Wednesday, 27 February 2013

(10.00 am)

(Delay in proceedings)

(10.15 am)

MRS ANN NOBLE (continued)

Questions from MR WOLFE (continued)

MR WOLFE: Good morning, Mrs Noble.

A. Good morning.

Q. I want to take up where we left off yesterday, which is with Raychel coming back from theatre to Ward 6 after her appendicectomy. As I understand the position, you were on your break when Raychel was at theatre.

A. Yes.

Q. And when you arrived back, you tell us in your witness statement that you were told that Raychel had a mildly congested appendix.

A. Yes.

Q. Who would have informed you of that?

A. I think it was Staff Nurse Patterson.

Q. Staff Nurse Patterson was the nurse who had gone to theatre to fetch Raychel back to the ward, if you like.

A. Yes.

Q. And it was your responsibility, or partly your responsibility, during the early hours of the morning to carry out observations with respect to Raychel.

A. Yes.

Q. And as we noted from the care plan yesterday, initial observations post-operatively are quite close in time. In other words, there's observations every 15 minutes for the first, I think, two hours, correct me if I'm wrong.

A. Yes.

Q. And then stretching into half hourly and then hourly, and then for the rest of the day, four-hourly.

A. Yes.

Q. Perhaps if I could just take a look at those. There's a document at 020-015-029, if we could have that on the screen, please. I think this is the first time we've looked at this document. We can see that at the top of the page it was opened by Staff Nurse Patterson, who made an entry at 9.50, which was preoperatively, and various observations are made: temperature, pulse, blood pressure, respiratory rate, and a pain rating. Then there is an opportunity to make comments in the right-hand margin. As we can see, this was completed throughout the day with the last entry being 9.15, by which time you had come back on to duty; isn't that right, Mrs Noble?

A. That's correct.

Q. We can see if we pick up on 1.55 am, that's the second

entry from the top. That is in fact the first entry made post-operatively; isn't that correct?

A. That's correct.

Q. And it's made by Staff Nurse Patterson. I can't read her writing. If you can help us perhaps ...

A. "Sleeping but easily roused on return to ward. Wound site satisfactory."

Q. Yes. And then Nurse Patterson makes the next entry:

"Sleeping [again], wound site satisfactory, colour pink."

Then you make the rest of the entries up to 5 am; is that correct?

A. That's correct.

Q. Without going through each of them, if you briefly look at the observations, temperature, pulse, blood pressure, respiratory rate and the comments, is the summary of the position that Raychel is progressing satisfactorily and there's no cause for concern or alarm?

A. That's correct.

Q. You tell us in your witness statement that you had a brief conversation with the parents at the point of observations.

A. Well, I would normally speak to the parents and maybe just reassure them that everything looked okay and everything was fine. I don't recall the exact

conversation I had with the parents. I think I might have advised one of the parents to go home, as Raychel was so well settled, and I think I remember saying that it might be better if one of them went home to have a sleep because Raychel would probably need them better -- more the next morning when she was awake and mobilising.

Q. One of the parents, Mr Ferguson, remembers -- we see this in his witness statement at 021/1, page 3, we needn't bring it up on the screen. He remembers you being quite abrupt and telling the parents that only one of them could stay; is that your recollection?

A. I don't recall being abrupt. I would make them aware that it was hospital policy and ward policy that only one parent should stay at night, but I didn't force anybody to leave.

Q. In any event, Mrs Ferguson left the hospital in the early hours of the morning; do you remember that?

A. I don't remember her leaving, no.

THE CHAIRMAN: Do I take it from that that you don't remember her leaving, but that you do recall that she left, so there was only one parent who stayed? Or are you unsure?

A. I'm unsure of the exact ...

MR WOLFE: Given that we have this document up on the

screen, I want to ask you some questions about the whole issue of record keeping and note making, which is an issue which the inquiry wishes to examine. A concern has been expressed by some of the experts retained on behalf of the inquiry about the absence of note keeping or note making by nurses particularly during the day of 8 June. It's suggested by those experts that there might have been an under-recording of Raychel's symptoms and particularly her vomiting. That's obviously something that we will test out as we go along. But I just want to ask you about the importance of note keeping and the facilities available to nurses for note keeping. In your experience and practice, what is the importance of note keeping or recording of a patient's symptoms?

A. So that the person -- another person coming on, taking over from that nurse who had been looking after the patient, could see exactly what happened and could see from the observations chart an exact idea of the condition of the child throughout the day.

Q. Yes. So, for example, if a nurse comes on duty not having had any experience or exposure to a particular patient, they should be able to pick up --

A. Yes.

Q. -- the notes and say, "That's what happened to that

child or patient in the last five hours", for example?

A. Yes.

Q. The document that we have in front of us, one can see that -- if we look at the period from 9 am to 5 pm, I'm conscious of course that you aren't on duty during that period, but we don't see any record in that period of the four vomits that are otherwise recorded in the fluid balance chart. Could you tell me whether this document is designed for the purpose of recording features or episodes such as vomiting?

A. The fluid balance sheet would be the ideal place to record vomiting, but personally if I had witnessed it, I might have recorded in the comments column that the child had been nauseated and vomited as well, but I wasn't on duty during the day.

THE CHAIRMAN: Can I get this clear from you? This sheet is the observations sheet that you're going back at 30-minute intervals and then hourly intervals and two-hourly intervals. So does that means that you only record on that sheet what you actually see at that specific observation?

A. Yes, or I would even record if the parents had expressed any concerns or, if I had noted the parents to be overly anxious, I would have also written something like that.

THE CHAIRMAN: Yes, but is that from a discussion which you

might have with them when you go to see Raychel to make the observation?

A. Yes, at that time.

THE CHAIRMAN: There's a reference to vomiting in the very last entry at the bottom of the page at 9.15, isn't that right, 21.15?

A. Mm-hm.

THE CHAIRMAN: Does that mean that there was vomiting at the time of the observation, but from the absence of any reference to vomiting earlier in the day it means that there was no vomiting at the specific time of the observation?

A. I can't speak for whoever wrote in the vomiting at that time, whether they had just noted the vomiting at that time or whether they had been informed of the vomiting.

THE CHAIRMAN: Okay. So if Claire was vomiting, let's say between 1 pm and 5 pm -- there was certainly some vomiting around 3 o'clock and there's an issue around how often, but do I understand your evidence to be that the reason why that is not on this observation sheet is probably because she was not vomiting at the time of the observation at 1 pm or at the time of the observation at 5 pm?

A. Yes.

THE CHAIRMAN: So we have to look elsewhere to find a record

of vomiting?

A. Yes.

THE CHAIRMAN: Right.

MR WOLFE: If we go to document 020-016-031, and if we could have that up on the screen with the next page, 032. Each of these documents, as is clear, are called observation sheets, same piece of stationery. There's one for 7 June and one for 8 June. The one on the left-hand side records Raychel's condition at about 8 o'clock when she first came to the hospital or shortly after coming to the hospital. And then the one on 9 June records the particular episode of Raychel's seizure and the nursing events that flowed from that. So for example, as we understand it, Nurse Gilchrist recorded blood pressure on that sheet, but I think -- is the top part of the sheet your entry, "Child found on side "?

A. Yes, that's all my writing on that page.

Q. My question at this stage is simply limited to: what is the purpose of this kind of observation sheet by contrast with the observations we've just looked at?

A. The previous observation sheet was usually used when a child would have come back from theatre and this particular observation sheet on 9 June was a close observation sheet. And the one on 8 June was

discontinued and a four-hourly graph chart had been used because they felt that Raychel's observations had been stable enough to go on to a graph sheet. And then when she fitted, I found it was necessary to start a close observation sheet about her.

Q. I'm not sure I picked you up correctly. You said the one for 8 June was discontinued.

A. Yes, the one of 8 June, the last entry by Staff Nurse Gilchrist, she had documented at 21.15, and she had mentioned her vomiting. And then whenever the girls went to do their observations again at 2 am, there was a graph sheet that was used.

Q. Yes. Sorry, what I am anxious to explore before we go to the graph sheet is: should there not have been a similar observation sheet in place to record significant episodes that occurred during the day of 8 June? In other words, we have this observation sheet, one for 7th, one for the 9th. Obviously they record, if you like, significant episodes, Raychel coming into the hospital and her condition at that time, 9 June, Raychel's seizure. But would you not expect to find one for 8 June, for example recording the passage of vomits that occurred during the day?

A. Well, the one on 8 June, that was a nurse during the day, she obviously felt that there was enough space to

document Raychel's progress throughout the day. I wasn't there and, as I say, I probably would have continued on the sheet post-operatively.

Q. You refer to a graph sheet that was used.

A. Yes.

Q. And I think that's to be found at 020-015-028. Is that the document you referred to?

A. Yes.

Q. I think what you told us is that the observation sheet that we looked at earlier was discontinued and you instituted a graph format.

A. We had finished the observations, Nurse Gilchrist resumed the observations. We're supposed to keep a graph chart as well to document any spikes in temperature so that you can see if there's any maybe potential for infection. Sometimes the girls would omit to use the graph sheet as well as the observation sheet post-operatively, but Staff Nurse Gilchrist started at 10 o'clock to write in her observations, as had the girls during the day, at the specific times, 2 pm and 6 pm.

Q. Yes, but this was not a replacement for the observation sheet we looked at earlier.

A. No.

Q. This is a document that had been used throughout.

A. In conjunction with, yes.

Q. And indeed, looking at this document -- and we'll come on and look at the evening and night of 8 June presently -- if one looks at it towards the bottom, you can see a space for vomiting.

THE CHAIRMAN: This is the second line from the bottom?

A. Yes.

MR WOLFE: So whoever was completing this was not fully completing it.

A. That's correct. We wouldn't normally have written about the vomiting in those sheets, we would have concentrated our observations on the fluid balance sheet at that time.

Q. So if a doctor came along and decided simply, for convenience or for whatever reason, just to look at this document, thinking he would see all of the relevant data, he would be missing something, wouldn't he?

A. Yes.

Q. What was the instruction or training from Altnagelvin at that time in relation to the completion of this sheet?

A. Mostly, the temperature, pulse and respiration and possibly a blood pressure on admission were filled out on that sheet. We normally did put a weight in, but we concentrated on marking down and taking output on either a feed chart or the fluid balance chart.

