she had
21 been seen by the surgical junior house officer and, if
22 so, what was that plan?"
23 You say:
24 "The plan was to continue to observe her in the
25 normal way."

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1 Q. Well, you say everybody was aware of that. Clearly --
2 THE CHAIRMAN: If nobody saw Dr Curran, how did you all know
3 that.
4 A. That she had had her cyclizine? It was left out for
5 Dr Curran to administer and obviously sign for as having
6 been given.
7 THE CHAIRMAN: Left out by who?
8 A. I'm not sure. I can't remember at that time whether
9 I left it out or whether Nurse Gilchrist got the keys
10 and left it out for him with Raychel's kardex.
11 THE CHAIRMAN: Is this not the point that Mr Wolfe was
12 asking about a few minutes ago, that in a sense, far
13 from Dr Curran coming in to do an investigation and
14 analysis of how Raychel is and what's wrong with her,
15 the nurses between them have effectively already
16 decided, at least for their part, "We know what's wrong
17 with Raychel, she needs another dose of anti-emetic, so
18 we'll leave it out". So Dr Curran comes along and he
19 could form the view: well, I've got experienced nurses
20 here, this is what we do for Raychel, I'll give her the
21 anti-emetic.
22 A. That's what had worked in my experience with a lot of
23 the other children that we had nursed post-operatively.
24 THE CHAIRMAN: Okay.
25 A. That was the experience that I had at that time.

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1 MR WOLFE: Yes. The point being, however, Mrs Noble, that
2 whatever about the responsibilities of a registered
3 medical practitioner, Dr Curran -- and he will obviously
4 be tasked with some questions about his actions on that
5 night -- would the inquiry be wrong to form the
6 impression that nurses took all diagnosing out of the
7 equation by providing the remedy to the doctor to
8 administer when he arrived, without him having to apply
9 any thought processes? You put the medication on the
10 table for him.
11 A. We knew Raychel was vomiting and we knew that the first
12 anti-emetic didn't work and that there was an
13 alternative anti-emetic that possibly could work.
14 Q. And is it fair to say then that the only reason
15 Dr Curran was called is that nurses aren't legally
16 permitted to prescribe and administer such an
17 anti-emetic, rather than getting him along to carry out
18 an investigation?
19 A. Well, that's the doctor's responsibility to come and
20 make an assessment of any patient before they would
21 administer any medication to see if it was warranted.
22 Q. It's a chicken-and-egg situation, isn't it?
23 A. It is.
24 Q. If you're telling the doctor, "All this child needs is
25 an anti-emetic for a little bit of post-operative

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1 Q. Did Raychel vomit again?
2 A. I think she had had a mouthful around midnight or so.
3 Q. If we could have up on the screen the fluid balance
4 chart at 020-018-037. We know that Dr Curran attended
5 at 10.15. At least, that's when he logged the
6 administration of the Valoid; isn't that right?
7 A. Yes.
8 Q. And at that time, in terms of the recording of vomit
9 during the night shift, we have, "Vomiting coffee
10 grounds, plus plus", with Staff Nurse Gilchrist signing.
11 And then a further vomit, of multiplied by 3, at the
12 2200 hours slot. And within the 2300 hours slot, "small
13 coffee-ground vomit"; do you see that?
14 A. Yes.
15 MR CAMPBELL: Just for the record, the middle entry reads:
16 "Vomited small amount by 3."
17 MR WOLFE: Thank you. I did stumble over the handwriting.
18 I'm obliged.
19 So it does appear that here was a further vomit
20 which occurred after Dr Curran had seen this patient.
21 A. But a lessening amount and hopefully the anti-emetic was
22 starting to work. It doesn't work straightaway.
23 Q. Then there is a further vomit found on the child's
24 pyjamas at 35 minutes after midnight, isn't that
25 right --

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1 nausea", a junior doctor, rightly or wrongly, might be
2 minded to simply accept that advice from an experienced
3 nurse, such as yourself or Mrs Gilchrist. Whereas if
4 you're saying to the doctor, "Actually, there's
5 something strange going on here, this child is departing
6 from what we expected of her post-operative recovery
7 pathway", then he's going to have to think and apply his
8 medical mind to it; do you see the distinction?
9 A. Yes.
10 Q. And the mindset here, as I think you've accepted
11 earlier, is that this was normal and that's the mindset
12 that was conveyed, was it?
13 A. Well, again, we had no experience to make us think
14 otherwise.
15 Q. In terms of what happened afterwards then, you say that
16 nobody was given a particular responsibility to monitor
17 the effect of the anti-emetic.
18 A. No.
19 Q. Should somebody have been given that responsibility?
20 A. Well, there were three nurses on that night and we all
21 would have spoken between ourselves, and had Raychel
22 vomited, it would have been communicated. And
23 obviously, had she vomited, we would have assumed the
24 anti-emetic was not effective and would have contacted
25 the doctor again to say that she was still vomiting.

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1 A. Yes.
2 Q. -- which wasn't recorded?
3 A. Yes.
4 Q. You've described yourself and two other nurses being
5 dedicated to this ward and that you were working as
6 a team; isn't that right?
7 A. Yes.
8 Q. And the team, in order to monitor the effect of the
9 anti-emetic, would need to know that an anti-emetic had
10 been prescribed; isn't that right?
11 A. Yes.
12 Q. And would need to know that such a plan was being
13 implemented, in other words monitoring the child?
14 A. Yes.
15 Q. And yet the person who brings the 11 o'clock vomit to
16 the attention of you or your nurses was not one of the
17 three of you; isn't that right?
18 A. I can't recall.
19 Q. You see, Nurse Patterson, who was dedicated to the
20 infants' unit on that particular night, received a vomit
21 bowl from Raychel's father. It was her that wrote the
22 small coffee-ground vomit into the notes. Were you
23 aware of that?
24 A. I can't recall that I was made aware that she had had
25 that small coffee-ground vomit. I can't recall that

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1 I was made aware of that.
2 Q. Nurse Patterson says that she accepted a vomit bowl from
3 Raychel's father at 2300 hours. She recorded and
4 reported the vomit, but she doesn't know to who.
5 A. Yes.
6 Q. In fairness to you, you have told us that you were
7 advised of the vomits at 2200 hours and 2300 hours by
8 either Gilchrist or Bryce, but you've also said the
9 implications of those vomits weren't discussed. Dealing
10 with the 2300 hours vomit, which was the one picked up
11 by Nurse Patterson, who wasn't one of the team that
12 night --
13 A. Yes.
14 Q. -- firstly, if the plan was to monitor the effect of an
15 anti-emetic on a child who had been very sick with
16 coffee-ground vomits, how was it that one of the team
17 dedicated to the task of monitoring Raychel didn't pick
18 up on it?
19 A. Maybe it was just a bit of coffee-ground vomit that was
20 left in Raychel's stomach that needed to come out. It's
21 not usually tolerated very well and maybe that was the
22 beginning of the anti emetic starting to work, but the
23 substance in her stomach needed to come out.
24 THE CHAIRMAN: Maybe it was and maybe it wasn't; isn't that
25 the problem?

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1 MR WOLFE: You have a situation, Nurse Noble, where you have
2 this series of coffee-ground vomits, you get an
3 anti-emetic put in and then you have a further vomit.
4 You tell us in your statement that the effect of the
5 anti-emetic is to be monitored.
6 A. Yes.
7 Q. It doesn't appear to have been monitored in the sense
8 that it took another nurse, not dedicated to this ward
9 that night, to pick up on this. She brings it to
10 someone's attention and you tell us in your witness
11 statement that the implications of the vomiting --
12 MR CAMPBELL: Mr Chairman, that question is based on the
13 proposition that it was other than a coincidence.
14 Nurse Patterson was walking through the ward and was
15 given the bowl by the father and dealt with it. That's
16 the reasoning behind that situation.
17 THE CHAIRMAN: So your suggestion is that that's not
18 inconsistent with Raychel being monitored?
19 MR CAMPBELL: Yes. It's pure coincidence that
20 Nurse Patterson happened to be walking past the father
21 just as he came out with the bowl.
22 THE CHAIRMAN: Okay.
23 MR WOLFE: Let's work with that point. The vomits having
24 been brought to your attention, was there not an
25 obligation on you as the lead nurse, in conjunction with

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1 A. Yes.
2 THE CHAIRMAN: That could be a sign that Dr Curran's
3 prescription isn't working.
4 A. Yes. Well, it had only been given 45 minutes, roughly,
5 beforehand.
6 THE CHAIRMAN: Yes, but how can you assume, Mrs Noble, that
7 the fact that Raychel vomits again 45 minutes later may
8 be just a leftover vomit which hasn't yet come out of
9 her? How can you assume that?
10 A. Maybe that was just what I assumed at that time.
11 THE CHAIRMAN: The other interpretation is that she has been
12 vomiting -- she's vomited at some time after 9 o'clock,
13 she's vomited some time again after 10 o'clock, she gets
14 drug from Dr Curran that you and Nurse Gilchrist thought
15 she should get and, 45 minutes later, she vomits again.
16 Then there's another one. So the other interpretation
17 is that actually this run of vomiting hasn't stopped,
18 this isn't just something which the anti-emetic will
19 sort out.
20 A. Yes, but we thought the anti-emetic would obviously take
21 a while to work and that the effects of it would be
22 ongoing. I think it's usually every 8 hours or so that
23 you would give cyclizine. So we would hope that maybe
24 it would eventually settle her vomiting, or certainly
25 lessen it, which it happened to do so.

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1 your colleagues, to assess the implications of this
2 further vomit and, in particular, to report it back to
3 the doctor?
4 A. Well, at that time, we thought Raychel was going to
5 settle.
6 Q. Yes.
7 A. And in hindsight, yes, we probably should have called
8 a doctor back to re-evaluate the effectiveness of the
9 anti-emetic, but because the amounts were less, then we
10 thought things were settling down.
11 Q. You see, this was obviously at a very key period of
12 time, given what we now know.
13 A. Yes.
14 Q. Obviously, at that time, you didn't appreciate that this
15 was a child suffering increasing intracranial pressure
16 and hyponatraemia. But as nurses, you had an
17 obligation, had you not, to stand back and think about
18 how serious the situation was; isn't that right?
19 A. Yes.
20 Q. And while no doubt you did the right thing to get
21 a doctor there in the first place, albeit there are
22 issues about what that doctor was told to do, having got
23 that doctor there surely, as nurses, you should have
24 been reporting back to the doctor when the anti-emetic
25 didn't, it would appear, work in the sense of preventing

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1 further vomiting, at least initially?
2 A. But the vomiting was lessening, the amount was
3 lessening, and we felt that the anti-emetic was working.
4 THE CHAIRMAN: I think I interpret what Mrs Noble said a few
5 minutes ago -- and please correct me if I'm wrong -- as
6 saying that the view you took at that time was that
7 although Raychel was still vomiting, the vomits were
8 smaller.
9 A. Yes.
10 THE CHAIRMAN: And you, as it turns out wrongly, interpreted
11 that or understood that to be consistent with the
12 anti-emetic working.
13 A. Yes.
14 THE CHAIRMAN: As opposed to a sign that it wasn't working.
15 A. Yes.
16 THE CHAIRMAN: And given what then happened in the following
17 few hours, you regret that that was the view you took.
18 A. Yes. Very much so.
19 MR WOLFE: Staff Nurse Bryce identified further vomit on the
20 child's pyjamas, as I've said, at 0035 hours. In other
21 words, the early hours of 9 June.
22 A. Yes.
23 Q. Again, while that was a small vomit, it didn't make its
24 way into the notes and records. Is that indicative of
25 a conclusion having been reached that this wasn't

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1 wanted to go to sleep.
2 MR WOLFE: Is this Nurse Gilchrist or Nurse Bryce?
3 A. Nurse Gilchrist.
4 THE CHAIRMAN: Do you know what either Mr or Mrs Ferguson
5 said about that? No, they'd gone by then.
6 A. They had gone by that stage.
7 THE CHAIRMAN: Okay. We'll break for lunch and try and
8 resume at 2.15. Thank you.
9 (1.30 pm)
10 (The Short Adjournment)
11 (2.15 pm)
12 Timetabling discussion
13 MR CAMPBELL: Before we resume, I wonder if I could raise
14 the issue of timetabling? I understand there have been
15 some proposed changes to that in view of the overrunning
16 of Mrs Noble's evidence. The witnesses who were
17 scheduled for today, that's nurses Patterson and Bryce,
18 both travelled here from the Derry area yesterday in
19 order to familiarise themselves with the proceedings
20 here and overnighted last night and would have been
21 prepared to overnight tonight in order to give their
22 evidence tomorrow. I understand, however, that it is
23 proposed that Sister Millar will give her evidence
24 tomorrow.
25 I can say that one of my two ladies, Patterson and

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1 something to be concerned about?
2 A. Well, at that time I had since left the ward, around
3 12.30 or so, to go on my break, and from getting
4 a handover on how the patients were coming back from my
5 break, I was told that she had vomited a mouthful, that
6 obviously the nurse felt was a very small amount, a very
7 small amount, and maybe didn't warrant ...
8 THE CHAIRMAN: Sorry, which one?
9 A. The one at half twelve, 12.35.
10 THE CHAIRMAN: So you were told about that when you --
11 A. When I came back from my break.
12 THE CHAIRMAN: Your break would be roughly how long?
13 A. 45 minutes to an hour.
14 THE CHAIRMAN: Roughly between 1 and 2, is it?
15 A. Yes, I think it was about 2 o'clock whenever I came
16 back. On occasion, on night duty, you would maybe take
17 the first break and the last break together.
18 THE CHAIRMAN: Right. But in any event, when you came back
19 from your break, which you think might have been about
20 2 o'clock, you were told that there was a further small
21 vomit, which was on Raychel's pyjamas.
22 A. Yes, and that the nurses --
23 THE CHAIRMAN: Did you interpret that in the same way?
24 A. I recall that Nurse Gilchrist had spoken to Raychel at
25 that time and asked how she was and she said she just

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1 Bryce, is particularly distressed about being told that
2 her evidence is on on one day and bracing herself for
3 that and then being told it's not today, it's tomorrow,
4 and now being told in fact that it's proposed it should
5 be next Monday. I wonder if the chair could give
6 consideration to facilitating them and hearing their
7 evidence tomorrow.
8 THE CHAIRMAN: I think the problem is this, Mr Campbell --
9 and it's a problem that lawyers are familiar with and
10 maybe sometimes we don't understand enough the effect it
11 has on potential witnesses. Mrs Noble's evidence has
12 gone on longer than expected and that's not because
13 she's necessarily facing a lot more criticism than other
14 people, but because she is the first of a number of
15 witnesses who was on duty on the Thursday evening shift
16 and then on the Friday evening shift, so Mrs Noble's
17 evidence on what happened on those two shifts will take
18 longer than the evidence of the nurses who come after it
19 because a lot of the evidence that Mrs Noble gives
20 will not have to be repeated by them. Okay?
21 That was why what we had envisaged was that after
22 Mrs Noble gave evidence, Mrs Patterson and Mrs Bryce,
23 who were also on those shifts, would follow after that
24 because, insofar as you can make this chronological and
25 coherent, that would help. The difficulty about not

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1 taking Ms Millar tomorrow is that Mr Zafar is flying in
2 to give evidence on Friday and our view is that it
3 doesn't really help very much to have his evidence if
4 we haven't heard from Miss Millar, who was working
5 during the day on Friday.

