1 Tuesday, 12 March 2013
2 (10.00 am)
3 THE CHAIRMAN: Ms Anyadike-Danes?
4 MR STITT: Mr Chairman, if I may, just before
5 Ms Anyadike-Danes commences. We have completed the task
6 which I indicated and that was done in the early hours
7 of the morning.
8 THE CHAIRMAN: Thank you.
9 MR STITT: The originals and the copies have arrived and
10 I would like the opportunity just to scan through them
11 to make sure they're in order and we will have them
12 very, very shortly.
13 THE CHAIRMAN: Thank you.
14 MS ANYADIKE-DANES: Thank you.
15 Good morning. Could I please call Dr Trainor?
16 DR BERNIE TRAINOR (called)
17 Questions from MS ANYADIKE-DANES
18 MS ANYADIKE-DANES: Can I just check, firstly, that you have
19 your CV; is that the document to your left there?
20 A. Yes.
21 Q. Thank you. Dr Trainor, you've made some statements
22 relating to Raychel already. You made a statement for
23 the Trust; that was on 15 December 2001.
24 A. Yes.
25 Q. The reference for that is 012-011-109. Then you gave



1 evidence at the inquest.
2 A. Yes.
3 Q. So there is your deposition with some handwritten
4 comments after that, when you were being asked questions
5 after you read out your statement. The deposition is at
6 012-035-166. You have made two statements for the
7 inquiry.
8 A. Yes.
9 Q. The first is dated 15 July 2005, the second is dated
10 26 June 2012, and the series numbers for those are 030;
11 is that correct?
12 A. Yes.
13 Q. Subject to anything that you want to say or develop in
14 your evidence today, do you adopt those statements as
15 accurate in terms of your evidence?
16 A. Yes, I do.
17 Q. And have you had an opportunity to look at those before
18 coming here today?
19 A. Yes.
20 Q. Can I ask you if you've also had an opportunity to look
21 at the statements of the other clinicians in relation to
22 Raychel's case?
23 A. Yes, I've looked at some of them.
24 Q. And have you seen any of the transcripts of their
25 evidence?



1 A. I've seen some of them as well.
2 Q. Can I ask you whose transcripts you have seen?
3 A. I read Dr Johnston's and just a couple of the nursing
4 staff's as well.
5 Q. Have you also seen some of the experts' reports? The
6 inquiry has its own experts. Have you seen Mr Foster's
7 report?
8 A. Yes.
9 Q. Dr Scott-Jupp, who's the paediatrician?
10 A. Yes.
11 Q. The Trust also engaged an expert, Mr Orr, as a surgeon.
12 Have you had an opportunity to see his report?
13 A. Yes, I've read his report as well.
14 Q. Thank you. Without going through all the other reports
15 there are, when I ask you about them, tell me if
16 you have had an opportunity to see them, but I'll be
17 taking you to specific passages in certain of the expert
18 reports.
19 I wonder if I could ask you a little bit about your
20 CV. We can pull that up, in fact there are two pages so
21 if we could have the two together, 317-027-001 and 002.
22 You're still with Altnagelvin.
23 A. I am.
24 Q. As a consultant?
25 A. Yes.



1 Q. If we then look under the previous employment, looking
2 at the left-hand side, for a year you did your pre-reg
3 at the Ulster Hospital.
4 A. Yes.
5 Q. And you had six months in general medicine and six
6 months in surgery.
7 A. Yes.
8 Q. Did you do the general medicine first or the surgery
9 first?
10 A. I honestly -- it's that long ago, I honestly can't
11 remember.
12 Q. That's fair enough. Then you had two years at the
13 Children's Hospital --
14 A. Yes.
15 Q. -- August 1998 to August 2000, and you were there as
16 an SHO.
17 A. Yes.
18 Q. In fact, we don't need to pull it up, but from your
19 second witness statement -- I'll give the reference,
20 it's 030/2, page 2 -- you give a little bit of detail of
21 when you were at the Children's Hospital. You say that
22 you spent some time in Cupar Street, community
23 paediatrics. I think about six months.
24 A. Yes, six months there.
25 Q. Then you had about three months in Allen Ward.