Q. If we go to the next page again --

MR STITT: May I interrupt for one moment? I apologise as ever. I think it's only fair, if one is looking at the system which is in force -- and obviously the point is why is there no reference to vomiting because the "vomiting" column horizontally is empty. I think it's only fair, before one moves away from this point, to point out to the inquiry that this is actually entitled, on the top left-hand corner, a "4-hourly TPR chart". This is not a fluid balance chart. I appreciate it says "vomiting" below, but nonetheless, to put into the balance, so to speak, this is actually a four-hourly TPR -- temperature, pulse and respiration -- chart. That's the purpose of this chart.

THE CHAIRMAN: Well, I think it must be more than that, Mr Stitt, because if I understood Mrs Noble correctly she said that this graph sheet is to be used with the observations sheet, and the observation sheet isn't restricted -- the observations don't just come every four hours, the observations come every 15 minutes, the half hourly, then hourly, then two hours, then four hours. So there must be more to this sheet than just a four-hourly chart.

MR STITT: Well, I have to say, the three sources of the information are: the observation sheet, which we have

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

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

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

THE CHAIRMAN: Yes, thank you.

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

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

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

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

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

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

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

A. Possibly.

Q. Do you know or are you speculating?

A. I'm speculating.

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

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

A. Yes.

THE CHAIRMAN: And 5 o'clock?

A. Yes.

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

A. That's correct.

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

A. No.

THE CHAIRMAN: Nor were you there at 5 pm.

A. No.

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

A. That's correct.

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

A. Yes.

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

THE CHAIRMAN: Thank you.

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

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

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

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

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

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

A. Because she was on intravenous fluids, yes.

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

A. On the fluid balance sheet.

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

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

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

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

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

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

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

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

necessarily a nurse present with the doctor when the doctor arrived. So if you called for the doctor, then it'd be much preferable that instead of the doctor just looking at the notes, that there would be a nurse like yourself or somebody else there to explain why he was being called and what the extent of your concern was; isn't that right?
A. But you mightn't always accompany the doctor to the bedside with the child.
THE CHAIRMAN: No, because you might be doing something else.
A. Yes.
THE CHAIRMAN: But you would at least want to grab a few words with the doctor to explain why he or she was being called?
A. Yes.
MR WOLFE: So by that exchange I understand you're saying that whether you're with the doctor as he attends the child or not, you would be, in your practice, looking to give the doctor as much information about the recent history as possible?
A. Yes.
Q. And then clearly, it's a medical decision what action to take in light of that.
A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

staff, that is Staff Nurse Gilchrist; is that correct?
A. Correct.
Q. Staff Nurse Bryce?
A. Yes.
Q. And an auxiliary nurse, Lynch?
A. That's right.
Q. You also had Staff Nurse Patterson back on duty that night, but she was allocated to the infants' unit; is that correct?
A. That's correct.
Q. She had previously been Raychel's named nurse when she was first admitted and had drafted the care plan; isn't that correct?
A. Yes.
Q. And clearly had some familiarity with Raychel's situation overnight?
A. Yes.
Q. Why did it make sense to allocate her to the infants' unit when she was Raychel's named nurse or had been Raychel's named nurse?
A. It was the duty of the senior nurse or sister during the day to make allocation for the nurses on night duty to what area they were going to work in.
Q. So that wasn't your duty?
A. That wasn't my duty, no.

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

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

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

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

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

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

and Lisa home."

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

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

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

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

And so on:

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

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

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

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

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

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

A. That's correct.

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

A. Yes.

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

process --

A. Yes.

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

A. I wasn't aware of this.

Q. Well --

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

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

A. Yes.

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

A. Yes.

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

Nurse Gilchrist recording that:

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

A. Yes, that's correct.

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

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

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

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

Q. You've seen it commonly?

A. Yes.

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

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

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

A. Yes.

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

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

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

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

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

A. No.

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

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

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

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

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

contributing to her symptoms as these could have been due to the reaction to the anaesthetic medication or post-operative nausea and vomiting that some children had experienced in the past."

So we're back, in a way, to an issue which we dealt with in general terms yesterday and let's just apply it to Raychel. You were aware now, arising out of this report from Staff Nurse Gilchrist, that this child had been vomiting for various episodes since 8 o'clock. So she's coming up on 14 hours since this vomiting had started. Starting at 8 o'clock in the morning, she's still vomiting at 9 o'clock at night and later; isn't that right?

A. That's correct.

Q. And would you agree with the suggestion of the experts that have looked at this that this vomiting must now fall into the severe and prolonged category?

A. Yes.

Q. You have accepted, I think, that with vomiting develops a risk of sodium depletion, that electrolytes are being lost through vomiting and there's a risk of depletion.

A. Yes, but because her fluids were in progress, I wasn't unduly concerned at that time. Had she not been on fluids, then I would have been concerned.

Q. But you --

A. More concerned.

Q. You must have known, Mrs Noble, that the fluids that she was getting, the aim of those fluids or the objective of those fluids was maintenance. Nobody had come to see her to prescribe replacement fluids.

A. Well, the children that usually had vomiting, even as excessive as Raychel's, in my experience, were only ever treated with their maintenance fluids and anti-emetics. And Solution No. 18 was always the solution that had been in use up until then in my practice.

THE CHAIRMAN: Do you know if they were children who also got the right rate of fluid?

A. I couldn't comment.

THE CHAIRMAN: Because there's a major issue here about Raychel getting too much fluid. So it's not just the type of fluid she was getting, in other words Solution No. 18 as against Hartmann's or something else; it's the rate of fluid she was getting, which was arguably higher than required before the operation, but I think the view of all of the experts is that it was too much after the operation.

A. Yes, well, I can't comment on the other rates of fluids because the doctors prescribe the rates of fluids.

THE CHAIRMAN: Of course, the problem is that the rate of fluid which was being given to Raychel all day Friday,

I think, was -- yes, the fluid that was given to Raychel all day Friday was the rate of fluid that had been prescribed for her on Thursday night before she went into the operation --

A. Yes.

THE CHAIRMAN: -- which is precisely one of the problems.

A. Yes.

MR QUINN: There's one point that I want to raise before this point finishes. I would like through you, Mr Chairman, to ask: could they describe Raychel as giving no cause for concern? I use those words cautiously because those are the words that seem to appear throughout the nurses' statements. There are three, at least, of the nurses who have used those words, including Nurse Millar at WS056/2, if that could be brought up. Page 7. You'll see under (e), second paragraph:

"Raychel was on four-hourly observations. Raychel was bright and alert despite the vomits. She was giving no other cause for concern."

I want to know if that could be an accurate description of how Raychel was during this nurse's shift. And I want to ask a second question following from that.

MR CAMPBELL: Mr Chairman, is that a fair question, because

the statement from Sister Millar was made during the day shift? We're now talking upwards of maybe 6, 8 or 12 hours later.

THE CHAIRMAN: Can I ask you it this way, Mrs Noble? Can I take it from the fact that there had been so much vomiting around 8, 9, and then up towards 10 o'clock that that was a cause of concern?

A. Yes, and we had communicated that to a doctor.

THE CHAIRMAN: This might ease the way for later questioning for you and others: does the fact that a doctor is brought in in itself mean there's a cause for concern?

A. Yes.

THE CHAIRMAN: Right. The only question is how great the cause of concern is, but a doctor would not be called unless you were concerned about a patient?

A. Exactly, yes.

THE CHAIRMAN: Okay.

MR QUINN: The second point I want to make is -- quite rightly, my learned friend has, as it were, pointed out that that was on the day shift. But could this nurse have given any doctor information after midnight, for example, that Raychel had been reasonably well? And I want to make that point because I want brought up 012-040-200. This is a statement by Dr Johnson, who came along at the latter stages after 3 o'clock in the

morning. You'll see in the handwritten notes a question by Mr Foster five lines down. It says:

"I had been told Raychel had been reasonably well. I may have been told that she vomited once or twice."

Where did that information come from? Because this was the nurse in charge on that shift when Dr Johnson was brought in.

THE CHAIRMAN: Okay. Dr Johnson will give evidence, I think he's scheduled for next week, Mrs Noble. On the face of this answer which he gave to the coroner, if he told the coroner that he had been told that Raychel had been reasonably well, is that something that you could have told him?

A. I don't recall. I don't recall.

THE CHAIRMAN: Well, was it your view that when you were -- I think at the handover you were not -- [OVERSPEAKING] at the time of the handover at about 8 pm you were not particularly concerned about Raychel, but after the events of around 9 o'clock, 10 o'clock, you had become concerned about Raychel.

A. Yes. And we had got a doctor to come and see her, who had given her another anti-emetic.

THE CHAIRMAN: Even to the extent that you thought that that might have worked, would you have told any doctor that Raychel had been reasonably well?

A. Well, I can't recall what I said to the doctor. But at that time Raychel had appeared to settle after the second dose of anti-emetic and appeared to settle to sleep and appeared settled enough that her parents were happy enough to go home. I think that might have been what I was trying to imply to Dr Johnson at that time.

MR QUINN: Mr Chairman, she had a Mallory-Weiss tear. Something has to be put to this nurse that in view of her own view that she had a Mallory-Weiss tear that was not communicated to the first doctor who came on duty to give her the drugs required, how can anybody get information from whoever it was received from that she had been reasonably well? How could that occur?

THE CHAIRMAN: Well, it depends how it's read, Mr Quinn. If it's read that Raychel -- it could not be said that Raychel had been reasonably well, for instance, for the duration of Mrs Noble's night shift.

MR QUINN: That's correct. But these are the night shift nurses who were telling the doctor that information.

THE CHAIRMAN: We'll explore this more, but it depends at what point the "had been reasonably well" refers to. Does it refer to after the arrival of the doctor, about 10-ish, and there's another anti-emetic given. She seems to settle, she seems to go to sleep. If you can find the time frame to that point, it may be that

Mrs Noble can say she can't remember saying this, but on that interpretation, "I had been told Raychel had been reasonably well (since the events but from 9 to 10 or 9 to 11), but after that she had settled". We'll hear from Dr Johnson more about that.

The second point that Mr Quinn raised, Mrs Noble, was that Dr Johnson says, "I may have been told that she vomited once or twice". Well, she had certainly vomited -- this again depends on timescale. But Dr Johnson does not appear to have known that she had been vomiting on a fairly regular basis from about 8 am and had particularly been vomiting in the evening, so that at around about 8 o'clock -- to the extent she needed her bed changed, then after 9 o'clock, and then 25 minutes later she had vomited again. That doesn't appear to be what Dr Johnson had picked up if that statement is right.