6 None of this is perfect, but there's a better
7 match-up between Ms Millar giving her evidence on
8 Thursday and then Mr Zafar coming in to give his
9 evidence on Friday about what happened during the Friday
10 day shift. That's why this unfortunate decision is
11 shaping up -- Mrs Noble will finish today, so when she
12 leaves here today, her evidence will be complete, so at
13 least I can give you that reassurance that I'm not going
14 to ask you to come back overnight again. I don't think
15 there's any difficulty about that, Mr Wolfe, that that
16 evidence will be complete.

17 MR WOLFE: That's right.

18 THE CHAIRMAN: If Mrs Noble's evidence had been finishing
19 earlier today, around lunchtime, which is what we had
20 hoped overnight, then I would have dealt with at least
21 one of Nurse Patterson or Nurse Bryce between this
22 afternoon and tomorrow morning. But the fact that we
23 have run over into the afternoon makes that difficult to
24 envisage.

25 So my inclination is to say to you that subject to

1 me, please, Nurse Gilchrist's statement at WS053/2 at
2 page 8? As you've described earlier, Nurse Gilchrist is
3 one of your two nurses working on this ward on this
4 night. She's asked a number of questions about her
5 knowledge of the vomits that occur after the doctor has
6 seen Raychel. At (e) there, she's asked about the small
7 coffee-ground vomit, which in fact Nurse Patterson had
8 recorded. She says:

9 "I didn't record this vomit."

10 The implication of the question to her had been that
11 she had, but she had simply signed off on her
12 observations at that time, I think:

13 "I did not record this vomit. It is not my
14 handwriting. My signature is in reference to the IV
15 fluid check at this time."

16 And she says she wasn't aware of the vomit at
17 question (f). Then she's asked at (h):

18 "What monitoring arrangements were in place for
19 Raychel after she had been seen by Dr Curran?"

20 She says:

21 "I am unaware of arrangements as I didn't see
22 Dr Curran at the time."

23 And then over the page if you would, please --

24 THE CHAIRMAN: Sorry, before you go over the page, if you
25 just look at (g), just to add to that:

1 anything happening later on this afternoon that I'm
2 afraid -- and I'm sorry and I do apologise to
3 Mrs Patterson and Mrs Bryce because I know, as someone
4 who has given evidence myself various times, that this
5 is not something you look forward to and it's
6 disappointing if you're put off, but to get some
7 sequence of events, that is what we'll have to do.

8 MR CAMPBELL: Very well.

9 MR WOLFE: Mr Chairman, I must take some responsibility for
10 trying to predict the length of time witnesses would
11 take. So to the extent that an apology is due to the
12 witnesses who are being inconvenienced and, to some
13 extent, distressed, I would echo that.

14 MRS ANN NOBLE (continued)

15 Questions from MR WOLFE (continued)

16 MR WOLFE: Mrs Noble, if I can take up again, you have
17 described the situation where you wanted to have the
18 effect of this anti-emetic monitored so that you could
19 work out whether Raychel was getting the benefit of it
20 and settling, and we have heard that there were two
21 vomits, albeit small in nature, at 11 o'clock and at
22 roughly 12.30, one of which was recorded, the other one
23 not in the notes.

24 I just want to further examine your evidence about
25 the monitoring of the effect. Could you bring up for

1 "If the surgical team [in other words Dr Curran]
2 wasn't informed, please explain why they weren't
3 informed."

4 And her answer seems to be that they weren't
5 informed because she wasn't aware of it: is that your
6 recollection?

7 A. I'm not aware whether Staff Nurse Gilchrist was aware of
8 it myself.

9 THE CHAIRMAN: Sorry, the reason I'm asking is because I got
10 the impression before lunch, in the last session before
11 lunch, that when you were talking about the two further
12 vomits after Dr Curran's visit, that when you said they
13 were smaller and that's why you thought it wasn't
14 necessary to bring Dr Curran or anyone else back, I got
15 the impression that you were giving me that evidence
16 that that was something that you had decided with
17 somebody because you referred a number of times to:

18 "We hoped the cyclizine would eventually settle her
19 vomiting and would lessen it. We should have called the
20 doctor back, but we thought she was settling and the
21 vomits were less".

22 If Staff Nurse Gilchrist wasn't aware of that vomit,
23 that then suggests to me that if there was any thought
24 given to what was continuing to go wrong with Raychel
25 after she got the anti-emetic, it was really your

1 thinking as the nurse in charge rather than any
2 collective thinking with Staff Nurse Gilchrist.
3 Do you see what I mean?
4 A. Yes, I do see what you mean, but obviously whenever she
5 first received the anti-emetic, we obviously all felt
6 that hopefully she would settle after that. And if
7 Staff Nurse Gilchrist wasn't aware of that vomit at that
8 time, it was written in her fluid balance sheet and
9 I know that she -- Nurse Bryce and Sandra had -- Staff
10 Nurse Gilchrist had helped to change Raychel at 25 to
11 12.
12 THE CHAIRMAN: Right.
13 A. So they hadn't communicated any concerns to me about
14 that when I came back from my break.
15 THE CHAIRMAN: Well, let me ask you it in a slightly
16 different way. When you're saying:
17 "We hoped the cyclizine would eventually settle her
18 vomiting. We should have called the doctor back, but we
19 thought she was settling and the vomits were smaller."
20 When you say "we" do you include Staff
21 Nurse Gilchrist in that?
22 A. I did, yes.
23 THE CHAIRMAN: Okay, thank you.
24 MR WOLFE: The implications of the answers that are set out
25 in front of you are that not only was she not aware of

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1 a general observation of the patient.
2 MR WOLFE: But if you are talking about the children as you
3 describe -- I'm conscious that it's not just Raychel on
4 the ward, but Raychel was a particularly sick child on
5 this evening. If you are talking together as colleagues
6 about the condition of children, would I be wrong to
7 suggest that this is a significant event in a sense,
8 this is a further vomit, she's just had an anti-emetic,
9 nurses should perhaps be getting together to say, "What
10 are the implications of this? Should we be getting the
11 doctor? Should we give it a further period of time?".
12 Was there any such discussion?
13 A. With the experience that I had at that time, we had
14 encountered other children who had vomited similarly,
15 post-operatively, and at that time I didn't expect
16 Raychel to deteriorate any further because her fluids
17 were in progress. I thought it was a matter of just
18 getting her vomiting stopped and getting her a restful
19 night with the pain relief that I'd administered earlier
20 and that she should settle.
21 Q. The point being the larger point. In terms of trying
22 to, as a group of nurses, work out what is happening
23 here -- and Nurse Gilchrist will give her evidence in
24 due course -- the impression to be formed perhaps from
25 those answers is that, as a group of nurses, you hadn't

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1 that vomit, but moreover, as you can see at (h), when
2 asked about monitoring arrangements, she's unaware of
3 arrangements. So I'm not sure to what extent you wish
4 to paint a picture for the inquiry of formal
5 arrangements being put in place to monitor the effect of
6 the anti-emetic, but whether formal or informal, this
7 nurse, one of your key nursing resources that night,
8 didn't seem to be aware of a need to monitor or a plan
9 to monitor.
10 A. Well, there was no formal process for monitoring, but as
11 a team we all collectively discussed the patients at
12 various times during the night and any concerns that
13 were about each patient were communicated between us
14 all.
15 THE CHAIRMAN: Your other point about monitoring was that
16 because the fluids had to be checked, that that
17 became -- the fluids had to be checked hourly.
18 A. That was a point at which you could assess the patient
19 and, you know, it would have been a time that the
20 parents could have spoken to you or a time that you
21 would have used your powers of observation to see how
22 the patient was settling. So she was being checked
23 hourly with the IV fluids. Her cannula site would have
24 been checked and the rate of fluids and the amount
25 infused would have been checked every hour, as well as

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1 got together to discuss how Raychel was to be monitored
2 or observed.
3 A. Well, I can't recall any specific getting together at
4 that particular time because, as you say, there were
5 a lot of other patients on the ward. But anybody that
6 had any concerns about any of the patients would have
7 highlighted them to me.
8 Q. Could I look at what your other nurse, Nurse Bryce, is
9 saying about this? If I could have brought up on the
10 screen, please, WS054/2 at page 6. She is the nurse
11 who, in company with Nurse Gilchrist, observes the vomit
12 on the pyjamas at half past midnight, 0035, which went
13 unrecorded. She's being asked in that statement:
14 "Before seeing Raychel at 12.30 [it has been
15 abbreviated to 12.30, I think she actually at some point
16 gives a time at some point of 00.35], had you received
17 any updates on how she had been progressing in the
18 period since you came on duty at 7.45?"
19 And she says no.
20 So Mrs Noble, you have a small enough team working,
21 apparently, as a team, a doctor who's come to give an
22 anti-emetic and Raychel is supposed to be monitored.
23 Yet this nurse is saying that since coming on duty at
24 7.45 she had received no update in relation to how
25 Raychel was progressing. How can that be?

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1 A. Well, sometimes some of the nurses would have
2 concentrated their care to patients at a different end
3 of the ward and maybe I had more interaction with
4 Nurse Gilchrist at that time about Raychel and
5 it wouldn't be until maybe we were going to our break at
6 half 12 that we would have discussed anybody that
7 we would have any concerns about.
8 Q. But does the evidence of Nurse Bryce here, and the
9 evidence of Nurse Gilchrist, in which she doesn't seem
10 to know about the 11 o'clock vomit, does that suggest
11 communications on the ward in respect of this key
12 matter, in other words the monitoring of Raychel at this
13 important time, left something to be desired?
14 A. In light of what we know now, yes.
15 THE CHAIRMAN: The division of responsibility was that you
16 were doing the medications and the other two, Mrs Bryce
17 and Mrs Gilchrist were doing the observations; is that
18 right?
19 A. Yes.
20 THE CHAIRMAN: But do I take it from what you have just said
21 that they would not work together doing the
22 observations, they would work separately?
23 A. They would maybe go to opposite ends of the ward.
24 THE CHAIRMAN: Right. Thank you.
25 MR WOLFE: Can I just pick up on a few points that maybe

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1 to SHOs, registrar or consultant. I understand that's
2 a practice, but I don't think that can be regarded as
3 a given, Mr Campbell. For instance, let's suppose
4 a nurse is unhappy with what the JHO has done. Does she
5 just leave it and say, "Look, I've done my job, I have
6 called in the junior house officer, I'm going to leave
7 it at that"? I take the --
8 MR CAMPBELL: Surely in the first instance it's appropriate
9 for the nurse to seek assistance from the first doctor
10 on the ladder.
11 THE CHAIRMAN: Yes. I think depending on the extent of
12 concern, I think that's probably right. Really, the
13 question which arises from this is whether that's the
14 extent of the nurse's responsibility to only go up one
15 step up the ladder.
16 MR WOLFE: Moreover, and allied to this point is a related
17 point made by Mr Orr in his report. He says that junior
18 house officers are reliant on nursing staff to alert
19 them to any concerns regarding the patient. And that's
20 because they are (a) generally inexperienced and (b)
21 don't have the benefit of having observed a patient over
22 a lengthy period of time. He says that it's regrettable
23 that nurses didn't bring to the attention, as he
24 perceives it, information about the coffee-ground
25 vomiting and the other factors that I outlined earlier.

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1 should have been put to you earlier? When we talk about
2 coffee-ground vomiting, according to Mr Foster, the
3 expert surgeon retained on behalf of the inquiry, he
4 says that's an indication of severe vomiting and
5 retching; would you agree with that?
6 A. It was, but it wasn't uncommon to what we had
7 experienced -- well, my experience in the years that
8 I had been there.
9 Q. And whether common or uncommon, because of its
10 indication of severe vomiting, he is of the view that
11 you as nurses should have been insisting that Dr Curran,
12 when he came to the ward, should call his senior
13 colleagues or a senior colleague and not to have done so
14 is evidence of substandard practice.
15 MR CAMPBELL: Mr Chairman, surely it is for the doctor to
16 choose whether he needs to go further up the line for
17 senior assistance.
18 THE CHAIRMAN: I certainly agree with you on this point,
19 Mr Campbell, there's certainly an issue about whether
20 the doctors should go up the line. I think it's an open
21 question about whether a nurse should also go up the
22 line, but I've heard Mrs Noble say this morning that
23 there was effectively a hierarchy. If you were
24 concerned, you would call in the JHO and for it to go
25 beyond that, it was the JHO's decision to go beyond that

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1 That's how he reads the evidence. Again, I think you've
2 agreed with me that the information that I outlined
3 earlier about the full context, the full history of
4 Raychel's condition, ought to have been brought to the
5 doctor's attention.
6 A. Yes.
7 Q. Whether it was or not, we will perhaps learn from
8 Nurse Gilchrist, when she gives evidence, and Dr Curran.
9 But you would agree with the broad proposition, would
10 you, that junior doctors are reliant on nurses for that
11 kind of information?
12 A. Well, it's the nurse's job, in the first instance, to
13 explain why they have called a doctor to the ward to see
14 a patient.
15 THE CHAIRMAN: I understand it wasn't you who called
16 Dr Curran, but when Dr Curran is telephoned to come to
17 the ward, it's the expectation, isn't it, that when he
18 comes to the ward he will speak to one of the nursing
19 team, who will explain the full extent of the problems?
20 A. Yes.
21 THE CHAIRMAN: It's not the expectation that whatever is
22 said on the phone call will be the extent of the
23 discussion with the doctor?
24 A. Yes.
25 THE CHAIRMAN: Okay. We'll find out, as the next week or so

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1 goes on, what Mrs Gilchrist said to Dr Curran, but if he
2 then came to the ward, he didn't speak to the nurses, he
3 found the anti-emetic left out, sitting beside Raychel
4 for him to give, and he seems to have given it and gone
5 off again. It doesn't particularly matter who carries
6 the responsibility for that or any blame for that, but
7 that's not really good enough, sure it isn't.
8 A. Well, I feel he should have made a full assessment
9 before giving his medication, and I feel he should have
10 come to one of the nurses and explained what his
11 assessment of Raychel was at that time and that he was
12 happy enough to just administer the anti-emetic.
13 THE CHAIRMAN: I understand why you're saying, look, when we
14 call the doctor, the doctor should be talking to us, and
15 maybe the doctor might accept that or maybe he'll say if
16 they wanted to give me a bigger picture, they should
17 have made a point of speaking to me when I was there
18 because I did come to see Raychel. But in a sense, I'm
19 not so much concerned about whether it's more his fault
20 or Mrs Gilchrist's fault or your fault. I'm making the
21 more general point that how it happened really wasn't
22 quite good enough.
23 A. No.
24 MR WOLFE: Could I also raise a point with you, Mrs Noble,
25 which Mrs Ramsay makes in her report for the inquiry?

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1 Blood pressure in children doesn't deteriorate until
2 a very latent [sic] stage in a disease process or
3 a pre-terminal event. Children usually compensate quite
4 well up until they deteriorate very quickly.
5 MR WOLFE: Obviously nobody can say for sure now what might
6 have been detected if blood pressure had been analysed,
7 but in the presence, as we now know, of raising
8 intracranial pressure with the hyponatraemia, it might
9 well have given an indication of a problem.
10 A. Possibly.
11 Q. And in the presence of continuing vomiting with
12 continuing intravenous fluids, it would have been good
13 practice to measure blood pressure?
14 A. Yes.
15 Q. Moreover, Ms Ramsay makes the point that in the presence
16 of continued vomiting, the plan that had been put on
17 paper to look at Raychel's observations every four hours
18 ought to have been adjusted to have more frequent
19 observations.
20 A. Yes.
21 Q. Again, even after the anti-emetic was administered at
22 10 o'clock, you say no special treatment was brought to
23 bear on Raychel in terms of observations.
24 A. Yes.
25 Q. Do you agree that this child would have benefited from

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1 She says that as the vomiting continued through that
2 night, so starting at the point of the nursing handover
3 at about 8 o'clock, the vomiting continues certainly for
4 a number of further hours. Blood pressure wasn't
5 monitored during that period. In fact, blood pressure
6 hadn't been monitored since 7 am at the conclusion of
7 your first shift, if you like, in this sequence of
8 shifts. Why was blood pressure not monitored,
9 notwithstanding continued vomiting?
10 A. Well, I can't answer for the girls who were on during
11 the day. And on night duty, as I said, I wasn't
12 carrying out the observations. I don't know, if I had
13 been there, would I have carried out a blood pressure on
14 her? I would like to think I would have, but as I say,
15 we thought that Raychel was just vomiting
16 post-operatively and, in our previous experience, we
17 hadn't experienced anything like this before in that she
18 was going to further deteriorate and have a seizure
19 later on.
20 Q. You accept it would have been good practice to continue
21 to monitor blood pressure?
22 A. Yes.
23 THE CHAIRMAN: What in particular can the blood pressure
24 tell you or reassure you about?
25 A. Well, to be honest with you, in children very little.

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1 improved and more frequent observations?
2 A. Again, in light of what we now know, then yes.
3 Q. At the time, when you have a child vomiting coffee
4 grounds and has a series of coffee-ground vomits in
5 a short period of time, can I put it to you or suggest
6 to you that it's not with the benefit of hindsight that
7 increased observations should have been brought to bear;
8 you ought to have known that at the time.
9 A. As I say, I can't go back to that time and realise that
10 if I had been with her myself that I would have done
11 observations sooner. There were other activities going
12 on in the ward and other things to do, and hopefully we
13 had got the doctor down to give Raychel something to
14 stop her vomiting and the expectation was that it was
15 going to stop or lessen and that she would become
16 comfortable and sleep throughout the night. I didn't
17 experience anything like hyponatraemia until that event.
18 THE CHAIRMAN: Can I ask you, just to tell me what happens
19 now. If something like this -- and you now know from
20 what happened after Raychel died, you know more about
21 hyponatraemia and there are guidelines and so on.
22 A. Yes.
23 THE CHAIRMAN: Even moving away from hyponatraemia, if
24 a child is causing concern now in Altnagelvin -- sorry,
25 are you still there?

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1 A. Still there.
2 THE CHAIRMAN: Would it still be just that you would call
3 the junior house officer and leave it up to the JHO to
4 decide whether to take it up the line?
5 A. No, junior house officers, since Raychel's passing, have
6 not been allowed to come on to Ward 6. The only
7 surgical people who have contact with the children are
8 senior house officers.
9 THE CHAIRMAN: Okay.
10 A. And again, they would be called after two vomits.
11 THE CHAIRMAN: Thank you.
12 MR WOLFE: Again, Ms Ramsay advises the inquiry in her
13 report that as vomiting and intravenous fluid continued,
14 nurses should have known that there was a risk of
15 electrolyte imbalance. Without going over the various
16 sequences that we've gone over on that, did you at any
17 point stand back and take into account all of the
18 factors that we know about in Raychel and try to assess
19 whether this was anything more than post-operative
20 vomiting?
21 A. At that time, I probably didn't, because her fluids were
22 in progress and I thought that the fluids that were in
23 progress -- that every other child had had -- was going
24 to maintain her hydration and was going to maintain her
25 electrolyte balance despite the fact that she was

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1 requested by the anaesthetist.
2 Q. What was your understanding of the circumstances, the
3 physiological and medical circumstances, in which that
4 was being asked for?
5 A. That obviously something had maybe occurred in theatre
6 that the anaesthetist would have preferred that this
7 particular fluid was used for that child on return to
8 the ward for a certain period of time.
9 Q. Had you any understanding of what was dictating it in
10 medical or clinical terms?
11 A. I thought maybe the child had maybe had an electrolyte
12 profile carried out, maybe intraoperatively, or maybe
13 they had an electrolyte profile carried out just before
14 going to theatre. Maybe some of the children would have
15 gone to the theatre straight from A&E as opposed to
16 coming to the ward and being monitored. It could have
17 been a reflection on what their bloods were previously.
18 THE CHAIRMAN: There might have been significant blood loss
19 during an operation?
20 A. Exactly.
21 THE CHAIRMAN: Might that lead to using Hartmann's rather
22 than Solution No. 18?
23 A. Possibly, I'm not aware fully.
24 MR WOLFE: You were familiar with the concept of an
25 electrolyte assessment or an electrolyte assay.

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1 vomiting. As I say, that was my understanding at that
2 time.
3 Q. Are you able to square the fact that Raychel was being
4 given a fifth of normal sodium by way of a fluid and yet
5 was vomiting, and that vomiting wasn't being replaced
6 with equal amounts of sodium? Have you stood back and
7 tried to work out how you fell into this trap of
8 thinking her fluids were being adequately replaced?
9 A. At that time I didn't take those factors into account.
10 What we were mostly concerned about was that she was on
11 fluids and that, because she was a previously well and
12 healthy child, we would have had no expectation for her
13 electrolytes to be imbalanced with one day of vomiting,
14 despite how severe it was.
15 Q. You told us yesterday, in answer to questions from the
16 chairman, that Hartmann's solution was available on
17 Ward 6.
18 A. Yes it was. A few bags.
19 Q. A few bags I think you said, yes. What did you
20 understand the purpose of Hartmann's being on that ward
21 for? What circumstances did you anticipate it might be
22 used in?
23 A. Occasionally, a request from theatre would have been an
24 insistence that a child returned to the ward from
25 theatre would have to receive Hartmann's solution as

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1 A. Yes.
2 Q. And you would appreciate that that is conducted, in
3 part, to attempt to measure the biochemical condition of
4 a child or a patient.
5 A. Yes.
6 Q. And would you appreciate that an electrolyte assessment
7 would be appropriate -- I'm talking now back in 2001 --
8 in circumstances where you have had a situation of
9 severe vomiting or severe vomiting and diarrhoea or in
10 combination? Would you have appreciated that at the
11 time?
12 A. Yes.
13 Q. And would you have seen situations where electrolyte
14 measurements or electrolyte assessment took place even
15 in the presence of ongoing intravenous fluids?
16 A. Yes.
17 Q. This was a case where a child was, as we know from the
18 fluid balance sheet, having up to nine vomits recorded
19 up to 11 o'clock that night. And there's a whole issue
20 about whether that's an accurate recording. But working
21 with the information that was recorded, can you tell us
22 why, if you thought about it at all, you didn't think
23 that electrolytes needed to be assessed by that time
24 in the evening?
25 A. Well, the normal practice on Ward 6 was that children on

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1 IV fluids, medical patients on IV fluids, had their
2 electrolytes checked daily.
3 Q. Yes.
4 A. And the surgical patients, if they had been on
5 intravenous fluids, it was the doctor's decision whether
6 they wanted electrolytes carried out on that patient.
7 And a lot of the times, because the doctors weren't on
8 the ward at that time all the time, it was mostly
9 Sister Millar who would have asked them to carry out
10 electrolyte profiles on those children.
11 Q. In the case of paediatric medical children, was there
12 a routine or a fixed step that electrolytes be measured
13 or assessed after a period of time?
14 A. Yes, every 24 hours. If a child was on IV fluids, the
15 medical people would have assessed the electrolytes of
16 the children on IV fluids or, more often if there was an
17 imbalance, maybe up to six-hourly, four to six-hourly.
18 Q. And here we had a situation with Raychel commencing IV
19 fluids at roughly 10 pm on the evening of 7 June. And
20 by the time she's experiencing these coffee-ground
21 vomits and Dr Curran arriving at 10 pm on the 8th,
22 24 hours had elapsed.
23 A. Yes, but that was Dr Curran's decision in light of the
24 information he was given and his assessment of the child
25 to determine whether or not he would have initiated --

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1 MR CAMPBELL: The records do record one passage of urine,
2 early -- I think at 8 o'clock in the morning.
3 MR WOLFE: Yes, they do. Just focusing on that, there are
4 no other records of passing urine; isn't that right?
5 A. Yes.
6 Q. This child had received in excess of a litre of fluid by
7 the time you're seeing her in the evening of 8 June;
8 isn't that right?
9 A. Yes.
10 Q. You would have expected her to have gone to the toilet
11 more often, would you not?
12 A. Yes, but she was on maintenance fluids and she had
13 vomited a few times, so that might have lessened her
14 urinary output.
15 Q. Is that something you give consideration to?
16 A. Yes, I would.
17 Q. Are you telling us that you did give consideration to
18 whether there was fluid retention issues, whether there
19 was electrolyte issues, whether they needed to be
20 assessed, or did you not?
21 A. I don't remember at that time considering it. My main
22 concern was to make sure that Raychel stopped vomiting
23 and hopefully could get a comfortable night and that her
24 vomiting would stop.
25 Q. When you think about it now, Mrs Noble, do you reproach

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1 the nurses didn't ask the doctors to do certain blood
2 tests.
3 Q. Yes, but you've indicated that Sister Millar, who
4 we will hear from in due course -- she's a nurse,
5 obviously, and she had the wherewithal to raise requests
6 for electrolyte assessments in her capacity at various
7 times in your experience.
8 A. I heard this, after Raychel's passing, that she would
9 have said that she would have had to ask the surgical
10 doctors to check the electrolyte profiles on their
11 patients.
12 Q. But again, this, if I may say so, Mrs Noble, is the kind
13 of area which is ripe for nursing input. The nurses
14 have the benefit of the whole day overview, they've got
15 all the material at their fingertips and they have
16 prolonged exposure to the patient. So would it not have
17 been appropriate, and indeed essential at the 24-hour
18 mark, in the presence of eight or nine vomits, at
19 10 o'clock on the evening of 8 June, in the absence of
20 the child going to the toilet, according to the records,
21 for you to insist that a doctor arrange for electrolyte
22 assessment?
23 A. I was not with Dr Curran at Raychel's examination, so
24 I therefore could not insist that he checked her
25 electrolytes.

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1 yourself for not having asked for a more intensive
2 investigation to be conducted by the doctor?
3 A. Yes.
4 Q. And what do you take into account in reproaching
5 yourself?
6 A. The fact that there was no nurse present to discuss
7 Raychel with him. Ideally, I would have liked to have
8 been the nurse going to speak to Dr Curran at that time
9 and I don't know at that time if I would have asked him
10 to check her electrolytes. I hope that I would have.
11 So I reproach myself for that.
12 Q. Clearly, you would accept that there was a missed
13 opportunity --
14 A. Yes.
15 Q. -- to get to grips with Raychel's condition at quarter
16 past 10 when Dr Curran arrived.
17 A. Yes. Again, at that time, because we had never
18 encountered anything like this happening before -- and
19 all other children vomiting for prolonged periods of
20 time on a first day post-operatively -- some of them
21 even vomited into the second day and may not have had
22 their electrolyte profiles checked because the surgeons
23 were not good at that time at monitoring electrolyte
24 profiles. As I say, it was very, very unfortunate
25 that -- I wasn't expecting Raychel to deteriorate due to

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1 an electrolyte imbalance.
2 Q. When you think about it -- and you've often said in your
3 evidence that we had seen children --
4 A. Yes.
5 Q. -- with similar, perhaps worse conditions --
6 A. Yes.
7 Q. -- and not suffer Raychel's unfortunate fate. With the
8 benefit of looking back at it, do you see that perhaps
9 you and your nursing colleagues got locked into
10 a mindset, which was: this is going to be okay, it
11 doesn't require deeper investigation?
12 A. I accept that, yes.
13 Q. Do you accept that had you or your colleagues raised
14 these other features of Raychel's history and pressed
15 the doctor to carry out investigations that things might
16 have been different?
17 A. I wish that I knew then what I know now.
18 THE CHAIRMAN: I think to be entirely fair to you,
19 Mrs Noble, and to ... (Pause). We'll take a break,
20 Mrs Noble.
21 To be fair to Mrs Noble and to various other people
22 in Altnagelvin who will give evidence, there was more
23 knowledge within the Health Service in Northern Ireland
24 about hyponatraemia than reached Altnagelvin and that's
25 part of why we've been looking at the cases in sequence

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1 through in less detail with the next two or three
2 witnesses from those shifts, so we won't need to cover
3 all the same ground. So in a sense there's an element
4 of bad luck that you're the first one of the three or
5 four to give evidence.
6 A. I appreciate that.
7 THE CHAIRMAN: The second point I wanted to make is that
8 while we obviously do have concerns and there obviously
9 are criticisms about what happened about when Raychel
10 was in Altnagelvin, one of the points which the Ferguson
11 family have and which the other families in the inquiry
12 have is the failure to learn lessons as a result of
13 earlier events when Adam died, perhaps more particularly
14 when Claire died, when Lucy Crawford died, which would
15 have meant in June 2001, if those lessons had been
16 learnt, you would have been more alert to what might go
17 wrong. I won't lose sight of that when I'm doing the
18 report.
19 A. Thank you.
20 MR QUINN: Mr Chairman, just before my learned friend
21 starts, you asked me to investigate Mr Ferguson's
22 recollection about Dr Curran's visit. It appears on
23 WS021/1, page 10 and page 11.
24 THE CHAIRMAN: Thank you.
25 MR QUINN: I would also add that to the best of

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1 and part of our concern about the failure to learn
2 lessons when Adam died, the failure to learn lessons
3 when Claire died and we'll be looking at what happened
4 after Lucy Crawford died. This isn't just about what
5 happened in Altnagelvin.
6 (3.07 pm)
7 (A short break)
8 (3.25 pm)
9 THE CHAIRMAN: Mrs Noble, I think we're still on track to
10 get your evidence finished today and I know that you
11 don't want to have to come back tomorrow, so let's see
12 how we can get through it.
13 I just want to make a point, which I'm not sure
14 you'll have heard because you were distressed when we
15 broke. I hope you understand that we have to ask you
16 the questions which Mr Wolfe is going through.
17 A. Yes.
18 THE CHAIRMAN: If there is any unfairness about the
19 questions, Mr Campbell will intervene to assist and
20 I myself have a role to intervene to assist. But what
21 I wanted to say specifically is two points which I made
22 earlier. One is that because you are the first of the
23 nurses to give evidence who was there on the Thursday
24 night and on the Friday night, we're going through some
25 things in detail with you, which we'll be able to go