A. All I know is that I probably would have told him about the vomits that I had been aware of on my shift.

THE CHAIRMAN: Okay, thank you. We'll take a break for ten minutes.

(12.06 pm)

(A short break)

(12.26 pm)

MR WOLFE: Mrs Noble, just a very brief point, which

Mr Campbell has asked me to raise with you. Just going back some distance to the issue about whether there was a delay in Raychel coming back from theatre. He's invited me to ask you would there have been a typical time or an expectation of how long surgery would take in this kind of case?

A. Well, usually I would have told the parents at that time to expect their children back on the ward after about an hour and a half or two hours. That would have been generally my experience of how long it would take and I usually would have told the parents that the children would have spent longer in the recovery area than they would actually in the theatre itself.

Q. Very well.

THE CHAIRMAN: It's not one of the fundamental points, Mrs Noble, but if Mr and Mrs Ferguson got the impression or were told that Raychel might only be away from the ward for an hour, that was certainly too short, wasn't it?

A. Yes.

THE CHAIRMAN: Because even though the operation going well will take less than an hour --

A. Yes.

THE CHAIRMAN: -- Raychel or any other child, for that matter, has to be taken up to surgery, has to be

anaesthetised, then the operation, the time for recovery, and then she's brought down again.

A. Yes.

THE CHAIRMAN: So it was never going to be an hour.

A. Never, no.

MR WOLFE: Going back to the evening of 8 June, you got to see Raychel for the purposes of the medications round at about 25 past, half past 9; is that correct?

A. Yes.

Q. And you administered Flagyl --

A. Yes.

Q. -- which is the antibiotic, rectally, and the father raised with you -- that is Mr Ferguson raised with you -- a complaint that Raychel was suffering a headache --

A. Yes.

Q. -- and you suggested the administration of rectal paracetamol --

A. Yes.

Q. -- to address the headache.

A. Yes. And to help her to settle.

Q. And you recalled that she had been asleep at that time, but was unsettled and easily roused.

A. Yes.

Q. At that time, you would have known that Raychel had

suffered these coffee-ground vomits?

A. Yes.

Q. And at that time, would you have known that the plan was to get a doctor to come to the ward.

A. I think she had received her cyclizine prior to me coming.

Q. Well, is that right?

A. Yes.

Q. Because Dr Curran, we can look at this in a moment, seemed to have a recollection that the anti-emetic was administered by him at 10.15.

A. I'm not sure of that. I'm not sure of that. I didn't read Dr Curran's statement. But my impression was that at that time that the anti-emetic had been given and that the paracetamol would help her to settle and help relieve her headache.

Q. Maybe we'll come back to that point. At that time, as I've said, you have this headache in addition to the coffee-ground vomits, and the child is unsettled on your description. What was your impression of her condition, taking those factors into account?

A. My impression was that Raychel had had a difficult post-operative day and that she had vomited and, obviously, the latter had been a coffee-ground vomit, that she required a second dose of anti-emetic, that she

hadn't had any pain relief all day, which I thought could have accounted for her condition of being unsettled and in pain, and the vomiting I thought maybe was giving her a headache as well -- maybe the amount of times she had vomited, she had had a sore head. So I thought if we could relieve her headache, get her an anti-emetic while the fluids were being administered, that Raychel would hopefully settle to sleep and wake in the morning ready to try and start oral rehydration again.

Q. You had dealings with Mr Ferguson at that time --

A. Yes.

Q. -- at the time of doing the medical rounds. You've told us in your witness statement that he had concerns about the vomit and the headache.

A. Yes.

Q. But you sought to reassure him by explaining that this was not uncommon.

A. And it wasn't.

Q. His concerns weren't recorded by you in the care plan, were they?

A. Not at that time.

Q. Not at all.

A. Not at that time or at all because of the events that unfolded later on.

Q. Mr Ferguson, in his account which he give to the police in 2005, he described Raychel as being in a very poor state at that point in time. She was bright red in the face, she told her father that her head was "wild sore", then she vomited blood, as he describes it, on to the bed. The nurses came in and made Raychel stand while they changed the bed, yet she could hardly stand, given her state at that time. And she subsequently vomited again and thereafter he phoned his wife and told his wife the nurses weren't listening to him, weren't listening to his expressions of concern.

You had direct dealings with him; were you taking his concerns seriously?

A. From what I recall, I knew Raychel had vomited and I knew that she'd had a headache and Mr Ferguson had said that she wasn't settled and she was easily roused. I felt that if Raychel was given some pain relief, that she wouldn't vomit, that maybe she would settle. And when I assessed Raychel myself, she was able to communicate with me, she was coherent, and she was fully cooperative whenever I tried to get her to assume the position to receive a rectal suppository. So I felt Raychel was actually cooperative at that time.

Q. But did you get the impression that Mr Ferguson was very agitated about his daughter's condition?

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

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

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

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

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

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

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

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

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

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

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

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

doctor would know what the concerns are, so that even if you're with another child, the doctor who then goes to see Raychel has the information that you have. It doesn't have to be you, it could be --

A. It could be somebody else.

THE CHAIRMAN: It could be Nurse Gilchrist, and in this case it was Nurse Gilchrist who called the doctor and told you she was doing that and you thought that was entirely the right thing to do.

A. Yes.

THE CHAIRMAN: Whether either of you accompanied Dr Curran to see Raychel, wasn't it relevant or helpful for one of you to speak to Dr Curran?

A. Yes, it would have been.

THE CHAIRMAN: Right.

A. But I was continuing the rest of the medications at that time and Nurse Gilchrist and Nurse Bryce were on the ward and it would have been normal practice for one of those nurses to, if they had seen the doctor, either go with them or at least to speak with them after he had been to assess Raychel.

THE CHAIRMAN: Okay. Would it also have been normal for the doctor to come to speak to the nurse?

A. Yes.

THE CHAIRMAN: He comes along and he goes to see Raychel and

there isn't a nurse immediately to hand, then it's also fair to say that in the same way that you want to speak to the doctor, the doctor would want to speak to you.

A. I would expect that, yes.

MR WOLFE: It is the case that Staff Nurse Gilchrist contacted this doctor.

A. Yes.

Q. She has told the inquiry in her statement that she wasn't present when he attended because she was attending to other children.

A. Yes.

Q. If she didn't attend him and you didn't attend him, the only other option is Nurse Bryce, and there's no suggestion that she attended him.

A. Or he had gone on his own.

Q. He obviously then came on to the ward, administered the anti-emetic, and it appears that his only point of contact was the telephone call from Nurse Gilchrist to him, asking him to come; is that right?

A. Well, as far as I'm aware, yes.

Q. And what Nurse Gilchrist tells us is that she contacted Dr Curran, explained to him about Raychel's nausea and vomiting, and he said he would come to see her. If that's all he was told, Mrs Noble, that wasn't enough, was it?

A. Well, I would hope that the doctor would make a full and frank assessment of the child when he would come to see her.

Q. But this is a doctor, just so that we understand the context here, who is a junior house officer, so he's very inexperienced; isn't that right?

A. This was in June and Dr Curran would have been there, I'm sure, from --

Q. The previous August?

A. The previous August. He would have been used or au fait with assessing patients.

Q. He has not had the opportunity that you and your colleagues have had to observe this child over a period of time; isn't that right?

A. Yes.

Q. So the duty, as Ms Ramsay describes it, is for you as the nurse or your colleagues as nurses to put the doctor in the picture, to make him understand all of the things that have happened so that he can then apply his medical mind to the appropriate treatment plan or diagnosis?

A. Yes.

Q. But can I suggest to you that all that you and your colleagues did as nurses was to ask Dr Curran to come to prescribe an anti-emetic without reflecting to him the difficulties that this child had had over a longer

period of time, which were inconsistent with all of the expectations for her?

A. Well, basically I just felt that ... We had never encountered anything like hyponatraemia before and that the vomiting wasn't unusual, that the first anti-emetic hadn't been effective, that hopefully by the second anti-emetic that Raychel would respond, the vomiting would stop and her fluids were in progress, and the doctor would make a full assessment of Raychel. On night duty, it wasn't uncommon that the doctors didn't go to the patient's bedside themselves and they knew who -- they were advised of who they were going to have to see. Doctors normally would have taken the patient's notes, read through them and gone and made an assessment of the patient before administering anything. And usually, they would come and tell the nurses what they had done and what their opinion was and what the plan would be. But I don't recall Dr Curran coming to speak to either me after he had given Raychel her anti-emetic ...

Q. Let me ask you about that. I think you've agreed with me that if the doctor was simply told "this child has been vomiting, please give her an anti-emetic", that was insufficient, wasn't it --

A. Yes.

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

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

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

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

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

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

A. Yes.
Q. Then you're asked:
"What was the treatment plan for Raychel after she had been seen by the surgical junior house officer?"
And it was to:
"Monitor the effects of medication which had been administered and report any change in condition."
A. Yes.
Q. And you were asked:
"What notes or records, if any, were made in relation to the attendance of the surgical junior house officer and the steps taken by him?"
You say:
"No notes were made and I only realised this retrospectively."
A. Yes.
Q. So there was, it suggests here, a plan to monitor the effects of the medication --
A. Yes.
Q. -- which had been administered. Was anybody given the specific task of doing that?
A. No, but obviously we were all aware that Raychel had been given a second anti-emetic and we would have been noting the effect that it would have had, whether it would have ceased her vomiting.

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

MR WOLFE: Yes. The point being, however, Mrs Noble, that whatever about the responsibilities of a registered medical practitioner, Dr Curran -- and he will obviously be tasked with some questions about his actions on that night -- would the inquiry be wrong to form the impression that nurses took all diagnosing out of the equation by providing the remedy to the doctor to administer when he arrived, without him having to apply any thought processes? You put the medication on the table for him.

A. We knew Raychel was vomiting and we knew that the first anti-emetic didn't work and that there was an alternative anti-emetic that possibly could work.

Q. And is it fair to say then that the only reason Dr Curran was called is that nurses aren't legally permitted to prescribe and administer such an anti-emetic, rather than getting him along to carry out an investigation?

A. Well, that's the doctor's responsibility to come and make an assessment of any patient before they would administer any medication to see if it was warranted.