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1 Mr Ferguson's recollection, there was no discussion
2 between himself and Dr Curran. Just to add to that, so
3 that my learned friend can pick it up in
4 cross-examination of any other witnesses, he will say
5 that he appeared back. He was out for a moment and when
6 he appeared back in the room the doctor was already
7 giving the injection.
8 THE CHAIRMAN: Is that indicating that if Mr Ferguson only
9 stepped out briefly --
10 MR QUINN: He stepped out, he thinks, to go to the loo and
11 came back into the room and at that stage the doctor had
12 arrived without him being there. There was no sign of
13 any nurse, he confirms that, there was no nurse with
14 him. The doctor was giving the injection, which he had
15 already been informed by Nurse Gilchrist was going to
16 occur. But he had no discussion whatsoever with the
17 doctor. There were no words crossed between himself,
18 there was no investigation and there were no enquiries
19 made by the doctor as to how Raychel was, et cetera, so
20 that's the best he can --
21 THE CHAIRMAN: I presume that the family would agree with
22 the point that Mrs Noble has already made that quite
23 apart from it being better if a nurse is there for the
24 doctor to speak to, the doctor also then has the
25 opportunity to speak to the family when he's examining

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1 Raychel and investigating what's wrong because the
2 family will be able to give their perspective and their
3 history of what has been wrong over the previous number
4 of hours.
5 MR QUINN: The family are also making this point -- and
6 I checked this over the break and at lunchtime -- the
7 family really want to investigate why the nurses
8 pre-empted the doctor's diagnosis, that is left the
9 drugs out, wherever they left them, at the drugs cabinet
10 or wherever they left the drugs for the doctor to come
11 along with. Because Mr Ferguson's first comment to me
12 was, "I wasn't asked anything, nor did I say anything to
13 the doctor". So that reinforces the family's view that
14 the nurses had made a decision about what was wrong with
15 Raychel and that the doctor was just coming along
16 because he was qualified to give an IV drug.
17 THE CHAIRMAN: That point has been raised, but even if
18 that's the -- and I understand why you say that's an
19 interpretation. In fairness to Mrs Noble, she
20 volunteered the evidence that the drug was left out by
21 the nurses for the doctor.
22 MR QUINN: Yes.
23 THE CHAIRMAN: But even to the extent that that might be
24 indicating their mindset about what was wrong with
25 Raychel and what needed to be done, that does not mean

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1 you just explain to me again, why was one not completed
2 for the incidences that occurred on 8 June?
3 A. Regarding the vomiting?
4 Q. Well, I suppose maybe we will approach it in this way.
5 The purpose of a document marked "observation sheet"
6 such as this is what? What is the purpose of it?
7 A. For close observation.
8 Q. Right. So close observation occurs in what
9 circumstances?
10 A. When you are particularly worried about a patient or
11 that you see any signs of deterioration.
12 Q. Right. So you were particularly worried on 7 June
13 because Raychel was a new patient, she was coming in and
14 she might have to go to theatre. In fact, the plan was
15 for her to go to theatre, so there was close observation
16 in that circumstance and you produced one of these
17 sheets and completed it for that purpose.
18 A. On 7 June, that sheet was actually commenced in A&E.
19 Q. Right.
20 A. That wasn't completed on the ward -- because we knew
21 Raychel was potentially going to theatre, the first
22 observations done by Staff Nurse Patterson were baseline
23 observations to see what her observations were prior to
24 going to theatre.
25 Q. Right. Then this sheet, the 9 June sheet, is

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1 that that's the end of Dr Curran's responsibility.
2 MR QUINN: We'll hear from Dr Curran as well.
3 THE CHAIRMAN: Yes. Thank you.
4 MR WOLFE: Good afternoon, Mrs Noble. Can I just pick up on
5 one point that Mr Quinn has asked me to seek
6 clarification on? You'll remember this morning that we
7 looked at various observation sheets --
8 A. Yes.
9 Q. -- and I asked you questions about them. I just want to
10 revisit something you said.
11 Let me get this straight. Could we have up on the
12 screen 020-015-029? I understand the transcript's been
13 checked on this and what you appear to have said is that
14 this document, or the completion of this document, was
15 discontinued as you felt, the nurses felt, that
16 Raychel's observations were stable enough to go on to
17 a graph chart.
18 A. Yes.
19 Q. Does that tally with what you recall saying?
20 A. Yes.
21 Q. We then looked at the graph chart. There's another
22 document which I would ask you to bring up, 020-016-032.
23 We know that there's a document like that for the 7th,
24 when she came into hospital and this one relates to the
25 point at which the seizure occurred on 9 June. Could

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1 self-evidently the need for close observation when the
2 child had suffered this very significant seizure.
3 A. Yes.
4 MR WOLFE: Any questions arising out of that, Mr Quinn?
5 MR QUINN: No, thank you very much.
6 MR WOLFE: One other point -- and again I'm not sure that
7 anything particularly turns on it, apart from perhaps
8 accuracy of recollection.
9 The parents of Raychel Ferguson in their statements
10 have said that they recall leaving the ward in the early
11 hours of 9 June at or about 20 minutes to 1. Whereas
12 you in your witness statement assert that the parents
13 leave at or about 11.30.
14 A. Yes. That's my recollection.
15 Q. It's a difference of an hour or so.
16 A. Yes. Well, usually the nurses will have finished the
17 observations, completed the intravenous antibiotics and
18 then and only then would the nurses sit down to have
19 a cup of tea.
20 Q. Right.
21 A. And usually it's about 11, 11.15, 11.30, usually when
22 we're finished that tea, again depending on admissions
23 to the ward or depending on what was going on, but it
24 was usually about 11.30 we were finished with our tea.
25 Q. When you say half 11, apart from relating it to when

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1 perhaps you would commonly have your tea, have you any
2 particular recollection of them leaving?
3 A. No. Mr and Mrs Ferguson, I think, came to the door of
4 the kitchen when we were at tea, saying that they were
5 going home.
6 THE CHAIRMAN: And because you would normally have tea at
7 about 11.30, you're putting those two together, that it
8 was probably at about that time?
9 A. Yes, and I had made my statement just two days after
10 that had happened, so it was quite fresh in my
11 recollection.
12 THE CHAIRMAN: Thank you.
13 MR WOLFE: Could I have the fluid balance chart up on the
14 screen again to raise a discrete point with Mrs Noble?
15 It's at 020-018-037.
16 We know, Mrs Noble, that at or about ten past
17 midday, in other words in the middle of 8 June,
18 a Dr Butler wrote up another bag of Solution No. 18 for
19 Raychel. Clearly, that bag was infused at 80 ml
20 an hour, as was the case throughout that day. Doing the
21 maths on that, running a 1 litre bag at 80 ml an hour
22 would take roughly 13 hours to complete --
23 A. Yes.
24 Q. -- so that Raychel would need a new bag of fluids by 1
25 or 2 o'clock in the morning, approximately. The inquiry

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1 straightaway and the doctor would say, "Look, just put
2 up another bag and I will come up later on and sign for
3 it, but I'm happy enough for that bag of fluids to
4 continue".
5 Q. And you're not able to assist us on how that happened?
6 A. I can't recall.
7 Q. I think you've told us that the vomit at 35 minutes past
8 midnight was discussed with you --
9 A. Yes.
10 Q. -- and that no further action was taken.
11 A. No.
12 Q. Raychel appeared settled and asleep.
13 A. Yes. It was just a mouthful and insignificant in
14 amount.
15 Q. Is it right to say that your next involvement with
16 Raychel was at or about the time of her seizure?
17 A. Yes.
18 Q. At 3 am you tell us in your witness statement that your
19 attention was drawn to Raychel by Nursing
20 Auxilliary Lynch --
21 A. That's right.
22 Q. -- who told you that Raychel appeared to be fitting.
23 A. Yes.
24 Q. Did you attend Raychel?
25 A. Straightaway, yes.

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1 is aware of no record and nobody has claimed to have
2 visited Raychel for the purposes of re-prescribing the
3 Solution No. 18 in the early hours of 9 June. Is it the
4 case that if Raychel, as appears self-evident, needed
5 another bag of fluids to comply with the fluid plan, as
6 it was, whether that plan was right or wrong, would
7 a doctor have had to come and write a prescription?
8 A. Yes.
9 Q. Maths isn't my strong point, but do you agree with me
10 that that sounds logical and mathematically correct,
11 that by about 1 or 2 o'clock in the morning a new bag of
12 fluids would have been needed?
13 A. Yes. It sounds right.
14 Q. Can you say anything to assist the inquiry in terms of
15 how she got a new bag of fluids? Because presumably,
16 she did if the fluids at 80 ml an hour continued to run.
17 A. I have no recollection of a new bag of fluids going up
18 at that time. I can't recall.
19 Q. What would the process have been in order to obtain the
20 assistance of a doctor to write up a new bag of fluids
21 at night-time?
22 A. At night-time, if we had rang the doctor and told him
23 that the patient was on a solution, ie Solution No. 18,
24 could he come and write up another bag of fluids, on
25 occasion, the doctor wouldn't be able to come

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1 Q. Where were you when --
2 A. In the bed directly -- I was administering paracetamol
3 to a child in the bed directly opposite Raychel in
4 room I.
5 Q. So you and Ms Lynch were in the room at the same time?
6 A. Yes.
7 THE CHAIRMAN: Was she working with you at that point or was
8 that just a coincidence?
9 A. It was just a coincidence. She was seeing to a child
10 in the bed -- it was actually a child in a cot beside
11 me. She was comforting a child in a cot beside me and
12 I had the curtains round giving paracetamol to a child
13 opposite Raychel and Elizabeth Lynch made me aware that
14 Raychel appeared to be fitting. And I went straightaway
15 to Raychel.
16 THE CHAIRMAN: And she noticed that because she's nursing
17 the child and --
18 A. Yes, and was diagonally --
19 THE CHAIRMAN: -- can look around and see what else is going
20 on?
21 A. Diagonally opposite Raychel.
22 THE CHAIRMAN: So all you had to do was to finish the
23 injection of the --
24 A. I think it might have been rectal paracetamol I was
25 giving the child and it was given very, very quickly and

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1 I straightaway went to attend to Raychel.
2 THE CHAIRMAN: Thank you.
3 MR WOLFE: Obviously, Mrs Noble, you can't say how long
4 Raychel had been in that state.
5 A. I didn't see it myself, but I didn't hear Raychel, the
6 clothes on the bed, I didn't hear any agitation of the
7 bed clothes, whereas I think that was what drew
8 Elizabeth Lynch's attention to her, that she heard
9 Raychel fistling in the bed.
10 Q. And when you attended, you found Raychel in a left
11 lateral position.
12 A. Yes.
13 Q. She wasn't cyanosed?
14 A. No, not that I could see.
15 Q. But she had been incontinent of urine --
16 A. Yes.
17 Q. -- and was in what you would describe as a tonic state.
18 A. Yes.
19 Q. Does that mean a rigid state?
20 A. Yes. Her fists were up, clenched.
21 Q. That must have been a shocking discovery for you.
22 A. Yes, it was. I certainly didn't anticipate finding
23 Raychel in that state.
24 Q. Your response to that was to seek out Dr Johnson, who
25 was nearby.

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1 You asked Dr Johnson to attend:
2 "He requested diazepam and diazemuls and Raychel was
3 given oxygen via a non-rebreathing mask at 10 litres per
4 minute. Her colour suggested she was well perfused.
5 The doctor was unsuccessful in his attempt to insert an
6 airway."
7 Is that that doctor at that time?
8 A. Yes, I just didn't recall that part of it. I know that
9 I put oxygen on Raychel and while I was maybe going to
10 get the diazemuls and the diazepam I had obviously made
11 an airway available to Dr Johnson to ensure that she had
12 a patent airway, but I wasn't -- I remember at that time
13 writing it, but I didn't actually observe him trying to
14 insert an airway, but I know she didn't have one in.
15 Q. What were the implications of his lack of success
16 in that respect?
17 A. Obviously, she was still fitting and her teeth were
18 tightly clenched and he couldn't access the airway
19 because of her teeth.
20 Q. Yes, but was he able to substitute -- was he able to
21 take any steps to address the situation of being unable
22 to insert an airway?
23 A. Well, her colour remained -- she was well perfused
24 throughout the fitting episode and she had oxygen nearby
25 that when she was breathing, that she was breathing

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1 A. Dr Johnson was literally outside the door at the
2 doctors/nurses' station, and I called him to attend to
3 Raychel.
4 Q. We looked at the plan layout of the premises yesterday.
5 That's the station where you pointed out to me the
6 sister's office was behind it at that time --
7 A. Yes.
8 Q. -- very close. So was there any delay in him getting to
9 you --
10 A. No.
11 Q. -- or getting to the patient?
12 A. No.
13 Q. Was your recollection that Dr Johnson was unsuccessful
14 in obtaining an airway?
15 A. I can't recall. I know that there was oxygen placed
16 near Raychel via a non-rebreathing mask.
17 Q. Could I ask you to bring up 021-069-162? This is
18 a statement which you prepared at the request of your
19 employers at or shortly after Raychel's death. Halfway
20 down the page you say:
21 "At 0300 hours, whilst administering medication to
22 a patient adjacent to Raychel, Nurse Auxiliary Lynch
23 informed me that Raychel was fitting. I immediately
24 attended her and observed that she was lying in a left
25 lateral position, not cyanosed ..."

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1 oxygen-enriched air. She hadn't lost colour.
2 Q. So in fact, are you suggesting she didn't, at that time,
3 need an airway but he was taking that approach as
4 a precaution?
5 A. Yes.
6 Q. And then I think you tell us that you administered the
7 5 milligrams of diazepam rectally --
8 A. Yes.
9 Q. -- while Dr Johnson observed for effect.
10 A. Yes.
11 Q. But there was no effect.
12 A. No.
13 Q. It wasn't successful at bringing --
14 A. It didn't stop her fitting.
15 Q. -- at controlling the fit.
16 A. That's right.
17 Q. So he then administered a higher dose --
18 A. Yes.
19 Q. -- and the seizure stopped.
20 A. Intravenously, yes.
21 Q. At that time, Raychel's pupils were reacting to light,
22 were they?
23 A. Yes.
24 Q. And they were equal?
25 A. Yes.

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1 Q. Dr Johnson was a senior house officer on the paediatric
2 side of the house, if you like.
3 A. Yes.
4 Q. He obviously wanted to obtain input from somebody from
5 the surgical side of the house.
6 A. Yes.
7 Q. And Dr Curran, who we have earlier heard about, came to
8 the room.
9 A. Yes.
10 Q. Were you able to assist Dr Johnson in giving a history
11 of Raychel's condition up to that point?
12 A. Yes. I had told -- I can't recall the exact
13 conversation, but I would have given him a history of
14 what I had known about Raychel at that time.
15 Q. And can you recall that for us now?
16 A. I can't recall the exact conversation, but I would have
17 told him that she had been vomiting and had required two
18 different anti-emetics and that she had settled to sleep
19 and we thought that she had been fine.
20 Q. Dr Curran arrived and was asked by Dr Johnson to make
21 contact with his surgical registrar and senior house
22 officer.
23 A. Yes.
24 Q. Were you aware of that?
25 A. Yes.

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1 getting an ECG machine down to facilitate that
2 investigation. And the bloods in the meantime had been
3 taken and sent off to the lab and Dr Johnson -- I can't
4 recall at what stage the results had come back, but
5 I knew that Dr Johnson was sufficiently worried enough
6 about Raychel to seek help from his registrar,
7 Dr Trainor.
8 Q. So in terms of the situation you describe, it was
9 obviously a period of great activity?
10 A. Yes.
11 Q. Was it a calm situation or panicked?
12 A. It was probably a bit panicked.
13 Q. And to the suggestion that you might have seen fit to
14 contact someone more senior on the surgical or medical
15 side, what would you say?
16 A. Well, my priority was Raychel at the time. I didn't
17 leave Raychel until the doctors had -- there was
18 somebody else going to be there with her. And at that
19 time I left Raychel to try and contact the family.
20 Q. Yes. You left Nursing Auxiliary Lynch with Raychel
21 while you attempted to contact the family.
22 A. Continuous monitoring was in place at that time, her
23 heart rate, her oxygen saturations, and she had stopped
24 fitting at that time.
25 Q. You say in your witness statements that you had to make

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1 Q. And as it happens, none of the senior surgeons, whether
2 registrar or SHO, were in a position to come according
3 to their statements to the inquiry.
4 A. Apparently so.
5 Q. You would have appreciated that, if you like, the
6 surgical cavalry hadn't arrived.
7 A. Yes.
8 Q. Indeed, it was much later in the morning before
9 Mr Bhalla and Mr Zafar attended; isn't that right?
10 A. Yes.
11 Q. So at that stage you had a senior house officer, who's
12 a paediatrician, and a junior house officer, who was
13 a surgeon.
14 A. Yes.
15 Q. Did you give any consideration as to whether more senior
16 personnel should have been brought to the situation?
17 A. My priority at the time was to make sure that Raychel
18 was being monitored and that I was assisting the doctors
19 with the investigations that they needed to carry out.
20 I knew they were going to have to carry out blood tests
21 and I had to set up monitoring for Raychel to ensure
22 that we could monitor her vital signs. And I knew that
23 Dr Johnson was speaking to Dr Curran about seeking
24 senior help. They had asked then for an ECG to be
25 carried out on Raychel and we were in the process of

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1 several attempts before you could reach telephone
2 contact with Mr Ferguson.
3 A. Yes.
4 Q. And contact was eventually established at 3.45, which is
5 about 45 minutes after the fit had started.
6 A. Roughly about 15 -- sorry, 30 to 45 minutes. I think it
7 was around about 3.15 that she had fitted.
8 Q. Well, in terms of the number of contacts, attempted
9 contacts, you made, can you remember how many?
10 A. I don't know, I can't recall exactly how many. And
11 I know that Mr Ferguson disputes that there were several
12 attempts made, and I myself have revisited this on
13 numerous occasions and wondered had I misdialled because
14 it was obviously a very anxious --
15 THE CHAIRMAN: Yes. You had a single phone number, did you?
16 A. Yes.
17 THE CHAIRMAN: So whatever number you were ringing on your
18 recall of events, you rang a number of times, you didn't
19 get any answer?
20 A. I got a dialling tone, I knew that a call had been made,
21 there wasn't an engaged tone or an unavailable tone.
22 THE CHAIRMAN: You got a ringing tone?
23 A. Yes.
24 THE CHAIRMAN: And when you tried again at some slightly
25 later point, there was an answer?

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1 A. I think it might have been on the third or fourth
2 attempt.
3 THE CHAIRMAN: Okay.
4 MR WOLFE: The telephone system in the Altnagelvin allowed
5 you to phone out directly, did it, or did you go through
6 a switchboard?
7 A. I think it allowed you to dial out directly to local
8 numbers.
9 Q. It's Mr Ferguson's assertion that he didn't miss any
10 calls, that he answered on the first call that he
11 received. You can't explain that?
12 A. I can't.
13 Q. What did you tell Mr Ferguson when you established
14 contact?
15 A. I don't exactly remember the full conversation, but
16 I think I told him that Raychel had fittted and I asked
17 him was there any family history of seizure activity
18 because I hadn't anticipated that an electrolyte
19 imbalance would have caused this seizure episode. He
20 assured me that there was no family history and I said,
21 "You know, I think you should make your way in to see
22 Raychel", and he asked me, "Should I bring my wife?",
23 and I told him, "That's up to you". And again, in
24 hindsight, I didn't fully appreciate the seriousness of
25 Raychel's condition at that time.

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1 Q. Are you sure that that was you? I ask that question
2 because Staff Nurse Gilchrist has also given the inquiry
3 information suggesting that she was the person assisting
4 Dr Curran?
5 A. I was assisting with investigations and I thought I must
6 have been there when the bloods were taken. I know
7 Staff Nurse Gilchrist came back and a few of us were
8 around Raychel. I can't recall exactly whether it was
9 me or Staff Nurse Gilchrist, but we were probably both
10 there because the ECG was actually carried out, I think,
11 on two or three occasions because they didn't maybe get
12 a reading, a satisfactory reading maybe on the first
13 occasion. So I'm sorry, I can't say for definite that
14 it was me, but I know that that's what we were doing at
15 that time, assisting the doctors.
16 Q. Ultimately, there were two sets of bloods taken; isn't
17 that right?
18 A. Yes.
19 Q. The first set of bloods went off and Dr Johnson, in his
20 account to the inquiry, reflects upon a delay or
21 a confusion with those bloods; they didn't come back as
22 quickly as he thought they might have, and that was
23 because of a confusion between the labs; did you
24 appreciate that?
25 A. Well, I wasn't dealing with that confusion or with that

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1 Q. You thought it sufficiently serious to make the call.
2 A. Yes.
3 Q. And you thought it sufficiently serious to request the
4 attendance of him. If you were asking for one parent to
5 come in, does it not follow you should have been asking
6 for both?
7 A. Well, I felt that the parents would have a conversation
8 and decide between them whether one or both of them
9 needed to attend.
10 THE CHAIRMAN: Just a quick point, Mrs Noble. When a child
11 is fitting, is that not inevitably a very serious event?
12 A. Yes, but my experience of seizure activity would maybe
13 have been a child with epilepsy, a child with
14 hypoglycaemia, a child who had maybe a condition. I had
15 never anticipated or seen a child who had basically
16 fittted as a result of vomiting.
17 THE CHAIRMAN: Right. Thank you.
18 MR WOLFE: At or about this time, there's obviously quite
19 a few things going on at the same time.
20 A. Yes.
21 Q. You've told us that you assisted Dr Curran in obtaining
22 bloods --
23 A. Yes.
24 Q. -- for electrolyte analysis.
25 A. Yes.

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1 issue. I wasn't aware that Dr Johnson felt that there
2 was a delay because I was with Raychel.
3 Q. The haematology lab apparently had the sample, whereas
4 the biochemistry lab needed the sample to do the
5 electrolytes.
6 A. That would be correct.
7 Q. Staff Nurse Bryce was in attendance; is that correct?
8 A. I think so. I think we were all there at that time.
9 Q. And at some point, possibly between 3.30 and 4.00,
10 Dr Johnson leaves the ward and it appears that he goes
11 to speak to his more senior senior house officer, who
12 was Dr Trainor at that time.
13 A. That's correct.
14 Q. Did he inform you that he was leaving the ward for that
15 purpose?
16 A. Yes. I also recall saying to Dr Curran, "What about
17 your senior house officer and registrar? Is there any
18 way that they can possibly come to attend Raychel?".
19 I know I might have said it on a few occasions to him,
20 and he told me at that time that they were busy in A&E,
21 dealing with a man with bleeding oesophageal varices and
22 they couldn't come up.
23 Q. This is Dr Zafar?
24 A. It must have been, at that time, the registrar and SHO.
25 Q. Was any consideration given to contacting the consultant

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1 under whose care Raychel had been admitted, who was
2 Mr Gilliland, or the on call consultant?
3 A. I didn't give consideration at that time because I knew
4 Dr Johnson was going to speak to Dr Trainor, who was
5 a registrar.
6 Q. Yes, but on the surgical side. You advised Dr Curran
7 that it might be sensible, prudent perhaps to inform his
8 seniors.
9 A. Yes.
10 Q. And there was no senior input from a surgical
11 perspective until much later.
12 A. Yes.
13 Q. Did you give any consideration to the --
14 A. Again, I thought it was up to Dr Curran to seek help
15 where he could and my job was to ensure Raychel was
16 continually monitored and observed.
17 Q. During this period, you recall that Raychel was having
18 intermittent tonic episodes?
19 A. Uh-huh, briefly.
20 Q. So the diazepam had initially settled her, but after
21 a period of time, intermittent tonic episodes were
22 provoked and were observed.
23 A. Yes.
24 Q. Was she given anything for that?
25 A. No, they weren't continuous or they weren't really

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1 A. Yes, she was second on call to Dr Johnson.
2 Q. Very well. Dr Trainor comes to Ward 6 to see Raychel --
3 A. Yes.
4 Q. -- and Dr Johnson doesn't come back. As we understand
5 it, he took up Dr Trainor's duties.
6 A. Yes.
7 Q. Is that your understanding?
8 A. Yes, from what I recall, yes.
9 Q. By this stage, Raychel's tonic episodes, according to
10 your original statement, were every two to three
11 minutes.
12 A. Yes, they were becoming more frequent.
13 Q. And at that time her pupils were becoming --
14 A. Sluggish.
15 Q. Did you regard that as a sign of further deterioration?
16 A. Yes.
17 Q. Dr Trainor explains her actions upon arrival in terms of
18 receiving the biochemistry results, which Dr Johnson was
19 processing on the computer at that point. Sorry,
20 I should say Dr Curran was processing on the computer at
21 that point. They were abnormally low.
22 A. Yes.
23 Q. She asked for repeat electrolytes to be performed.
24 A. Yes.
25 Q. Do you understand why repeat electrolytes were regarded

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1 regular. They were just occasional tonic gestures, from
2 what I recall.
3 Q. You say in your statement to the Trust at the time that
4 Staff Nurse Gilchrist bleeped Dr Trainor.
5 A. Yes.
6 Q. Whereas Dr Johnson tells us that he was bleeped while
7 he was speaking to Dr Trainor and advised that Raychel
8 looked more unwell and that he should come back to the
9 ward. Just the final piece of this jigsaw: Dr Trainor
10 doesn't mention any bleep in the accounts that she has
11 given. So perhaps you could help us with that little
12 point of confusion.
13 A. Well, as I say, you'll have to ask Staff Nurse Gilchrist
14 because it was her who bleeped the doctor and whoever
15 was on switchboard may well have misheard and said,
16 "Bleep the SHO", or maybe they would have heard, "Bleep
17 the registrar", so I can't account for that.
18 Q. Dr Trainor herself describes herself as a senior house
19 officer --
20 A. Yes, but --
21 Q. -- albeit she might have been --
22 A. Albeit she was our registrar.
23 Q. So she was sufficiently experienced --
24 A. Yes.
25 Q. -- in her SHO role to be regarded as the registrar?

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1 as necessary in this situation?
2 A. Yes. It could be an abnormally low result. We had
3 never seen a sodium so low in a child. That would have
4 been why Dr Trainor would have insisted on a second
5 sample being sent to confirm and to establish that the
6 first one was a true reading.
7 Q. So there is an element of -- maybe this is to put it too
8 far -- not quite believing what you were seeing --
9 A. Exactly.
10 Q. -- and that needed to be checked out?
11 A. Yes.
12 Q. And did Dr Trainor explain her thinking or rationale to
13 you?
14 A. No, I had seen that happen before with other medical
15 patients, that again if an abnormally high result or
16 abnormally low result of any given aspect of their blood
17 tests -- they would be repeated to establish that that
18 was a true condition or true reading.
19 Q. It would appear that no steps were taken at that stage
20 to alter the fluid regime that Raychel was still
21 receiving, notwithstanding this result.
22 A. Yes. As I say, I had no idea of the treatment of
23 hyponatraemia at that time and would not have been aware
24 of the fluid that she should be put on or the rate,
25 whether it be two-thirds, half maintenance or whatever.

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1 And obviously, Dr Trainor was a senior registrar and
2 I left it -- it was her call to change fluids.
3 Q. Yes, it would have been her call to make.
4 A. Yes.
5 Q. But in terms of your understanding of why she didn't
6 make that call, do you have any understanding?
7 A. I think I remember saying, "Should we change these
8 fluids?", and I think I recall Dr Trainor saying, "We'll
9 wait for the second result".
10 Q. So she was concerned, as you've explained earlier, that
11 this is perhaps a rogue result?
12 A. Yes.
13 Q. And that it was premature --
14 A. Yes.
15 Q. -- to affect the fluids one way or the other?
16 A. Yes.
17 Q. Was there a general realisation at that point that this
18 child had suffered a tonic episode, which was continuing
19 secondary to an electrolyte problem?
20 A. Yes. And as well as that, Dr Trainor had noticed some
21 petechiae on Raychel's face, which weren't apparent
22 earlier when we were checking Raychel over, and again
23 she suspected that Raychel had somehow contracted
24 meningitis and maybe this was the cause of her
25 deterioration, and she had begun to noticeably become

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1 A. Yes.
2 Q. And the next step in the sequence seems to be that
3 Dr Trainor asked you to contact Dr McCord.
4 A. Yes.
5 Q. Dr McCord was her consultant, the consultant on the
6 paediatric side.
7 A. Yes.
8 Q. And you made the call and presumably gave the receiver
9 to --
10 A. Dr Trainor, yes.
11 Q. Were you privy to that conversation?
12 A. Between Dr Trainor and Dr McCord?
13 Q. Yes.
14 A. No.
15 Q. Do you know what Dr Trainor intended to tell Dr McCord?
16 A. About how unwell Raychel had become and that she
17 suspected an electrolyte imbalance and that she was very
18 worried for her.
19 Q. I'm conscious of your last answer that you weren't privy
20 to the conversation. One of the pieces of information
21 that you had now at this stage was the blood sample
22 back, the electrolyte sample back, showing low serum
23 sodium --
24 A. Yes.
25 Q. -- and the plan that had been activated at that point,

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1 more unwell and she explained to Mr Ferguson that
2 Raychel was very ill and to contact Mrs Ferguson and
3 bring her to the hospital.
4 Q. Yes. At the point at which Dr Trainor examines the
5 child, her pupils had become fixed and dilated.
6 A. Yes.
7 Q. "Unreactive and dilated" is the word, I think, that's
8 been used.
9 A. Yes.
10 Q. Is there a distinction to be drawn between unreactive --
11 I mistakenly used the word "fixed". When the
12 word "unreactive" is used in that context by Dr Trainor,
13 is that what she means, do you think? Were her pupils
14 fixed?
15 A. I don't recall looking at Raychel's pupils myself, but
16 fixed pupils would mean that whenever you would shine
17 a light on to the pupil that it would not -- normally,
18 dilated pupils would constrict when light was shone into
19 them and if Raychel's pupils were fixed, they weren't
20 reacting to light the way you would imagine them to do
21 so.
22 Q. Clearly, at that stage, it was realised that Raychel was
23 very ill --
24 A. Yes.
25 Q. -- and, as you say, Mr Ferguson was advised of this.