Q. It's a chicken-and-egg situation, isn't it?

A. It is.

Q. If you're telling the doctor, "All this child needs is an anti-emetic for a little bit of post-operative

nausea", a junior doctor, rightly or wrongly, might be minded to simply accept that advice from an experienced nurse, such as yourself or Mrs Gilchrist. Whereas if you're saying to the doctor, "Actually, there's something strange going on here, this child is departing from what we expected of her post-operative recovery pathway", then he's going to have to think and apply his medical mind to it; do you see the distinction?

A. Yes.

Q. And the mindset here, as I think you've accepted earlier, is that this was normal and that's the mindset that was conveyed, was it?

A. Well, again, we had no experience to make us think otherwise.

Q. In terms of what happened afterwards then, you say that nobody was given a particular responsibility to monitor the effect of the anti-emetic.

A. No.

Q. Should somebody have been given that responsibility?

A. Well, there were three nurses on that night and we all would have spoken between ourselves, and had Raychel vomited, it would have been communicated. And obviously, had she vomited, we would have assumed the anti-emetic was not effective and would have contacted the doctor again to say that she was still vomiting.

Q. Did Raychel vomit again?

A. I think she had had a mouthful around midnight or so.

Q. If we could have up on the screen the fluid balance chart at 020-018-037. We know that Dr Curran attended at 10.15. At least, that's when he logged the administration of the Valoid; isn't that right?

A. Yes.

Q. And at that time, in terms of the recording of vomit during the night shift, we have, "Vomiting coffee grounds, plus plus", with Staff Nurse Gilchrist signing. And then a further vomit, of multiplied by 3, at the 2200 hours slot. And within the 2300 hours slot, "small coffee-ground vomit"; do you see that?

A. Yes.

MR CAMPBELL: Just for the record, the middle entry reads:

"Vomited small amount by 3."

MR WOLFE: Thank you. I did stumble over the handwriting. I'm obliged.

So it does appear that here was a further vomit which occurred after Dr Curran had seen this patient.

A. But a lessening amount and hopefully the anti-emetic was starting to work. It doesn't work straightaway.

Q. Then there is a further vomit found on the child's pyjamas at 35 minutes after midnight, isn't that right --

A. Yes.

Q. -- which wasn't recorded?

A. Yes.

Q. You've described yourself and two other nurses being dedicated to this ward and that you were working as a team; isn't that right?

A. Yes.

Q. And the team, in order to monitor the effect of the anti-emetic, would need to know that an anti-emetic had been prescribed; isn't that right?

A. Yes.

Q. And would need to know that such a plan was being implemented, in other words monitoring the child?

A. Yes.

Q. And yet the person who brings the 11 o'clock vomit to the attention of you or your nurses was not one of the three of you; isn't that right?

A. I can't recall.

Q. You see, Nurse Patterson, who was dedicated to the infants' unit on that particular night, received a vomit bowl from Raychel's father. It was her that wrote the small coffee-ground vomit into the notes. Were you aware of that?

A. I can't recall that I was made aware that she had had that small coffee-ground vomit. I can't recall that

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

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

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

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

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

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

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

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

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

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

MR WOLFE: That's right.

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

So my inclination is to say to you that subject to

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

MR CAMPBELL: Very well.

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

MRS ANN NOBLE (continued)

Questions from MR WOLFE (continued)

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

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

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

"I didn't record this vomit."

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

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

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

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

She says:

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

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

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

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

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

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

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

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

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

thinking as the nurse in charge rather than any collective thinking with Staff Nurse Gilchrist. Do you see what I mean?

A. Yes, I do see what you mean, but obviously whenever she first received the anti-emetic, we obviously all felt that hopefully she would settle after that. And if Staff Nurse Gilchrist wasn't aware of that vomit at that time, it was written in her fluid balance sheet and I know that she -- Nurse Bryce and Sandra had -- Staff Nurse Gilchrist had helped to change Raychel at 25 to 12.

THE CHAIRMAN: Right.

A. So they hadn't communicated any concerns to me about that when I came back from my break.

THE CHAIRMAN: Well, let me ask you it in a slightly different way. When you're saying:

"We hoped the cyclizine would eventually settle her vomiting. We should have called the doctor back, but we thought she was settling and the vomits were smaller."

When you say "we" do you include Staff Nurse Gilchrist in that?

A. I did, yes.

THE CHAIRMAN: Okay, thank you.

MR WOLFE: The implications of the answers that are set out in front of you are that not only was she not aware of

that vomit, but moreover, as you can see at (h), when asked about monitoring arrangements, she's unaware of arrangements. So I'm not sure to what extent you wish to paint a picture for the inquiry of formal arrangements being put in place to monitor the effect of the anti-emetic, but whether formal or informal, this nurse, one of your key nursing resources that night, didn't seem to be aware of a need to monitor or a plan to monitor.

A. Well, there was no formal process for monitoring, but as a team we all collectively discussed the patients at various times during the night and any concerns that were about each patient were communicated between us all.

THE CHAIRMAN: Your other point about monitoring was that because the fluids had to be checked, that that became -- the fluids had to be checked hourly.

A. That was a point at which you could assess the patient and, you know, it would have been a time that the parents could have spoken to you or a time that you would have used your powers of observation to see how the patient was settling. So she was being checked hourly with the IV fluids. Her cannula site would have been checked and the rate of fluids and the amount infused would have been checked every hour, as well as

a general observation of the patient.

MR WOLFE: But if you are talking about the children as you describe -- I'm conscious that it's not just Raychel on the ward, but Raychel was a particularly sick child on this evening. If you are talking together as colleagues about the condition of children, would I be wrong to suggest that this is a significant event in a sense, this is a further vomit, she's just had an anti-emetic, nurses should perhaps be getting together to say, "What are the implications of this? Should we be getting the doctor? Should we give it a further period of time?". Was there any such discussion?

A. With the experience that I had at that time, we had encountered other children who had vomited similarly, post-operatively, and at that time I didn't expect Raychel to deteriorate any further because her fluids were in progress. I thought it was a matter of just getting her vomiting stopped and getting her a restful night with the pain relief that I'd administered earlier and that she should settle.

Q. The point being the larger point. In terms of trying to, as a group of nurses, work out what is happening here -- and Nurse Gilchrist will give her evidence in due course -- the impression to be formed perhaps from those answers is that, as a group of nurses, you hadn't

got together to discuss how Raychel was to be monitored or observed.

A. Well, I can't recall any specific getting together at that particular time because, as you say, there were a lot of other patients on the ward. But anybody that had any concerns about any of the patients would have highlighted them to me.

Q. Could I look at what your other nurse, Nurse Bryce, is saying about this? If I could have brought up on the screen, please, WS054/2 at page 6. She is the nurse who, in company with Nurse Gilchrist, observes the vomit on the pyjamas at half past midnight, 0035, which went unrecorded. She's being asked in that statement:

"Before seeing Raychel at 12.30 [it has been abbreviated to 12.30, I think she actually at some point gives a time at some point of 00.35], had you received any updates on how she had been progressing in the period since you came on duty at 7.45?"

And she says no.

So Mrs Noble, you have a small enough team working, apparently, as a team, a doctor who's come to give an anti-emetic and Raychel is supposed to be monitored. Yet this nurse is saying that since coming on duty at 7.45 she had received no update in relation to how Raychel was progressing. How can that be?

A. Well, sometimes some of the nurses would have concentrated their care to patients at a different end of the ward and maybe I had more interaction with Nurse Gilchrist at that time about Raychel and it wouldn't be until maybe we were going to our break at half 12 that we would have discussed anybody that we would have any concerns about.

Q. But does the evidence of Nurse Bryce here, and the evidence of Nurse Gilchrist, in which she doesn't seem to know about the 11 o'clock vomit, does that suggest communications on the ward in respect of this key matter, in other words the monitoring of Raychel at this important time, left something to be desired?

A. In light of what we know now, yes.

THE CHAIRMAN: The division of responsibility was that you were doing the medications and the other two, Mrs Bryce and Mrs Gilchrist were doing the observations; is that right?

A. Yes.

THE CHAIRMAN: But do I take it from what you have just said that they would not work together doing the observations, they would work separately?

A. They would maybe go to opposite ends of the ward.

THE CHAIRMAN: Right. Thank you.

MR WOLFE: Can I just pick up on a few points that maybe

should have been put to you earlier? When we talk about coffee-ground vomiting, according to Mr Foster, the expert surgeon retained on behalf of the inquiry, he says that's an indication of severe vomiting and retching; would you agree with that?

A. It was, but it wasn't uncommon to what we had experienced -- well, my experience in the years that I had been there.

Q. And whether common or uncommon, because of its indication of severe vomiting, he is of the view that you as nurses should have been insisting that Dr Curran, when he came to the ward, should call his senior colleagues or a senior colleague and not to have done so is evidence of substandard practice.

MR CAMPBELL: Mr Chairman, surely it is for the doctor to choose whether he needs to go further up the line for senior assistance.

THE CHAIRMAN: I certainly agree with you on this point, Mr Campbell, there's certainly an issue about whether the doctors should go up the line. I think it's an open question about whether a nurse should also go up the line, but I've heard Mrs Noble say this morning that there was effectively a hierarchy. If you were concerned, you would call in the JHO and for it to go beyond that, it was the JHO's decision to go beyond that

to SHOs, registrar or consultant. I understand that's a practice, but I don't think that can be regarded as a given, Mr Campbell. For instance, let's suppose a nurse is unhappy with what the JHO has done. Does she just leave it and say, "Look, I've done my job, I have called in the junior house officer, I'm going to leave it at that"? I take the --

MR CAMPBELL: Surely in the first instance it's appropriate for the nurse to seek assistance from the first doctor on the ladder.

THE CHAIRMAN: Yes. I think depending on the extent of concern, I think that's probably right. Really, the question which arises from this is whether that's the extent of the nurse's responsibility to only go up one step up the ladder.

MR WOLFE: Moreover, and allied to this point is a related point made by Mr Orr in his report. He says that junior house officers are reliant on nursing staff to alert them to any concerns regarding the patient. And that's because they are (a) generally inexperienced and (b) don't have the benefit of having observed a patient over a lengthy period of time. He says that it's regrettable that nurses didn't bring to the attention, as he perceives it, information about the coffee-ground vomiting and the other factors that I outlined earlier.

That's how he reads the evidence. Again, I think you've agreed with me that the information that I outlined earlier about the full context, the full history of Raychel's condition, ought to have been brought to the doctor's attention.

A. Yes.

Q. Whether it was or not, we will perhaps learn from Nurse Gilchrist, when she gives evidence, and Dr Curran. But you would agree with the broad proposition, would you, that junior doctors are reliant on nurses for that kind of information?