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1 presumably, was to repeat the bloods.
2 A. Yes.
3 Q. And Dr Curran had taken those steps. Can you say
4 whether it was in Dr Trainor's mind or whether it was
5 her intention to give that information to Dr McCord?
6 A. I wasn't --
7 MR CAMPBELL: Is that not an impossible question for this
8 witness, Mr Chairman?
9 THE CHAIRMAN: If she doesn't know, she doesn't know.
10 A. I'm sorry, I don't know.
11 MR WOLFE: But what you do know is that, between yourselves,
12 the discussion was of an electrolyte problem --
13 A. Yes.
14 Q. -- possibly being at the root of this.
15 A. With a possible meningococcal septicaemia.
16 Q. If I put this way, the preliminary differential
17 diagnosis was: is this infection --
18 A. Yes.
19 Q. -- for which antibiotics might be required?
20 A. Yes.
21 Q. And on the other side, well, is this an electrolyte
22 issue, for which a fluid solution might be necessary?
23 A. Yes.
24 Q. Is that fair?
25 A. Or maybe the infective process had caused the

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1 electrolyte imbalance as well.
2 Q. And are you aware of the conclusions that were reached
3 or the plan that was drawn up as a result of the
4 telephone conversation between McCord and Trainor?
5 A. All I know from that time was that Raychel had become so
6 unwell that it required transfer to the treatment room
7 because her oxygen saturation levels had dipped, and
8 that was a major concern, and I lifted Raychel from the
9 bed in room I and took her to the treatment room and in
10 between times the anaesthetic people were fast bleeped
11 and we maintained Raychel's oxygenation until the
12 anaesthetic people arrived.
13 Q. And Dr Date arrived to intubate and ventilate Raychel?
14 A. Yes.
15 Q. Thereafter, can you remember what other doctors arrived
16 at the scene?
17 A. Dr McCord arrived and I'm not sure of all the other
18 doctors. I think that the anaesthetic doctor had
19 requested senior help as well, but I don't remember his
20 name or her name. I can't remember.
21 Q. Dr Nesbitt is the consultant anaesthetist who came in
22 eventually. You didn't have any dealings with him?
23 A. No.
24 Q. In terms of the attention that was given to the
25 intravenous fluids that were still running at 80 ml

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1 Q. Can you say whether the fluids had been changed before
2 Dr McCord's arrival?
3 A. I'm not sure.
4 Q. In terms of your dealings with Mr and Mrs Ferguson at
5 this obviously very upsetting time, what were your
6 dealings with them?
7 A. I just informed them what had happened and made them
8 aware that the doctors would speak to them whenever they
9 had Raychel stabilised.
10 Q. Raychel, as you know, was transferred to Belfast --
11 A. Yes.
12 Q. -- for further observation.
13 A. Yes.
14 Q. And ultimately, her death occurred on 10 June.
15 A. Yes.
16 Q. Were you made aware of it on that date?
17 A. I think I was. I can't recall exactly when I was made
18 aware, but I know I had rang in to the hospital on a few
19 occasions looking for updates of what had happened with
20 Raychel.
21 Q. On 12 June, you attended a meeting that was convened by
22 Dr Fulton in the hospital; is that right?
23 A. Yes.
24 Q. If we could have up on the screen, please, WS049/2,
25 page 19. What was your understanding of the purpose of

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1 an hour, Solution No. 18, can you say when steps were
2 taken to stop those and start 0.9 sodium solution?
3 A. I can't recall at exactly what time that decision was
4 made. As I said, the discussion would have been between
5 the doctors, not with the nursing staff, and when
6 a decision would have been made, they would have asked
7 the nurses to run through a specific fluid.
8 Q. What was your last involvement in the treatment of
9 Raychel, the care of Raychel at that time?
10 A. I think I was assisting the anaesthetist, whatever, to
11 do her rapid sequence induction to get Raychel
12 ventilated, and when she was stably ventilated, I think
13 I went outside to speak to Mr and Mrs Ferguson to make
14 them aware of what was going on and told them that the
15 doctors would come out and inform them of what was
16 happening when they could and a plan was made to take
17 Raychel for -- I think it was a CT scan at that stage.
18 Q. In your first statement to the Trust, you indicated that
19 you asked what fluids were required.
20 A. Yes.
21 Q. Who did you direct that enquiry to?
22 A. I can't remember whether it was Dr McCord or Dr Trainor,
23 but I know I did ask were the fluids needing to be
24 changed. I can't recall the exact conversation or to
25 whom, but I know I did ask that question.

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1 that meeting, Mrs Noble?
2 A. Well, obviously it was because Raychel's sodium level
3 had been dangerously low and the fact that she hadn't
4 had any electrolyte profile carried out prior to this
5 event, that we obviously wanted to make things happen
6 that this shouldn't happen again to any other child
7 coming into Altnagelvin.
8 Q. Was there a realisation at the time of that meeting
9 that, without pointing fingers at anybody in particular,
10 that mistakes had been made by clinicians and nursing
11 staff at Altnagelvin?
12 A. Yes, I think there was.
13 Q. Could you perhaps provide us with a general sense of
14 what was said in terms of articulating what those
15 mistakes were?
16 A. I think the main mistake was that Raychel's electrolyte
17 profile was not monitored. The meeting was nearly
18 12 years ago, I'm sorry, I can't recall, and probably
19 I was quite -- still in shock from the events that had
20 unfolded over those few days.
21 Q. Within your statement to the inquiry you are asked about
22 that meeting and, in particular, at item (d), bang in
23 the middle of that page, you're asked what contribution
24 you made to it. If that could be highlighted, please.
25 You say:

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1 "I contributed how I felt things could be improved
2 for all other surgical children so that this would not
3 happen again, namely electrolyte profiles should be
4 performed at regular intervals whilst a child is
5 receiving intravenous fluids."
6 A. Yes.
7 Q. You felt that more senior doctors should be responsible
8 for overseeing fluid management of surgical children.
9 A. Yes.
10 Q. And you felt that the evidence gained from this
11 experience should be shared with all the trusts.
12 A. Yes.
13 Q. Just to be absolutely clear, are you saying that these
14 are points that came from you, that you articulated to
15 those conducting the meeting?
16 A. I think during the general consensus of that meeting --
17 again, I can't recall exactly what had gone on, but
18 I think we had heard that Solution No. 18 was no longer
19 being used in the Royal Belfast Hospital for Sick
20 Children because I had heard that a nurse had told the
21 Ferguson family that Raychel had been receiving the
22 wrong fluids in Altnagelvin. We were not aware of this
23 at all -- it had never been communicated down through
24 the trusts -- and I felt it would be beneficial that, as
25 a Centre of Excellence, that Belfast should have shared

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1 analysis?
2 A. Well, I mostly felt that Sister Millar had a strong
3 viewpoint on that in that she had to specifically ask
4 doctors on the ward round to ensure that doctors would
5 come and carry out electrolyte profiles on their
6 children.
7 Q. And that is by contrast with the situation you described
8 with the paediatricians --
9 A. Yes.
10 Q. -- who had maybe an unwritten rule, because nobody has
11 produced anything in writing to us, but an unwritten
12 rule that at the 24-hour mark or thereabouts, as may be
13 convenient -- you wouldn't necessarily wake a child out
14 of sleep, you might do it earlier -- but at the 24-hour
15 mark, give or take, they would do electrolyte
16 analysis --
17 A. Yes.
18 Q. -- whereas it's a much more --
19 A. Relaxed --
20 Q. -- approach on the part of the surgeons?
21 A. Very much so.
22 Q. Was it accepted at that meeting that, notwithstanding
23 that people may not have appreciated the danger, if you
24 like, of Solution No. 18 in particular circumstances,
25 that nevertheless electrolyte profiling should have been

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1 this information with everybody.
2 Q. Yes. Was that a point that was made at the meeting?
3 A. Yes.
4 Q. But in terms of your contribution, because that's how
5 you've answered this question on the page in front of
6 you, are you saying you made these important and
7 relevant contributions at the meeting yourself --
8 A. Yes.
9 Q. -- in that you say you made these contributions --
10 A. It had been discussed and I said, "Why can't we ensure
11 that this information should be passed down from other
12 areas? Where they realise that something is wrong, why
13 isn't the information passed down through the trusts?".
14 Q. The first point that's made here is that electrolyte
15 profiles should be performed at more regular intervals.
16 A. Yes. It was discussed at that meeting that the surgeons
17 were not very good at monitoring their children on IV
18 fluids.
19 Q. And who was making that point? Was that coming from the
20 paediatricians, was it coming from the nurses?
21 A. From the nurses.
22 Q. Unless you can put a name to the person who's making
23 that point, was that the consensus of the nursing staff
24 who were part of this sequence of events that the
25 surgeons weren't good at carrying out electrolyte

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1 done in Raychel's case?
2 A. Yes.
3 Q. Even though you didn't realise the full implications of
4 Solution No. 18?
5 A. Yes.
6 Q. So just to be clear, it was recognised that because
7 Raychel had been vomiting all day, that that vomiting
8 was severe and prolonged?
9 A. Yes.
10 Q. Because there was no great evidence, apart from one
11 episode of urination post-operatively, that in those
12 circumstances, with a drip continuing to run, that
13 electrolyte analysis was really an essential --
14 A. Yes.
15 Q. -- and that it should have been done.
16 A. Yes. And we had called a doctor to come and see Raychel
17 and it wasn't the nurses' job to ask for investigations.
18 I mean, we didn't request electrolyte profiles to be
19 done on the children; the doctors made that decision.
20 Q. It sounds as if it was a meeting where people, certainly
21 the nurses, were expressing themselves frankly.
22 A. Yes.
23 Q. Were there surgeons at this meeting?
24 A. I think there were, but I can't recall who exactly was
25 at the meeting. I know -- I think ... I can't remember

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1 if Mr Gilliland was there, the surgeon -- surgical
2 consultant.
3 MR WOLFE: If you'll allow me a moment, chairman. (Pause).
4 A. I'm sorry, I don't have a great memory for names.
5 Q. Dr Raymond Fulton, who chaired the meeting, as
6 I understand it --
7 A. That's right.
8 Q. -- was present.
9 A. Yes.
10 Q. Ms Therese Brown was present.
11 A. Yes.
12 Q. She was on the risk management side of the house; isn't
13 that right?
14 A. Yes.
15 Q. If I could ask you to put up on the screen, please,
16 095-011-049. You can see that this is a police
17 statement which Dr Fulton has given. He sets out the
18 staff who attended from the third line down. You can
19 see that in terms of surgeons who attended or those from
20 the surgical side of the house you have Mr Zafar and
21 Mr Gilliland.
22 A. Yes.
23 THE CHAIRMAN: Dr Makar.
24 MR WOLFE: And Dr Makar.
25 So you've described a meeting, Mrs Noble, where the

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1 THE CHAIRMAN: It just happens you don't remember whether
2 they were there or not?
3 A. Yes.
4 THE CHAIRMAN: Okay.
5 MR WOLFE: You subsequently attended a meeting with --
6 THE CHAIRMAN: Before we go on, could we go back to witness
7 statement 049/2, page 19, please? I think that was the
8 last document that was up. Could you highlight
9 paragraph (d) again, please?
10 You are explaining, I think, in particular the
11 strength of feeling that Sister Millar had about the
12 first point there about the electrolyte profiles.
13 A. Yes.
14 THE CHAIRMAN: And about the third point, you expressed the
15 concern which you and the nurses had, which is that if
16 the RBHSC has stopped using Solution No. 18, why didn't
17 anybody else know about that, and that's the sort of
18 thing that should be shared round.
19 A. Yes.
20 THE CHAIRMAN: I understand those two points. If we go to
21 the middle, point 2, why did you feel that more senior
22 doctors should be responsible for overseeing fluid
23 management? Sorry, as a lead into that, when you say
24 "more senior doctors", do you mean no more JHOs, it has
25 to be at least an SHO?

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1 nurses were frankly explaining how they felt Raychel had
2 been let down; isn't that right?
3 A. Yes.
4 Q. And to some extent you were directing your concern
5 towards the surgeons who --
6 A. Yes.
7 Q. -- who didn't carry out electrolyte tests --
8 A. Yes.
9 Q. -- and that was in the context of a system where they
10 seemed to be very relaxed about electrolytes in general.
11 A. I remember Sister Millar especially raising those
12 concerns.
13 Q. Was there any response from the surgeons to these
14 expressions of concern?
15 A. I think it was acknowledged. From my memory, it was
16 acknowledged.
17 Q. Could I ask you just about a couple of names that
18 appear? I think they appear in that list.
19 Dr Claire Jamison, SHO anaesthetics, and Dr Gund, SHO
20 anaesthetics. Can you recall whether they attended
21 at the meeting?
22 A. I don't remember them directly. I hadn't met Dr Gund or
23 Dr Jamison very often and I certainly hadn't been --
24 they wouldn't have been familiar to me because I wasn't
25 working in theatres.

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1 A. Yes.
2 THE CHAIRMAN: Thank you. Why did you feel that?
3 A. Because I felt that maybe Dr Curran didn't fully
4 appreciate how sick Raychel was, as we didn't at that
5 time, and that maybe -- now, Dr Johnson apparently
6 expressed that when she first fitted, he thought she had
7 fitted as a result of an electrolyte imbalance. That
8 was one of his diagnoses, and I thought with his
9 experience, being another year down the line, it would
10 have been appropriate that senior [sic] doctors were not
11 allowed to nurse children because they are a specialty.
12 THE CHAIRMAN: When your statement says that you felt that,
13 was that something which was felt by nurses generally?
14 MR CAMPBELL: Chairman, I think that last comment should be
15 "junior doctors". It's what the witness said, she said
16 "senior", but she meant "junior".
17 A. Sorry.
18 THE CHAIRMAN: Okay. The first line on page 174 [draft]:
19 "It would have been appropriate that junior doctors
20 were not allowed to nurse children."
21 Thank you.
22 Sorry, what I was going to ask you was: was that
23 something which was felt both by you and other nurses,
24 was it?
25 A. Yes. It was a discussion where we all supported what

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1 everybody else felt. And I think that everybody had the
2 same consensus that we needed to make vast improvements
3 into how things were managed.
4 THE CHAIRMAN: Without wanting to point the finger at any
5 particular JHO, is that a reflection of the fact that
6 sometimes -- and it's a point that Mr Wolfe has been
7 asking you about a few times today -- what a junior
8 house officer can add to what an experienced nurse knows
9 is really quite limited?
10 A. Well, I think the nurses always feel that the doctor, at
11 the end of the day, is more senior to them, that their
12 knowledge is a lot more, they have seven years' training
13 in medical school, and they are trained, you know, to
14 take advice from their seniors at all times. Whereas,
15 as nurses, we didn't order investigations, we just
16 observed, recorded what we saw, and passed on the
17 information.
18 THE CHAIRMAN: Okay, thank you. Sorry, Mr Wolfe, you were
19 going to move on.
20 MR WOLFE: Yes. Hopefully, I didn't miss this point as
21 I was reading my notes, but without taxing you,
22 Mrs Noble, in terms of the reforms that were put into
23 place or the improvements that were put into place after
24 Raychel's death, and as a result of Raychel's death, is
25 it the case that junior doctors such as JHOs were

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1 would have been time perhaps to address Raychel's ill
2 health so that she wouldn't encounter the seizures and,
3 ultimately, death?
4 A. Yes.
5 Q. And who was articulating that view, do you know?
6 A. I can't remember exactly who, but I know that the
7 fact ... The surgical children were discussed and it
8 was wondered how many other children had maybe had low
9 sodiums or low sodiums that may have required
10 intervention, but maybe the children had recovered and
11 gone off IV fluids and hadn't continued them. We were
12 wondering how many other children had slipped through
13 the net having had low sodium levels that weren't --
14 THE CHAIRMAN: Maybe they weren't getting too much --
15 A. Exactly.
16 THE CHAIRMAN: -- maybe even if it was the wrong fluid, they
17 weren't getting too much of it for too many hours.
18 A. Yes.
19 THE CHAIRMAN: Was it part of that discussion that, apart
20 from Solution No. 18, there was actually too much fluid
21 given to Raychel?
22 A. Yes.
23 THE CHAIRMAN: That was recognised?
24 A. That was recognised as well.
25 MR WOLFE: The last section I want to look at with you,

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1 removed on the surgical side from being, if you like,
2 the first-up attendees at sick patients?
3 A. Yes.
4 Q. And they were replaced by what level?
5 A. Senior house officers and registrars.
6 Q. Right.
7 THE CHAIRMAN: That's surgical only?
8 A. Surgical only, yes. There's only ever senior house
9 officers in paediatrics. There are no junior house
10 officers in paediatrics.
11 THE CHAIRMAN: Okay, thank you.
12 MR WOLFE: So is it fair to summarise the 12 June meeting
13 that you attended in the following terms, that while it
14 was regrettable that Altnagelvin was not in possession
15 of the information around Solution No. 18, and that
16 fingers were pointed at the Royal, if you like, in
17 respect of that, nevertheless Altnagelvin and its staff
18 recognised their own failures in terms of how they
19 treated Raychel?
20 A. Yes.
21 Q. And the primary failure which you articulate was
22 a failure to ensure that Raychel's electrolyte
23 assessment was carried out in or about the evening of
24 8 June. Was it also recognised that if that apparently
25 simple step had been taken in a timely manner there

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1 Mrs Noble, is your attendance in --
2 MR QUINN: Mr Chairman, just on that point, it has taken me
3 a little bit by surprise. Could we ask how and when?
4 THE CHAIRMAN: Sorry, we shouldn't let it sit as bluntly as
5 that, yes.
6 The last point I asked you about was whether it was
7 recognised that there was too much fluid had been given
8 to her. That isn't something that you had been alert to
9 at all during Raychel's treatment?
10 A. No.
11 THE CHAIRMAN: Can you remember how that emerged at the
12 meeting?
13 A. I think it might have been the anaesthetists, whatever,
14 using a formula to calculate a fluid requirement for
15 children. I think they were all aware of this formula
16 that, as nurses, we didn't use. They were aware of that
17 and realised that she had had too much fluids.
18 THE CHAIRMAN: That sort of begs the question about which
19 anaesthetists were there.
20 MR QUINN: This opens up a whole new front in this case.
21 I know my learned friend's going to address the meeting
22 of September 2001 because I've already alerted the team
23 to that and the issues arising out of that, but it must
24 be remembered that the parents were never told anything
25 about too much fluid. It was never raised by them. In

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1 fact, it was only raised when the reports were brought
2 in by the inquiry. So if this was raised at this time,
3 then somebody in Altnagelvin Trust knew -- and
4 I emphasise that point -- they knew that there was
5 negligence floating around, yet we have to face a denial
6 of liability in all of the civil side of this case.
7 This is a point that needs investigating because if in
8 fact it was discussed at the meeting, then it is a major
9 issue in this case about knowledge of what happened to
10 Raychel.

11 THE CHAIRMAN: Yes.

12 Your recollection, Mrs Noble, is that this
13 discussion that Raychel had received too much fluid came
14 from whichever anaesthetists were there, who had the
15 formula for calculating fluid. To the best of your
16 recollection, were they in terms saying there's an issue
17 about Solution No. 18, but there's also an issue about
18 how much fluid she got?

19 A. From what I recall, yes.

20 THE CHAIRMAN: Yes.

21 A. I didn't take any notes about that meeting.

22 THE CHAIRMAN: Can I also ask you this because it feeds into
23 this issue. Between the toing and froing, were any
24 anaesthetists saying, "We have told you or we have
25 prescribed Hartmann's before and you wouldn't use it on

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1 is that came from the anaesthetists who had perhaps had
2 a chance to look at Raychel's records, had seen what had
3 been given, and they were making the point that,
4 whatever about the fluid, Raychel had also received too
5 much fluid.

6 A. Yes.

7 THE CHAIRMAN: To your recollection, did that seem to be
8 accepted at the meeting as well?

9 A. Yes, but to be honest with you, from what I recall,
10 I think they said that, in effect, what she was having
11 was 15 ml extra per hour.

12 THE CHAIRMAN: You know the point that you've been asked
13 about before about how the fluid regime which Raychel
14 was on was in fact the preoperative regime and the
15 fluids had never been reviewed afterwards.

16 A. Or prescribed post-operative.

17 THE CHAIRMAN: Was that discussed as well?

18 A. I can't remember. I honestly can't remember.

19 THE CHAIRMAN: If there was discussion about her receiving
20 too much fluids, it might have been part of that, but
21 you don't remember?

22 A. I just don't recall it. I think I took the main points
23 and recall those.

24 THE CHAIRMAN: So it's the points that you have in your
25 statement plus the one that you've added, which is that

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1 the ward, so now you have to use it because now we know
2 what the position is in the Royal"? Was there any of
3 that?

4 A. I think that discussion was going to be made with the
5 anaesthetists and the doctors. I don't think that was
6 actually brought up at that meeting. I think they were
7 going to look at it to see what other fluid would be
8 appropriate if Solution No. 18 wasn't going to be used
9 any more.

10 THE CHAIRMAN: So you think that at that meeting on 12 June
11 there was a discussion -- sorry, it's on the screen here
12 actually, the next paragraph, (e):

13 "The main conclusion was Solution No. 18 should not
14 be used for surgical patients."

15 A. Yes.

16 THE CHAIRMAN: Was that one of the outcomes of the meeting?

17 A. Yes, that was one of the outcomes. And then a decision
18 was going to be made, if Solution No. 18 wasn't going to
19 be used, what was going to be the most appropriate
20 solution for surgical patients to be on. And I think it
21 was Dr Nesbitt who was going to find out what was used
22 in other trusts and what was used in the Royal.

23 THE CHAIRMAN: Okay. Let me go back to the bit we stumbled
24 over a few minutes ago, the notion or the acceptance
25 that too much fluid had been given and your recollection

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1 there was a recognition that Raychel had received too
2 much fluid?

3 A. Yes.

4 THE CHAIRMAN: Okay. And do you remember that being
5 a disputed issue or do you remember that being an issue
6 on which there was agreement?

7 A. I can't recall. I honestly can't recall.

8 THE CHAIRMAN: Okay, thank you.

9 A. It was discussed, but I can't recall whether it was
10 a dispute or an agreement.

11 THE CHAIRMAN: Mr Quinn, we'll pick it up with further
12 witnesses. I think Mrs Noble's probably taken us as far
13 as she can on that.

14 MR QUINN: It beggars belief that we now have a situation
15 where Dr Nesbitt goes back the next day and makes a
16 retrospective note in relation to fluid and this is the
17 first time in years of this that we've heard that
18 someone raised this at the meeting that the fluid was in
19 excess of the prescribed rate. It seems an impossible
20 scenario. Then we have the meeting of September when
21 one of the parents goes with her sister. This is never
22 mentioned. Never mentioned.

23 THE CHAIRMAN: That's why I'm saying I think Mrs Noble has
24 taken it as far as she can by giving us this information
25 about the 12 June meeting and we'll pick it up with the

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1 witnesses who are to come afterwards.
2 MR QUINN: What we want to know today, before this witness
3 leaves the witness box, is why Nurse Noble doesn't
4 mention this in the meeting of September?
5 THE CHAIRMAN: Well, Mr Wolfe is about to come on to the
6 September meeting, so let's move on to that.
7 MR LAVERY: Can I add one point in relation to the meeting?
8 I know the inquiry is due to hear evidence from the
9 Dr Fulton. Dr Fulton has put in his witness statement
10 that Dr Jamison and Dr Gund were both in that meeting.
11 He now accepts that they were not at the meeting and
12 that he made a mistake when he prepared his witness
13 statement. With the leave of the inquiry, he would wish
14 and seek that within the next week or so, in the next
15 few days, to put in a supplemental statement to that
16 effect.
17 What he will say is that he prepared his witness
18 statement four years after the event, that he was
19 drawing on notes and witness statements that had been
20 provided to him and they do appear in his witness
21 statements as quotations from doctors Gund and Jamison
22 as if they were at the meeting. He accepts now that
23 they weren't at the meeting and that was just a mistake
24 in the transcription of --
25 THE CHAIRMAN: Does that mean that what he has when he

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1 because he has prepared a statement already in draft
2 form.
3 THE CHAIRMAN: The sooner we have it the better. Could we
4 turn up the page from that meeting that identifies who
5 was there?
6 MR WOLFE: 095-011-049.
7 THE CHAIRMAN: I'm just trying to think. If it's now
8 accepted that Dr Jamison and Dr Gund weren't there, is
9 it confirmed that Dr Nesbitt was there?
10 MR LAVERY: Dr Nesbitt was there.
11 THE CHAIRMAN: So to the extent that Mrs Noble remembers a
12 discussion led by somebody from the anaesthetic side
13 about excessive fluids, then that is most likely to have
14 come from Dr Nesbitt because he is the only anaesthetist
15 who was there?
16 MR LAVERY: Indeed, Mr Chairman, yes.
17 THE CHAIRMAN: Thank you. We'll move on to September.
18 MR WOLFE: Yes.
19 Mrs Noble, you were part of the Trust delegation
20 that met with family members on 3 September --
21 A. Yes.
22 Q. -- 2001. And by that stage, as you have frankly
23 acknowledged, the clinicians and nursing staff had
24 appreciated their own failings in relation to the care
25 of the child.

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1 prepared his statement -- this is his police statement,
2 I think, isn't it?
3 MR LAVERY: Yes.
4 THE CHAIRMAN: Does that mean that among the documents that
5 he had to prepare his police statement were the notes
6 which had been made immediately after Raychel's death up
7 to and including 12 June? That he had spoken to
8 Dr Gund, that he had spoken to Dr Jamison, and those
9 were -- so he stands over his handwritten notes about
10 Dr Gund and Dr Jamison?
11 MR LAVERY: What he was doing was drawing on their
12 statements and he had them as quotations. When he was
13 preparing his own notes in advance of the meeting, he
14 was preparing his notes and what he did was he took some
15 information from the statements that he already had from
16 Dr Gund and Dr Jamison and then put that into his
17 statement.
18 THE CHAIRMAN: Okay. Let me just --
19 MR LAVERY: He was misinterpreting his own notes.
20 THE CHAIRMAN: If that helps to resolve that issue, that's
21 helpful, Mr Lavery, and certainly if he is going to make
22 a statement correcting what he told the police I would
23 like him to do it -- we are at Wednesday afternoon.
24 Could we have that by Monday afternoon?
25 MR LAVERY: Yes. We could even try and have it before then

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1 A. Yes.
2 Q. And in particular, as you have outlined, there was
3 a failure to conduct electrolyte analysis when it was
4 appropriate to do so and there was an excess of fluid
5 given to the child.
6 A. Yes.
7 Q. Moreover, you, by this stage, appreciated that the wrong
8 fluid type had been given to the child, albeit the
9 clinicians in the Altnagelvin would have said that that
10 was a failing of the Royal to communicate that round the
11 north of Ireland in respect of their knowledge of the
12 issue.
13 A. That was my impression, yes.
14 Q. The meeting of 3 September with the parents was
15 designed, I assume, to explain to family members how
16 Raychel had come to die in a situation where she had
17 entered hospital for a straightforward appendix
18 operation.
19 A. Yes.
20 Q. You had several opportunities to speak to the parents or
21 speak to Mrs Ferguson and, I believe, her sister, during
22 that meeting. You're recorded in the note of that
23 meeting, which can be found at 095-010-046i -- it's the
24 record that was maintained of the meeting. You can see
25 your name is one of the attendees. I don't intend to

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1 bring you to your various inputs to the meeting, but in
2 general terms, Mrs Noble, you referred at that meeting
3 to the observations and care that you brought to Raychel
4 during 8 and 9 June; isn't that right?
5 A. I can't recall the exact conversations. I can't recall
6 my direct input.
7 Q. Let me show you a few examples of what you said. If we
8 go forward to page K. The bottom of the page:
9 "Staff Nurse Noble said when she came to duty, she
10 got the report. She was told that Raychel had been sick
11 during the day, had been given Zofran for this. She was
12 not aware of any blood in the vomit, nor of Raychel's
13 sore head."
14 A. During the day, during the day.
15 Q. Yes. That's the context in which you say that.
16 Clearly, by the night-time you were aware of blood
17 in the vomit.
18 A. Yes.
19 Q. Then over the page, if we could move to the next page,
20 please. It's at the top of the page. If we take up
21 again with what you're saying:
22 "Staff Nurse Noble said that when she went down to
23 the ward, Raychel's father was there and Raychel was
24 dozing. [You] gave Raychel paracetamol suppositories
25 for the headache [as you've explained earlier]."

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1 the in-house meeting involving clinicians and nurses,
2 clearly behind closed doors --
3 A. Yes.
4 Q. -- what should have been said at that point is: Raychel
5 was on these fluids, there's an acceptance that she had
6 retained free fluid, but we made a mistake in not having
7 her electrolytes checked. Isn't that the conclusion
8 that had been reached in June?
9 A. I do know that Dr McCord felt that there was absolutely
10 nothing wrong with Solution No. 18, that it had been
11 used widely, and that, again, if her electrolytes had
12 been monitored, then this shouldn't have happened.
13 Q. The point is that --
14 THE CHAIRMAN: Sorry, just to make this point. You said to
15 me a few minutes ago that it was recognised on 12 June
16 that the main mistake which had been made was a failure
17 to monitor the electrolytes.
18 A. Yes.
19 THE CHAIRMAN: Right. Were Mrs Ferguson and her sister told
20 that in September?
21 A. I can't recall. I can't recall.
22 THE CHAIRMAN: There was also a discussion on 12 June that
23 Raychel had been given too much fluid.
24 A. Yes.
25 THE CHAIRMAN: It's correct, isn't it, that they weren't

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1 So that was at about 9.25 in the evening.
2 A. Yes.
3 Q. So there's various entries, and we needn't go through
4 them all, of you explaining how you brought treatment to
5 Raychel at various points --
6 A. Yes.
7 Q. -- on 8 and 9 June. If I could ask you to look at -- if
8 we could move forward to page O in the sequence. In the
9 middle of the page it's recorded that Mrs Doherty,
10 a relative of Mrs Ferguson, her sister:
11 "Mrs Doherty asked Dr Nesbitt if, on looking back,
12 he had learned anything from this. Dr Nesbitt said,
13 I do think it was a low sodium. I have been in contact
14 with children's hospitals and we will look at ways of
15 preventing this happening. This has made me change my
16 practice. I was totally devastated."
17 Then Dr McCord intervenes and he says:
18 "The same fluids were used for children up and down
19 the country. He felt there had been an innate
20 sensitivity in Raychel's case. These fluids had the
21 correct amount of sodium and glucose in the same amount
22 of water. Raychel retained free fluid and this made her
23 brain swell."
24 In light of what you have said, Mrs Noble, about
25 what was accepted at the meeting in June, if you like,

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1 told that in September?
2 A. Again, I can't recall the exact conversations or I don't
3 recall all the points of the meeting.
4 MR WOLFE: To the extent that the record tells us what was
5 said, we will not find anything in that record admitting
6 to the mistake of failing to carry out electrolyte
7 analysis. We won't find anything in that record
8 admitting that the wrong amount, the wrong rate of fluid
9 had been prescribed. Speaking for yourself personally,
10 given that you had earlier contributed to the 12 June
11 meeting and were privy to the acceptance that these were
12 real mistakes in Raychel's case, why didn't you, during
13 any of your contributions, make these admissions to
14 Mrs Ferguson.
15 A. From my recollection, it was mostly the consultants who
16 had spoken to Mrs Ferguson and her sister -- and I think
17 Sister Millar was speaking. I didn't -- I don't recall
18 thinking of that at the time, thinking that it was
19 obviously something that a senior person should discuss
20 with the family, not just the nurse.
21 THE CHAIRMAN: Well, let me put it this way: if the purpose
22 of the meeting, which you have described, was to explain
23 to representatives of the Ferguson family why she died,
24 then that should be explained to them in fairly clear
25 terms; isn't that right?