A. Well, it's the nurse's job, in the first instance, to explain why they have called a doctor to the ward to see a patient.

THE CHAIRMAN: I understand it wasn't you who called Dr Curran, but when Dr Curran is telephoned to come to the ward, it's the expectation, isn't it, that when he comes to the ward he will speak to one of the nursing team, who will explain the full extent of the problems?

A. Yes.

THE CHAIRMAN: It's not the expectation that whatever is said on the phone call will be the extent of the discussion with the doctor?

A. Yes.

THE CHAIRMAN: Okay. We'll find out, as the next week or so

goes on, what Mrs Gilchrist said to Dr Curran, but if he then came to the ward, he didn't speak to the nurses, he found the anti-emetic left out, sitting beside Raychel for him to give, and he seems to have given it and gone off again. It doesn't particularly matter who carries the responsibility for that or any blame for that, but that's not really good enough, sure it isn't.

A. Well, I feel he should have made a full assessment before giving his medication, and I feel he should have come to one of the nurses and explained what his assessment of Raychel was at that time and that he was happy enough to just administer the anti-emetic.

THE CHAIRMAN: I understand why you're saying, look, when we call the doctor, the doctor should be talking to us, and maybe the doctor might accept that or maybe he'll say if they wanted to give me a bigger picture, they should have made a point of speaking to me when I was there because I did come to see Raychel. But in a sense, I'm not so much concerned about whether it's more his fault or Mrs Gilchrist's fault or your fault. I'm making the more general point that how it happened really wasn't quite good enough.

A. No.

MR WOLFE: Could I also raise a point with you, Mrs Noble, which Mrs Ramsay makes in her report for the inquiry?

She says that as the vomiting continued through that night, so starting at the point of the nursing handover at about 8 o'clock, the vomiting continues certainly for a number of further hours. Blood pressure wasn't monitored during that period. In fact, blood pressure hadn't been monitored since 7 am at the conclusion of your first shift, if you like, in this sequence of shifts. Why was blood pressure not monitored, notwithstanding continued vomiting?

A. Well, I can't answer for the girls who were on during the day. And on night duty, as I said, I wasn't carrying out the observations. I don't know, if I had been there, would I have carried out a blood pressure on her? I would like to think I would have, but as I say, we thought that Raychel was just vomiting post-operatively and, in our previous experience, we hadn't experienced anything like this before in that she was going to further deteriorate and have a seizure later on.

Q. You accept it would have been good practice to continue to monitor blood pressure?

A. Yes.

THE CHAIRMAN: What in particular can the blood pressure tell you or reassure you about?

A. Well, to be honest with you, in children very little.

Blood pressure in children doesn't deteriorate until a very latent [sic] stage in a disease process or a pre-terminal event. Children usually compensate quite well up until they deteriorate very quickly.

MR WOLFE: Obviously nobody can say for sure now what might have been detected if blood pressure had been analysed, but in the presence, as we now know, of raising intracranial pressure with the hyponatraemia, it might well have given an indication of a problem.

A. Possibly.

Q. And in the presence of continuing vomiting with continuing intravenous fluids, it would have been good practice to measure blood pressure?

A. Yes.

Q. Moreover, Ms Ramsay makes the point that in the presence of continued vomiting, the plan that had been put on paper to look at Raychel's observations every four hours ought to have been adjusted to have more frequent observations.

A. Yes.

Q. Again, even after the anti-emetic was administered at 10 o'clock, you say no special treatment was brought to bear on Raychel in terms of observations.

A. Yes.

Q. Do you agree that this child would have benefited from

improved and more frequent observations?

A. Again, in light of what we now know, then yes.

Q. At the time, when you have a child vomiting coffee grounds and has a series of coffee-ground vomits in a short period of time, can I put it to you or suggest to you that it's not with the benefit of hindsight that increased observations should have been brought to bear; you ought to have known that at the time.

A. As I say, I can't go back to that time and realise that if I had been with her myself that I would have done observations sooner. There were other activities going on in the ward and other things to do, and hopefully we had got the doctor down to give Raychel something to stop her vomiting and the expectation was that it was going to stop or lessen and that she would become comfortable and sleep throughout the night. I didn't experience anything like hyponatraemia until that event.

THE CHAIRMAN: Can I ask you, just to tell me what happens now. If something like this -- and you now know from what happened after Raychel died, you know more about hyponatraemia and there are guidelines and so on.

A. Yes.

THE CHAIRMAN: Even moving away from hyponatraemia, if a child is causing concern now in Altnagelvin -- sorry, are you still there?

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

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

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

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

IV fluids, medical patients on IV fluids, had their electrolytes checked daily.

Q. Yes.

A. And the surgical patients, if they had been on intravenous fluids, it was the doctor's decision whether they wanted electrolytes carried out on that patient. And a lot of the times, because the doctors weren't on the ward at that time all the time, it was mostly Sister Millar who would have asked them to carry out electrolyte profiles on those children.

Q. In the case of paediatric medical children, was there a routine or a fixed step that electrolytes be measured or assessed after a period of time?

A. Yes, every 24 hours. If a child was on IV fluids, the medical people would have assessed the electrolytes of the children on IV fluids or, more often if there was an imbalance, maybe up to six-hourly, four to six-hourly.

Q. And here we had a situation with Raychel commencing IV fluids at roughly 10 pm on the evening of 7 June. And by the time she's experiencing these coffee-ground vomits and Dr Curran arriving at 10 pm on the 8th, 24 hours had elapsed.

A. Yes, but that was Dr Curran's decision in light of the information he was given and his assessment of the child to determine whether or not he would have initiated --

the nurses didn't ask the doctors to do certain blood tests.

Q. Yes, but you've indicated that Sister Millar, who we will hear from in due course -- she's a nurse, obviously, and she had the wherewithal to raise requests for electrolyte assessments in her capacity at various times in your experience.

A. I heard this, after Raychel's passing, that she would have said that she would have had to ask the surgical doctors to check the electrolyte profiles on their patients.

Q. But again, this, if I may say so, Mrs Noble, is the kind of area which is ripe for nursing input. The nurses have the benefit of the whole day overview, they've got all the material at their fingertips and they have prolonged exposure to the patient. So would it not have been appropriate, and indeed essential at the 24-hour mark, in the presence of eight or nine vomits, at 10 o'clock on the evening of 8 June, in the absence of the child going to the toilet, according to the records, for you to insist that a doctor arrange for electrolyte assessment?

A. I was not with Dr Curran at Raychel's examination, so I therefore could not insist that he checked her electrolytes.

MR CAMPBELL: The records do record one passage of urine, early -- I think at 8 o'clock in the morning.

MR WOLFE: Yes, they do. Just focusing on that, there are no other records of passing urine; isn't that right?

A. Yes.

Q. This child had received in excess of a litre of fluid by the time you're seeing her in the evening of 8 June; isn't that right?

A. Yes.

Q. You would have expected her to have gone to the toilet more often, would you not?

A. Yes, but she was on maintenance fluids and she had vomited a few times, so that might have lessened her urinary output.

Q. Is that something you give consideration to?

A. Yes, I would.

Q. Are you telling us that you did give consideration to whether there was fluid retention issues, whether there was electrolyte issues, whether they needed to be assessed, or did you not?

A. I don't remember at that time considering it. My main concern was to make sure that Raychel stopped vomiting and hopefully could get a comfortable night and that her vomiting would stop.

Q. When you think about it now, Mrs Noble, do you reproach

yourself for not having asked for a more intensive investigation to be conducted by the doctor?

A. Yes.

Q. And what do you take into account in reproaching yourself?

A. The fact that there was no nurse present to discuss Raychel with him. Ideally, I would have liked to have been the nurse going to speak to Dr Curran at that time and I don't know at that time if I would have asked him to check her electrolytes. I hope that I would have. So I reproach myself for that.

Q. Clearly, you would accept that there was a missed opportunity --

A. Yes.

Q. -- to get to grips with Raychel's condition at quarter past 10 when Dr Curran arrived.

A. Yes. Again, at that time, because we had never encountered anything like this happening before -- and all other children vomiting for prolonged periods of time on a first day post-operatively -- some of them even vomited into the second day and may not have had their electrolyte profiles checked because the surgeons were not good at that time at monitoring electrolyte profiles. As I say, it was very, very unfortunate that -- I wasn't expecting Raychel to deteriorate due to

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

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

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

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

Raychel and investigating what's wrong because the family will be able to give their perspective and their history of what has been wrong over the previous number of hours.

MR QUINN: The family are also making this point -- and I checked this over the break and at lunchtime -- the family really want to investigate why the nurses pre-empted the doctor's diagnosis, that is left the drugs out, wherever they left them, at the drugs cabinet or wherever they left the drugs for the doctor to come along with. Because Mr Ferguson's first comment to me was, "I wasn't asked anything, nor did I say anything to the doctor". So that reinforces the family's view that the nurses had made a decision about what was wrong with Raychel and that the doctor was just coming along because he was qualified to give an IV drug.

THE CHAIRMAN: That point has been raised, but even if that's the -- and I understand why you say that's an interpretation. In fairness to Mrs Noble, she volunteered the evidence that the drug was left out by the nurses for the doctor.

MR QUINN: Yes.

THE CHAIRMAN: But even to the extent that that might be indicating their mindset about what was wrong with Raychel and what needed to be done, that does not mean

that that's the end of Dr Curran's responsibility.

MR QUINN: We'll hear from Dr Curran as well.

THE CHAIRMAN: Yes. Thank you.

MR WOLFE: Good afternoon, Mrs Noble. Can I just pick up on one point that Mr Quinn has asked me to seek clarification on? You'll remember this morning that we looked at various observation sheets --

A. Yes.

Q. -- and I asked you questions about them. I just want to revisit something you said.

Let me get this straight. Could we have up on the screen 020-015-029? I understand the transcript's been checked on this and what you appear to have said is that this document, or the completion of this document, was discontinued as you felt, the nurses felt, that Raychel's observations were stable enough to go on to a graph chart.

A. Yes.

Q. Does that tally with what you recall saying?

A. Yes.

Q. We then looked at the graph chart. There's another document which I would ask you to bring up, 020-016-032. We know that there's a document like that for the 7th, when she came into hospital and this one relates to the point at which the seizure occurred on 9 June. Could

you just explain to me again, why was one not completed for the incidences that occurred on 8 June?