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1 A. Yes.
2 THE CHAIRMAN: I accept that, from your perspective, if it
3 has been decided or recognised at an internal meeting
4 that the electrolytes should have been checked and if it
5 has been recognised that she got too much fluid, then
6 the people who should face up to that and who should
7 tell the Fergusons that are the most senior people
8 at the meeting.
9 A. Yes.
10 THE CHAIRMAN: But let me put it to you this way: at the end
11 of that meeting, when the Fergusons left and they hadn't
12 been told that there was a mistake about checking the
13 electrolytes and they hadn't been told that Raychel had
14 got too much fluid, did you feel uneasy or unhappy that
15 the Fergusons were not being told the full story, or did
16 that occur to you or dawn on you at the end of that
17 meeting?
18 A. I can't remember.
19 THE CHAIRMAN: Do you see what I mean? There seems to have
20 been, on your recollection, a fairly frank meeting on
21 12 June --
22 A. Yes.
23 THE CHAIRMAN: -- at which the nurses and doctors face up to
24 what went wrong to a pretty significant extent and also,
25 to some extent, there's a bit of finger-pointing at the

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1 page 20. This nurse said at paragraph 47 of that page
2 -- one can see what she said:
3 "My memory is that Nurse Noble continually said that
4 they had no concerns about Raychel."
5 How does that fit with the evidence she's giving
6 now? I understand fully and one can fully understand
7 why this nurse shouldn't face up to the admissions made
8 by the Trust, but we still have to look at her behaviour
9 during this affair.
10 THE CHAIRMAN: Sorry, we're not at loggerheads on that at
11 all. I think that, looking back, thinking back over the
12 evidence that Mrs Noble has given yesterday, before
13 lunch, until now -- I'll ask Mrs Noble.
14 That's what Mrs Ferguson remembers of what you said
15 at that meeting, and it's clearly rather hurtful to her
16 that you were saying you had no concerns. Having
17 listened to your evidence for the last day and a half,
18 it seems to me that you did have concerns. But what
19 you --
20 A. I thought that the concerns that I had at the time were
21 dealt with, having got an anti-emetic on board, having
22 the fact that her fluids were still in progress, and
23 that she appeared to settle and the vomiting became
24 less. I mean, that was my reason for not having concern
25 for her, and I obviously didn't fully appreciate exactly

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1 Royal: if you're not using Solution No. 18, why didn't
2 you tell everyone else? Because if you're the
3 specialists and you're supposed to know best, you should
4 tell everyone else round Northern Ireland.
5 A. Yes.
6 THE CHAIRMAN: But it's not really good enough, Mrs Noble,
7 is it, that when the Fergusons met with this big team
8 from Altnagelvin in September that they weren't told at
9 least two of the very basic mistakes which had been
10 recognised?
11 A. Yes, I accept that.
12 THE CHAIRMAN: Do you accept that?
13 A. Yes.
14 THE CHAIRMAN: I have to say, subject to the evidence that
15 comes later, I think the admissions and facing up to
16 what went wrong should come from the most senior people
17 there and it's difficult to put the responsibility on to
18 somebody like Mrs Noble.
19 MR QUINN: I totally agree. I totally agree and the family
20 wouldn't expect this nurse to come out bluntly and say
21 there's mistakes made.
22 THE CHAIRMAN: When her more senior colleagues are sitting
23 around and not saying what mistakes are made.
24 MR QUINN: But what the nurse didn't have to say was what
25 appears on Marie Ferguson's statement, which is WS020/1,

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1 what was going on at that time, and I regret that.
2 THE CHAIRMAN: Yes. I think if you had said to Mrs Ferguson
3 something along the lines that you had concerns, but you
4 didn't realise just how gravely ill Raychel was, that
5 might have been a message which she took a bit easier
6 than the impression she appears to have got from you,
7 that you didn't have any concerns at all.
8 A. I regret that that was the impression I gave.
9 THE CHAIRMAN: Thank you.
10 MR QUINN: I make this as my last point: this witness had
11 eight opportunities that appear in the minutes of this
12 meeting to express any concerns that she had. She spoke
13 at the meeting eight separate times, which is just as
14 many times as any of the consultants spoke. So in my
15 respectful submission, she shouldn't be saying, "Well,
16 someone else should have spoken up". When you go to
17 a meeting and you hear that something goes wrong, surely
18 someone has to speak up, someone has to be responsible.
19 THE CHAIRMAN: Well, I think -- I'm not sure how far apart
20 you and I are on that, but we can come back to it. At
21 this stage, we recognise the primary responsibility --
22 MR QUINN: Yes, we do.
23 THE CHAIRMAN: -- on the people at that meeting.
24 Mr Wolfe?
25 MR WOLFE: Not to prolong the agony, but just to finalise,

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1 Mrs Noble, you would accept that the parents of a child
2 who died in untoward circumstances such as this have
3 a right to obtain full information about what caused the
4 death; would you agree with that?
5 A. Yes.
6 Q. And at this meeting in September 2001, the family were
7 not given the full story; isn't that right?
8 A. Well, from what I can see, yes. I can't recall the
9 actual meeting myself. I can't recall the exact points
10 of it.
11 Q. If the record that appears before us is accurate, they
12 weren't told the very things that were admitted among
13 yourselves behind closed doors.
14 A. Yes.
15 Q. Mrs Ferguson, in a witness statement, tells us that she
16 left that meeting utterly dissatisfied. As she says on
17 paragraph 49 in front of you, she looks back at the
18 meeting with "disgust, anger and annoyance" and she
19 thought this was just the beginning of a cover-up by
20 Altnagelvin Hospital. Regardless of who's to blame for
21 what went on at that meeting, when a family isn't given
22 the full truth about what happened to their daughter --
23 and in fact where Dr McCord is talking about the innate
24 sensitivity in Raychel's case -- that's exactly what
25 happened here, there was a cover-up; would you agree

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1 some of the position that it has taken. We had the
2 very, very unhappy moment in Claire's case when, I think
3 it was Mr Walby, who said that after the inquest into
4 Claire's death he thought, if the Roberts family sue,
5 just settle up because there was a failure to conduct an
6 electrolyte test. And that was, as you might remember,
7 and you might realise, very, very distressing for the
8 Roberts because they had no intention of suing. They
9 haven't sued, and it was very distressing for them to
10 hear that if they had sued, the Trust would effectively
11 admit responsibility, expressly or implicitly, by
12 settling, because the Trust recognised or some of the
13 most senior people in the Trust recognised that there
14 had been no electrolyte test. I'm not sure how far away
15 we are from that situation in Raychel's case where,
16 according to this witness, the Trust recognised within
17 days of Raychel's death there's no electrolyte testing
18 and there was too much fluid given. So I am not asking
19 for a response now, but I think that's something the
20 Trust might want to consider over the next few days.
21 MR LAVERY: Yes, Mr Chairman, but in terms of the civil
22 litigation that was brought by the Ferguson family
23 against the Trust, as I understand it, a writ of summons
24 was issued and because of the inquiry that was stayed
25 pending the outcome of the inquiry. That's where

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1 with me?
2 MR LAVERY: That's a matter [inaudible: no microphone].
3 I don't think that's an appropriate question for this
4 witness.
5 THE CHAIRMAN: I'm not sure it's inappropriate to ask this
6 witness.
7 Can you understand how Mrs Ferguson got the
8 impression that there was a cover-up? Because to put it
9 very, very succinctly, the mistakes which were admitted
10 to internally at the meeting on 12 June were not
11 admitted to externally with the Fergusons on
12 3 September.
13 A. Yes.
14 THE CHAIRMAN: So if you were sitting there like
15 Mrs Ferguson, you'd think, "That's a cover-up".
16 A. Yes.
17 THE CHAIRMAN: And it takes you to come to an inquiry to
18 find that what -- they'll sit around a table ... I will
19 put it in these terms: Mrs Ferguson and her family must
20 think the nurses and doctors will sit around a table and
21 talk about the mistakes they made, but when they sit
22 down with me, they won't tell me the mistakes they made.
23 A. I could understand why she would feel like that, yes.
24 THE CHAIRMAN: Because Mr Lavery, I'd like the
25 Western Trust, as successor to Altnagelvin, to consider

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1 matters were left, Mr Chairman. So it is something
2 certainly that the Trust will revisit --
3 MR QUINN: No, no, Mr Chairman, a statement of claim was put
4 in and a denial on all points was received. I opened
5 the case on that and my learned friend should know that.
6 THE CHAIRMAN: I'm not looking for a response now, but --
7 MR LAVERY: I would just say, Mr Chairman, that the matter
8 was stayed pending this inquiry and no further action
9 has been taken in respect of that claim.
10 THE CHAIRMAN: Mr Quinn's right --
11 MR QUINN: It has not been stayed. It has not been stayed.
12 I want to make this clear on the record. It has not
13 been stayed.
14 THE CHAIRMAN: Let me put it this way: it hasn't been
15 formally stayed, but it hasn't been pursued while the
16 inquiry is pending --
17 MR QUINN: No, it hasn't been pursued, but it hasn't been
18 stayed.
19 THE CHAIRMAN: The point is this: whether the Trust should
20 be showing one face internally and a different face
21 externally. That's the point. I'll take it no further
22 than that because all this is damaging and distressing
23 enough for everyone involved.
24 Mrs Noble, before we leave this, before this meeting
25 on 3 September, when you were all going to meet the

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1 Ferguson family, what did you know about what was to
2 happen at the meeting or how it was going to be
3 conducted?
4 A. I was just told that it was going to be an opportunity
5 for the Ferguson family to ask any questions that they
6 wanted clarity on.
7 THE CHAIRMAN: Can you remember who you spoke to or who
8 asked you to come to the meeting and who you spoke to
9 before you went to it?
10 A. I can't remember, but I know Sister Millar had made me
11 aware that there was going to be a meeting.
12 THE CHAIRMAN: Okay. What you said a few minutes ago to
13 Mr Wolfe was that you regarded that meeting as having as
14 its purpose explaining to the Ferguson family why
15 Raychel had died?
16 A. An opportunity for them to ask questions as well.
17 THE CHAIRMAN: Right.
18 MR WOLFE: I have no further questions. I'm not sure about
19 Mr Quinn or Mr Campbell or Mr Lavery.
20 MR QUINN: I just want to make one point. I'm rather upset
21 at my learned friend making the point that this
22 litigation is stayed --
23 THE CHAIRMAN: I want to let Mrs Noble out of the witness
24 box. I'll take your point in a minute.
25 Mrs Noble, you've been there for a long time, much

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1 Mr Justice Gillen and we actually -- my solicitor went
2 up and explained that this matter is now before the
3 hyponatraemia-related deaths inquiry. So it's still
4 being reviewed. The litigation is still in progress
5 being reviewed.
6 THE CHAIRMAN: Sorry, I just want to clarify one thing: did
7 you say a moment ago that it was being adjourned at the
8 request of the police?
9 MR QUINN: No.
10 THE CHAIRMAN: That was in the earlier period from 2005 to
11 2008?
12 MR QUINN: Yes, that's why it was delayed for a period.
13 THE CHAIRMAN: And now it is being adjourned --
14 MR QUINN: It's back into the Queen's Bench review court
15 and it's being reviewed every so many months by
16 Mr Justice Gillen. In fact, he made life a little bit
17 difficult for my solicitor until it was explained that
18 it was a matter for the inquiry to sort out.
19 MR LAVERY: That's exactly what I was saying, Mr Chairman.
20 No further action has been taken in respect of this
21 claim pending the outcome of this inquiry and this
22 tribunal will know that Mr Justice Gillen is not slow to
23 list medical negligence actions, particularly ones that
24 have been around for some time.
25 THE CHAIRMAN: Yes, okay. Look, we'll leave that point. In

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1 longer than you expected and longer than I expected.
2 I'm very grateful to you for coming. I know it has been
3 difficult for the reasons that are apparent to
4 everybody. Unless there's anything else you want to
5 add, you're now free to leave the witness box.
6 A. Thank you very much.
7 (The witness withdrew)
8 THE CHAIRMAN: Mr Quinn?
9 MR QUINN: Mr Chairman, my learned friend Mr Lavery made
10 a point that this litigation is stayed. Before counsel
11 gets on his feet to make such an assertion and asserts
12 that before this tribunal of inquiry, you should make
13 sure of your facts. If my learned friend has been
14 advised and instructed by a solicitor that it is stayed,
15 then so be it, that's his instructions. But my
16 instructions are that this matter has been continually
17 reviewed before Mr Justice Gillen at the medical
18 negligence review court and it was only put off being
19 litigated upon at the request of the PSNI. I would like
20 to know where my friend got his information from if in
21 fact he is asserting that it's stayed.
22 MR LAVERY: We're going to get into semantics, Mr Chairman.
23 THE CHAIRMAN: Sorry, but you're not saying that it is
24 still being adjourned because --
25 MR QUINN: It is. Only four months ago it was reviewed by

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1 essence, if you wanted the case to be heard in the
2 High Court now, you could get it heard. In essence,
3 it's for a while it'd be fair to say that -- my
4 understanding of it is that it's now been adjourned,
5 effectively at the plaintiff's request, pending the
6 finalisation of this inquiry.
7 MR QUINN: Yes.
8 THE CHAIRMAN: Okay. That brings Mrs Noble's evidence to
9 a completion. Unless there are any other points, we'll
10 start tomorrow morning. I would like to start at 10.15
11 rather than 10 o'clock or any earlier. We'll start at
12 10.15 with Mrs Millar. Thank you very much.
13 (5.15 pm)
14 (The hearing adjourned until 10.15 am the following day)
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