A. Regarding the vomiting?

Q. Well, I suppose maybe we will approach it in this way. The purpose of a document marked "observation sheet" such as this is what? What is the purpose of it?

A. For close observation.

Q. Right. So close observation occurs in what circumstances?

A. When you are particularly worried about a patient or that you see any signs of deterioration.

Q. Right. So you were particularly worried on 7 June because Raychel was a new patient, she was coming in and she might have to go to theatre. In fact, the plan was for her to go to theatre, so there was close observation in that circumstance and you produced one of these sheets and completed it for that purpose.

A. On 7 June, that sheet was actually commenced in A&E.

Q. Right.

A. That wasn't completed on the ward -- because we knew Raychel was potentially going to theatre, the first observations done by Staff Nurse Patterson were baseline observations to see what her observations were prior to going to theatre.

Q. Right. Then this sheet, the 9 June sheet, is

self-evidently the need for close observation when the child had suffered this very significant seizure.

A. Yes.

MR WOLFE: Any questions arising out of that, Mr Quinn?

MR QUINN: No, thank you very much.

MR WOLFE: One other point -- and again I'm not sure that anything particularly turns on it, apart from perhaps accuracy of recollection.

The parents of Raychel Ferguson in their statements have said that they recall leaving the ward in the early hours of 9 June at or about 20 minutes to 1. Whereas you in your witness statement assert that the parents leave at or about 11.30.

A. Yes. That's my recollection.

Q. It's a difference of an hour or so.

A. Yes. Well, usually the nurses will have finished the observations, completed the intravenous antibiotics and then and only then would the nurses sit down to have a cup of tea.

Q. Right.

A. And usually it's about 11, 11.15, 11.30, usually when we're finished that tea, again depending on admissions to the ward or depending on what was going on, but it was usually about 11.30 we were finished with our tea.

Q. When you say half 11, apart from relating it to when

perhaps you would commonly have your tea, have you any particular recollection of them leaving?

A. No. Mr and Mrs Ferguson, I think, came to the door of the kitchen when we were at tea, saying that they were going home.

THE CHAIRMAN: And because you would normally have tea at about 11.30, you're putting those two together, that it was probably at about that time?

A. Yes, and I had made my statement just two days after that had happened, so it was quite fresh in my recollection.

THE CHAIRMAN: Thank you.

MR WOLFE: Could I have the fluid balance chart up on the screen again to raise a discrete point with Mrs Noble? It's at 020-018-037.

We know, Mrs Noble, that at or about ten past midday, in other words in the middle of 8 June, a Dr Butler wrote up another bag of Solution No. 18 for Raychel. Clearly, that bag was infused at 80 ml an hour, as was the case throughout that day. Doing the maths on that, running a 1 litre bag at 80 ml an hour would take roughly 13 hours to complete --

A. Yes.

Q. -- so that Raychel would need a new bag of fluids by 1 or 2 o'clock in the morning, approximately. The inquiry

is aware of no record and nobody has claimed to have visited Raychel for the purposes of re-prescribing the Solution No. 18 in the early hours of 9 June. Is it the case that if Raychel, as appears self-evident, needed another bag of fluids to comply with the fluid plan, as it was, whether that plan was right or wrong, would a doctor have had to come and write a prescription?

A. Yes.

Q. Maths isn't my strong point, but do you agree with me that that sounds logical and mathematically correct, that by about 1 or 2 o'clock in the morning a new bag of fluids would have been needed?

A. Yes. It sounds right.

Q. Can you say anything to assist the inquiry in terms of how she got a new bag of fluids? Because presumably, she did if the fluids at 80 ml an hour continued to run.

A. I have no recollection of a new bag of fluids going up at that time. I can't recall.

Q. What would the process have been in order to obtain the assistance of a doctor to write up a new bag of fluids at night-time?

A. At night-time, if we had rang the doctor and told him that the patient was on a solution, ie Solution No. 18, could he come and write up another bag of fluids, on occasion, the doctor wouldn't be able to come

straightaway and the doctor would say, "Look, just put up another bag and I will come up later on and sign for it, but I'm happy enough for that bag of fluids to continue".

Q. And you're not able to assist us on how that happened?

A. I can't recall.

Q. I think you've told us that the vomit at 35 minutes past midnight was discussed with you --

A. Yes.

Q. -- and that no further action was taken.

A. No.

Q. Raychel appeared settled and asleep.

A. Yes. It was just a mouthful and insignificant in amount.

Q. Is it right to say that your next involvement with Raychel was at or about the time of her seizure?

A. Yes.

Q. At 3 am you tell us in your witness statement that your attention was drawn to Raychel by Nursing Auxiliary Lynch --

A. That's right.

Q. -- who told you that Raychel appeared to be fitting.

A. Yes.

Q. Did you attend Raychel?

A. Straightaway, yes.

Q. Where were you when --

A. In the bed directly -- I was administering paracetamol to a child in the bed directly opposite Raychel in room I.

Q. So you and Ms Lynch were in the room at the same time?

A. Yes.

THE CHAIRMAN: Was she working with you at that point or was that just a coincidence?

A. It was just a coincidence. She was seeing to a child in the bed -- it was actually a child in a cot beside me. She was comforting a child in a cot beside me and I had the curtains round giving paracetamol to a child opposite Raychel and Elizabeth Lynch made me aware that Raychel appeared to be fitting. And I went straightaway to Raychel.

THE CHAIRMAN: And she noticed that because she's nursing the child and --

A. Yes, and was diagonally --

THE CHAIRMAN: -- can look around and see what else is going on?

A. Diagonally opposite Raychel.

THE CHAIRMAN: So all you had to do was to finish the injection of the --

A. I think it might have been rectal paracetamol I was giving the child and it was given very, very quickly and

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

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

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

oxygen-enriched air. She hadn't lost colour.
Q. So in fact, are you suggesting she didn't, at that time, need an airway but he was taking that approach as a precaution?
A. Yes.
Q. And then I think you tell us that you administered the 5 milligrams of diazepam rectally --
A. Yes.
Q. -- while Dr Johnson observed for effect.
A. Yes.
Q. But there was no effect.
A. No.
Q. It wasn't successful at bringing --
A. It didn't stop her fitting.
Q. -- at controlling the fit.
A. That's right.
Q. So he then administered a higher dose --
A. Yes.
Q. -- and the seizure stopped.
A. Intravenously, yes.
Q. At that time, Raychel's pupils were reacting to light, were they?
A. Yes.
Q. And they were equal?
A. Yes.

Q. Dr Johnson was a senior house officer on the paediatric side of the house, if you like.
A. Yes.
Q. He obviously wanted to obtain input from somebody from the surgical side of the house.
A. Yes.
Q. And Dr Curran, who we have earlier heard about, came to the room.
A. Yes.
Q. Were you able to assist Dr Johnson in giving a history of Raychel's condition up to that point?
A. Yes. I had told -- I can't recall the exact conversation, but I would have given him a history of what I had known about Raychel at that time.
Q. And can you recall that for us now?
A. I can't recall the exact conversation, but I would have told him that she had been vomiting and had required two different anti-emetics and that she had settled to sleep and we thought that she had been fine.
Q. Dr Curran arrived and was asked by Dr Johnson to make contact with his surgical registrar and senior house officer.
A. Yes.
Q. Were you aware of that?
A. Yes.

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

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

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

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

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

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

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

under whose care Raychel had been admitted, who was Mr Gilliland, or the on call consultant?

A. I didn't give consideration at that time because I knew Dr Johnson was going to speak to Dr Trainor, who was a registrar.

Q. Yes, but on the surgical side. You advised Dr Curran that it might be sensible, prudent perhaps to inform his seniors.

A. Yes.

Q. And there was no senior input from a surgical perspective until much later.

A. Yes.

Q. Did you give any consideration to the --

A. Again, I thought it was up to Dr Curran to seek help where he could and my job was to ensure Raychel was continually monitored and observed.

Q. During this period, you recall that Raychel was having intermittent tonic episodes?

A. Uh-huh, briefly.

Q. So the diazepam had initially settled her, but after a period of time, intermittent tonic episodes were provoked and were observed.

A. Yes.

Q. Was she given anything for that?

A. No, they weren't continuous or they weren't really

regular. They were just occasional tonic gestures, from what I recall.

Q. You say in your statement to the Trust at the time that Staff Nurse Gilchrist bleeped Dr Trainor.

A. Yes.

Q. Whereas Dr Johnson tells us that he was bleeped while he was speaking to Dr Trainor and advised that Raychel looked more unwell and that he should come back to the ward. Just the final piece of this jigsaw: Dr Trainor doesn't mention any bleep in the accounts that she has given. So perhaps you could help us with that little point of confusion.

A. Well, as I say, you'll have to ask Staff Nurse Gilchrist because it was her who bleeped the doctor and whoever was on switchboard may well have misheard and said, "Bleep the SHO", or maybe they would have heard, "Bleep the registrar", so I can't account for that.

Q. Dr Trainor herself describes herself as a senior house officer --

A. Yes, but --

Q. -- albeit she might have been --

A. Albeit she was our registrar.

Q. So she was sufficiently experienced --

A. Yes.

Q. -- in her SHO role to be regarded as the registrar?

A. Yes, she was second on call to Dr Johnson.

Q. Very well. Dr Trainor comes to Ward 6 to see Raychel --

A. Yes.

Q. -- and Dr Johnson doesn't come back. As we understand it, he took up Dr Trainor's duties.

A. Yes.

Q. Is that your understanding?

A. Yes, from what I recall, yes.

Q. By this stage, Raychel's tonic episodes, according to your original statement, were every two to three minutes.

A. Yes, they were becoming more frequent.

Q. And at that time her pupils were becoming --

A. Sluggish.

Q. Did you regard that as a sign of further deterioration?

A. Yes.

Q. Dr Trainor explains her actions upon arrival in terms of receiving the biochemistry results, which Dr Johnson was processing on the computer at that point. Sorry, I should say Dr Curran was processing on the computer at that point. They were abnormally low.

A. Yes.

Q. She asked for repeat electrolytes to be performed.

A. Yes.

Q. Do you understand why repeat electrolytes were regarded

as necessary in this situation?

A. Yes. It could be an abnormally low result. We had never seen a sodium so low in a child. That would have been why Dr Trainor would have insisted on a second sample being sent to confirm and to establish that the first one was a true reading.

Q. So there is an element of -- maybe this is to put it too far -- not quite believing what you were seeing --

A. Exactly.

Q. -- and that needed to be checked out?

A. Yes.

Q. And did Dr Trainor explain her thinking or rationale to you?

A. No, I had seen that happen before with other medical patients, that again if an abnormally high result or abnormally low result of any given aspect of their blood tests -- they would be repeated to establish that that was a true condition or true reading.

Q. It would appear that no steps were taken at that stage to alter the fluid regime that Raychel was still receiving, notwithstanding this result.

A. Yes. As I say, I had no idea of the treatment of hyponatraemia at that time and would not have been aware of the fluid that she should be put on or the rate, whether it be two-thirds, half maintenance or whatever.

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

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

A. Yes.
Q. And the next step in the sequence seems to be that Dr Trainor asked you to contact Dr McCord.
A. Yes.
Q. Dr McCord was her consultant, the consultant on the paediatric side.
A. Yes.
Q. And you made the call and presumably gave the receiver to --
A. Dr Trainor, yes.
Q. Were you privy to that conversation?
A. Between Dr Trainor and Dr McCord?
Q. Yes.
A. No.
Q. Do you know what Dr Trainor intended to tell Dr McCord?
A. About how unwell Raychel had become and that she suspected an electrolyte imbalance and that she was very worried for her.
Q. I'm conscious of your last answer that you weren't privy to the conversation. One of the pieces of information that you had now at this stage was the blood sample back, the electrolyte sample back, showing low serum sodium --
A. Yes.
Q. -- and the plan that had been activated at that point,

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

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

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

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

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

"I contributed how I felt things could be improved for all other surgical children so that this would not happen again, namely electrolyte profiles should be performed at regular intervals whilst a child is receiving intravenous fluids."

A. Yes.

Q. You felt that more senior doctors should be responsible for overseeing fluid management of surgical children.

A. Yes.

Q. And you felt that the evidence gained from this experience should be shared with all the trusts.

A. Yes.

Q. Just to be absolutely clear, are you saying that these are points that came from you, that you articulated to those conducting the meeting?

A. I think during the general consensus of that meeting -- again, I can't recall exactly what had gone on, but I think we had heard that Solution No. 18 was no longer being used in the Royal Belfast Hospital for Sick Children because I had heard that a nurse had told the Ferguson family that Raychel had been receiving the wrong fluids in Altnagelvin. We were not aware of this at all -- it had never been communicated down through the trusts -- and I felt it would be beneficial that, as a Centre of Excellence, that Belfast should have shared

this information with everybody.

Q. Yes. Was that a point that was made at the meeting?

A. Yes.

Q. But in terms of your contribution, because that's how you've answered this question on the page in front of you, are you saying you made these important and relevant contributions at the meeting yourself --

A. Yes.

Q. -- in that you say you made these contributions --

A. It had been discussed and I said, "Why can't we ensure that this information should be passed down from other areas? Where they realise that something is wrong, why isn't the information passed down through the trusts?".

Q. The first point that's made here is that electrolyte profiles should be performed at more regular intervals.

A. Yes. It was discussed at that meeting that the surgeons were not very good at monitoring their children on IV fluids.

Q. And who was making that point? Was that coming from the paediatricians, was it coming from the nurses?

A. From the nurses.

Q. Unless you can put a name to the person who's making that point, was that the consensus of the nursing staff who were part of this sequence of events that the surgeons weren't good at carrying out electrolyte

analysis?

A. Well, I mostly felt that Sister Millar had a strong viewpoint on that in that she had to specifically ask doctors on the ward round to ensure that doctors would come and carry out electrolyte profiles on their children.

Q. And that is by contrast with the situation you described with the paediatricians --

A. Yes.

Q. -- who had maybe an unwritten rule, because nobody has produced anything in writing to us, but an unwritten rule that at the 24-hour mark or thereabouts, as may be convenient -- you wouldn't necessarily wake a child out of sleep, you might do it earlier -- but at the 24-hour mark, give or take, they would do electrolyte analysis --

A. Yes.

Q. -- whereas it's a much more --

A. Relaxed --

Q. -- approach on the part of the surgeons?

A. Very much so.

Q. Was it accepted at that meeting that, notwithstanding that people may not have appreciated the danger, if you like, of Solution No. 18 in particular circumstances, that nevertheless electrolyte profiling should have been

done in Raychel's case?

A. Yes.

Q. Even though you didn't realise the full implications of Solution No. 18?

A. Yes.

Q. So just to be clear, it was recognised that because Raychel had been vomiting all day, that that vomiting was severe and prolonged?

A. Yes.

Q. Because there was no great evidence, apart from one episode of urination post-operatively, that in those circumstances, with a drip continuing to run, that electrolyte analysis was really an essential --

A. Yes.

Q. -- and that it should have been done.

A. Yes. And we had called a doctor to come and see Raychel and it wasn't the nurses' job to ask for investigations. I mean, we didn't request electrolyte profiles to be done on the children; the doctors made that decision.

Q. It sounds as if it was a meeting where people, certainly the nurses, were expressing themselves frankly.

A. Yes.

Q. Were there surgeons at this meeting?

A. I think there were, but I can't recall who exactly was at the meeting. I know -- I think ... I can't remember

if Mr Gilliland was there, the surgeon -- surgical consultant.

MR WOLFE: If you'll allow me a moment, chairman. (Pause).

A. I'm sorry, I don't have a great memory for names.

Q. Dr Raymond Fulton, who chaired the meeting, as I understand it --

A. That's right.

Q. -- was present.

A. Yes.

Q. Ms Therese Brown was present.

A. Yes.

Q. She was on the risk management side of the house; isn't that right?

A. Yes.

Q. If I could ask you to put up on the screen, please, 095-011-049. You can see that this is a police statement which Dr Fulton has given. He sets out the staff who attended from the third line down. You can see that in terms of surgeons who attended or those from the surgical side of the house you have Mr Zafar and Mr Gilliland.

A. Yes.

THE CHAIRMAN: Dr Makar.

MR WOLFE: And Dr Makar.

So you've described a meeting, Mrs Noble, where the

nurses were frankly explaining how they felt Raychel had been let down; isn't that right?

A. Yes.

Q. And to some extent you were directing your concern towards the surgeons who --

A. Yes.

Q. -- who didn't carry out electrolyte tests --

A. Yes.

Q. -- and that was in the context of a system where they seemed to be very relaxed about electrolytes in general.

A. I remember Sister Millar especially raising those concerns.

Q. Was there any response from the surgeons to these expressions of concern?

A. I think it was acknowledged. From my memory, it was acknowledged.

Q. Could I ask you just about a couple of names that appear? I think they appear in that list.
Dr Claire Jamison, SHO anaesthetics, and Dr Gund, SHO anaesthetics. Can you recall whether they attended at the meeting?

A. I don't remember them directly. I hadn't met Dr Gund or Dr Jamison very often and I certainly hadn't been -- they wouldn't have been familiar to me because I wasn't working in theatres.

THE CHAIRMAN: It just happens you don't remember whether they were there or not?

A. Yes.

THE CHAIRMAN: Okay.

MR WOLFE: You subsequently attended a meeting with --

THE CHAIRMAN: Before we go on, could we go back to witness statement 049/2, page 19, please? I think that was the last document that was up. Could you highlight paragraph (d) again, please?

You are explaining, I think, in particular the strength of feeling that Sister Millar had about the first point there about the electrolyte profiles.

A. Yes.

THE CHAIRMAN: And about the third point, you expressed the concern which you and the nurses had, which is that if the RBHSC has stopped using Solution No. 18, why didn't anybody else know about that, and that's the sort of thing that should be shared round.

A. Yes.

THE CHAIRMAN: I understand those two points. If we go to the middle, point 2, why did you feel that more senior doctors should be responsible for overseeing fluid management? Sorry, as a lead into that, when you say "more senior doctors", do you mean no more JHOs, it has to be at least an SHO?

A. Yes.

THE CHAIRMAN: Thank you. Why did you feel that?

A. Because I felt that maybe Dr Curran didn't fully appreciate how sick Raychel was, as we didn't at that time, and that maybe -- now, Dr Johnson apparently expressed that when she first fitted, he thought she had fitted as a result of an electrolyte imbalance. That was one of his diagnoses, and I thought with his experience, being another year down the line, it would have been appropriate that senior [sic] doctors were not allowed to nurse children because they are a specialty.

THE CHAIRMAN: When your statement says that you felt that, was that something which was felt by nurses generally?

MR CAMPBELL: Chairman, I think that last comment should be "junior doctors". It's what the witness said, she said "senior", but she meant "junior".

A. Sorry.

THE CHAIRMAN: Okay. The first line on page 174 [draft]:

"It would have been appropriate that junior doctors were not allowed to nurse children."

Thank you.

Sorry, what I was going to ask you was: was that something which was felt both by you and other nurses, was it?

A. Yes. It was a discussion where we all supported what

everybody else felt. And I think that everybody had the same consensus that we needed to make vast improvements into how things were managed.

THE CHAIRMAN: Without wanting to point the finger at any particular JHO, is that a reflection of the fact that sometimes -- and it's a point that Mr Wolfe has been asking you about a few times today -- what a junior house officer can add to what an experienced nurse knows is really quite limited?

A. Well, I think the nurses always feel that the doctor, at the end of the day, is more senior to them, that their knowledge is a lot more, they have seven years' training in medical school, and they are trained, you know, to take advice from their seniors at all times. Whereas, as nurses, we didn't order investigations, we just observed, recorded what we saw, and passed on the information.

THE CHAIRMAN: Okay, thank you. Sorry, Mr Wolfe, you were going to move on.

MR WOLFE: Yes. Hopefully, I didn't miss this point as I was reading my notes, but without taxing you, Mrs Noble, in terms of the reforms that were put into place or the improvements that were put into place after Raychel's death, and as a result of Raychel's death, is it the case that junior doctors such as JHOs were

removed on the surgical side from being, if you like, the first-up attendees at sick patients?

A. Yes.

Q. And they were replaced by what level?

A. Senior house officers and registrars.

Q. Right.

THE CHAIRMAN: That's surgical only?

A. Surgical only, yes. There's only ever senior house officers in paediatrics. There are no junior house officers in paediatrics.

THE CHAIRMAN: Okay, thank you.

MR WOLFE: So is it fair to summarise the 12 June meeting that you attended in the following terms, that while it was regrettable that Altnagelvin was not in possession of the information around Solution No. 18, and that fingers were pointed at the Royal, if you like, in respect of that, nevertheless Altnagelvin and its staff recognised their own failures in terms of how they treated Raychel?

A. Yes.

Q. And the primary failure which you articulate was a failure to ensure that Raychel's electrolyte assessment was carried out in or about the evening of 8 June. Was it also recognised that if that apparently simple step had been taken in a timely manner there

would have been time perhaps to address Raychel's ill health so that she wouldn't encounter the seizures and, ultimately, death?

A. Yes.

Q. And who was articulating that view, do you know?

A. I can't remember exactly who, but I know that the fact ... The surgical children were discussed and it was wondered how many other children had maybe had low sodiums or low sodiums that may have required intervention, but maybe the children had recovered and gone off IV fluids and hadn't continued them. We were wondering how many other children had slipped through the net having had low sodium levels that weren't --

THE CHAIRMAN: Maybe they weren't getting too much --

A. Exactly.

THE CHAIRMAN: -- maybe even if it was the wrong fluid, they weren't getting too much of it for too many hours.

A. Yes.

THE CHAIRMAN: Was it part of that discussion that, apart from Solution No. 18, there was actually too much fluid given to Raychel?

A. Yes.

THE CHAIRMAN: That was recognised?

A. That was recognised as well.

MR WOLFE: The last section I want to look at with you,

Mrs Noble, is your attendance in --

MR QUINN: Mr Chairman, just on that point, it has taken me a little bit by surprise. Could we ask how and when?

THE CHAIRMAN: Sorry, we shouldn't let it sit as bluntly as that, yes.

The last point I asked you about was whether it was recognised that there was too much fluid had been given to her. That isn't something that you had been alert to at all during Raychel's treatment?

A. No.

THE CHAIRMAN: Can you remember how that emerged at the meeting?

A. I think it might have been the anaesthetists, whatever, using a formula to calculate a fluid requirement for children. I think they were all aware of this formula that, as nurses, we didn't use. They were aware of that and realised that she had had too much fluids.

THE CHAIRMAN: That sort of begs the question about which anaesthetists were there.

MR QUINN: This opens up a whole new front in this case. I know my learned friend's going to address the meeting of September 2001 because I've already alerted the team to that and the issues arising out of that, but it must be remembered that the parents were never told anything about too much fluid. It was never raised by them. In

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

THE CHAIRMAN: Yes.

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

A. From what I recall, yes.

THE CHAIRMAN: Yes.

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

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

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

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

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

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

A. Yes.

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

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

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

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

A. Yes.

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

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

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

A. Or prescribed post-operative.

THE CHAIRMAN: Was that discussed as well?

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

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

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

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

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

A. Yes.

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

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

THE CHAIRMAN: Okay, thank you.

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

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

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

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

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

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

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

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

bring you to your various inputs to the meeting, but in general terms, Mrs Noble, you referred at that meeting to the observations and care that you brought to Raychel during 8 and 9 June; isn't that right?

A. I can't recall the exact conversations. I can't recall my direct input.

Q. Let me show you a few examples of what you said. If we go forward to page K. The bottom of the page:

"Staff Nurse Noble said when she came to duty, she got the report. She was told that Raychel had been sick during the day, had been given Zofran for this. She was not aware of any blood in the vomit, nor of Raychel's sore head."

A. During the day, during the day.

Q. Yes. That's the context in which you say that. Clearly, by the night-time you were aware of blood in the vomit.

A. Yes.

Q. Then over the page, if we could move to the next page, please. It's at the top of the page. If we take up again with what you're saying:

"Staff Nurse Noble said that when she went down to the ward, Raychel's father was there and Raychel was dozing. [You] gave Raychel paracetamol suppositories for the headache [as you've explained earlier]."

So that was at about 9.25 in the evening.

A. Yes.

Q. So there's various entries, and we needn't go through them all, of you explaining how you brought treatment to Raychel at various points --

A. Yes.

Q. -- on 8 and 9 June. If I could ask you to look at -- if we could move forward to page O in the sequence. In the middle of the page it's recorded that Mrs Doherty, a relative of Mrs Ferguson, her sister:

"Mrs Doherty asked Dr Nesbitt if, on looking back, he had learned anything from this. Dr Nesbitt said, I do think it was a low sodium. I have been in contact with children's hospitals and we will look at ways of preventing this happening. This has made me change my practice. I was totally devastated."

Then Dr McCord intervenes and he says:

"The same fluids were used for children up and down the country. He felt there had been an innate sensitivity in Raychel's case. These fluids had the correct amount of sodium and glucose in the same amount of water. Raychel retained free fluid and this made her brain swell."

In light of what you have said, Mrs Noble, about what was accepted at the meeting in June, if you like,

the in-house meeting involving clinicians and nurses, clearly behind closed doors --

A. Yes.

Q. -- what should have been said at that point is: Raychel was on these fluids, there's an acceptance that she had retained free fluid, but we made a mistake in not having her electrolytes checked. Isn't that the conclusion that had been reached in June?

A. I do know that Dr McCord felt that there was absolutely nothing wrong with Solution No. 18, that it had been used widely, and that, again, if her electrolytes had been monitored, then this shouldn't have happened.

Q. The point is that --

THE CHAIRMAN: Sorry, just to make this point. You said to me a few minutes ago that it was recognised on 12 June that the main mistake which had been made was a failure to monitor the electrolytes.

A. Yes.

THE CHAIRMAN: Right. Were Mrs Ferguson and her sister told that in September?

A. I can't recall. I can't recall.

THE CHAIRMAN: There was also a discussion on 12 June that Raychel had been given too much fluid.

A. Yes.

THE CHAIRMAN: It's correct, isn't it, that they weren't

told that in September?

A. Again, I can't recall the exact conversations or I don't recall all the points of the meeting.

MR WOLFE: To the extent that the record tells us what was said, we will not find anything in that record admitting to the mistake of failing to carry out electrolyte analysis. We won't find anything in that record admitting that the wrong amount, the wrong rate of fluid had been prescribed. Speaking for yourself personally, given that you had earlier contributed to the 12 June meeting and were privy to the acceptance that these were real mistakes in Raychel's case, why didn't you, during any of your contributions, make these admissions to Mrs Ferguson.

A. From my recollection, it was mostly the consultants who had spoken to Mrs Ferguson and her sister -- and I think Sister Millar was speaking. I didn't -- I don't recall thinking of that at the time, thinking that it was obviously something that a senior person should discuss with the family, not just the nurse.

THE CHAIRMAN: Well, let me put it this way: if the purpose of the meeting, which you have described, was to explain to representatives of the Ferguson family why she died, then that should be explained to them in fairly clear terms; isn't that right?

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

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

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

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

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

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

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

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

Ferguson family, what did you know about what was to happen at the meeting or how it was going to be conducted?

A. I was just told that it was going to be an opportunity for the Ferguson family to ask any questions that they wanted clarity on.

THE CHAIRMAN: Can you remember who you spoke to or who asked you to come to the meeting and who you spoke to before you went to it?

A. I can't remember, but I know Sister Millar had made me aware that there was going to be a meeting.

THE CHAIRMAN: Okay. What you said a few minutes ago to Mr Wolfe was that you regarded that meeting as having as its purpose explaining to the Ferguson family why Raychel had died?

A. An opportunity for them to ask questions as well.

THE CHAIRMAN: Right.

MR WOLFE: I have no further questions. I'm not sure about Mr Quinn or Mr Campbell or Mr Lavery.

MR QUINN: I just want to make one point. I'm rather upset at my learned friend making the point that this litigation is stayed --

THE CHAIRMAN: I want to let Mrs Noble out of the witness box. I'll take your point in a minute.

Mrs Noble, you've been there for a long time, much

longer than you expected and longer than I expected. I'm very grateful to you for coming. I know it has been difficult for the reasons that are apparent to everybody. Unless there's anything else you want to add, you're now free to leave the witness box.

A. Thank you very much.

(The witness withdrew)

THE CHAIRMAN: Mr Quinn?

MR QUINN: Mr Chairman, my learned friend Mr Lavery made a point that this litigation is stayed. Before counsel gets on his feet to make such an assertion and asserts that before this tribunal of inquiry, you should make sure of your facts. If my learned friend has been advised and instructed by a solicitor that it is stayed, then so be it, that's his instructions. But my instructions are that this matter has been continually reviewed before Mr Justice Gillen at the medical negligence review court and it was only put off being litigated upon at the request of the PSNI. I would like to know where my friend got his information from if in fact he is asserting that it's stayed.

MR LAVERY: We're going to get into semantics, Mr Chairman.

THE CHAIRMAN: Sorry, but you're not saying that it is still being adjourned because --

MR QUINN: It is. Only four months ago it was reviewed by

Mr Justice Gillen and we actually -- my solicitor went up and explained that this matter is now before the hyponatraemia-related deaths inquiry. So it's still being reviewed. The litigation is still in progress being reviewed.

THE CHAIRMAN: Sorry, I just want to clarify one thing: did you say a moment ago that it was being adjourned at the request of the police?

MR QUINN: No.

THE CHAIRMAN: That was in the earlier period from 2005 to 2008?

MR QUINN: Yes, that's why it was delayed for a period.

THE CHAIRMAN: And now it is being adjourned --

MR QUINN: It's back into the Queen's Bench review court and it's being reviewed every so many months by Mr Justice Gillen. In fact, he made life a little bit difficult for my solicitor until it was explained that it was a matter for the inquiry to sort out.

MR LAVERY: That's exactly what I was saying, Mr Chairman. No further action has been taken in respect of this claim pending the outcome of this inquiry and this tribunal will know that Mr Justice Gillen is not slow to list medical negligence actions, particularly ones that have been around for some time.

THE CHAIRMAN: Yes, okay. Look, we'll leave that point. In

essence, if you wanted the case to be heard in the High Court now, you could get it heard. In essence, it's for a while it'd be fair to say that -- my understanding of it is that it's now been adjourned, effectively at the plaintiff's request, pending the finalisation of this inquiry.

MR QUINN: Yes.

THE CHAIRMAN: Okay. That brings Mrs Noble's evidence to a completion. Unless there are any other points, we'll start tomorrow morning. I would like to start at 10.15 rather than 10 o'clock or any earlier. We'll start at 10.15 with Mrs Millar. Thank you very much.

(5.15 pm)

(The hearing adjourned until 10.15 am the following day)

I N D E X