1 A. Yes, that was general medical.
2 Q. That's a general medical ward, isn't it?
3 A. Mm-hm.
4 Q. And then you also covered A&E, paediatric surgical
5 ward -- and that was Barbour Ward at the time?
6 A. Yes.
7 Q. And also neurology and, I think, genetics at the Belfast
8 City Hospital. And for the last six months you were
9 based in the regional NICU, is that the neonatal --
10 A. Neonatal intensive care unit.
11 Q. At the Royal Maternity Hospital. Can I ask you about
12 your time at the Children's Hospital? I'm sure you know
13 by now that Raychel is the fourth in a series of
14 children who have died with hyponatraemia being
15 implicated. The first was Adam in November 1995.
16 A. Yes.
17 Q. And he died -- in fact they all did -- at the Children's
18 Hospital. His inquest was in June 1996. When you were
19 at the Children's Hospital, was there any reference to
20 him at all?
21 A. No, I hadn't heard of the case before.
22 Q. Then if we come to Claire Roberts, she died
23 in October 1996, and she was treated by Dr Webb, who's
24 a paediatric neurologist, and I note that you had some
25 time in neurology. Was Claire Roberts' name ever



1 mentioned so far as you recall?
2 A. No, and whenever I was there I don't recall Dr Webb
3 either.
4 Q. Ah.
5 A. He maybe had retired at that stage, I'm not sure, but
6 I don't recall him either.
7 Q. If we come to Lucy Crawford, she died having been
8 transferred from the Erne Hospital, as you probably know
9 by now. She died in April 2000 and she was seen by
10 Dr Hanrahan, who was a consultant in paediatric
11 neurology. April 2000 is current with when you were
12 at the Children's Hospital.
13 A. Yes.
14 Q. Do you recall any reference to Lucy at all?
15 A. No, I can't recall anything about Lucy.
16 Q. Did you know Dr Hanrahan?
17 A. Yes, whenever I was in Paul Ward, which is the neurology
18 ward. Dr Hanrahan would have been there and Dr Hicks.
19 Q. But there was no mention of Lucy?
20 A. No, not that I can recall.
21 Q. Thank you. Then I wonder if you could help us with
22 a bit of terminology. When you come to be an SHO in
23 Altnagelvin, which you do in August 2000, we've heard
24 reference to "second-term SHO", which is what I think
25 you were in June 2001. Can you explain what that is?



1 A. Yes. Whenever I was in Altnagelvin Hospital from 2000
2 to 2001, I was classed as a middle-grade SHO, so I was
3 an SHO, but I was on the registrar rota. Whenever I was
4 in Children's before that, I was an SHO on the SHO rota.
5 As a middle-grade SHO, my title was still "middle-grade
6 SHO", but I was actually on the registrar rota with
7 other -- there was a couple of other middle-grade SHOs
8 at that time and then there was registrars as well. So
9 that was my first registrar year whenever I went to
10 Altnagelvin.
11 Q. Dr Johnston has explained that in contradistinction to
12 what happens with the surgical SHOs, a paediatric SHO
13 really is starting at the beginning in a way because you
14 don't have pre-reg in paediatrics.
15 A. Yes.
16 Q. Is that correct?
17 A. Yes, that is correct.
18 Q. So although there would be an SHO grade, in terms of
19 their experience and knowledge about paediatric matters
20 it wouldn't be at the same level as if they were an SHO
21 in another discipline, for example surgery?
22 A. Yes, it would be different if they were in medicine or
23 surgery. Paediatric SHO, it would usually be their
24 first paediatric attachment, their first year in
25 paediatrics.



1 Q. Does that mean there's perhaps greater liaison between
2 the paediatric SHOs and the paediatric registrars than
3 you would necessarily see in another discipline?
4 A. Whenever you start off in paediatrics, if I recall --
5 whenever I started off in the Royal Hospital as an SHO
6 in the two-year rotation, whenever you first start off
7 in paediatrics, paediatrics is very different from adult
8 medicine or adult surgery. So you are in very close
9 contact with your registrar because you're coming across
10 sick children that you've maybe never come across before
11 or conditions that you haven't come across before, so
12 you need a lot of input from the registrar about what to
13 do and what tests to do.
14 Q. Yes. And if you are thinking about it from that point
15 of view about the need for that, you, when you were in
16 Altnagelvin on Ward 6, would have been aware of the fact
17 that there were surgeons also coming to that ward
18 because there were surgical patients on that ward, which
19 would be their patients?
20 A. Yes.
21 Q. And so those would be surgeons who, for perhaps most of
22 their time, are dealing with adult cases and only
23 infrequently perhaps dealing with paediatric cases. So
24 did you find that there was very much liaison between
25 the surgical SHOs and their counterparts, if I can put

1 it that way, on the paediatric side, given their even
2 less perhaps familiarity with paediatric cases?
3 A. You mean the surgical SHOs asking the paediatric SHOs?
4 Q. Either the paediatric SHO or the paediatric registrar.
5 A. Occasionally. Because we were the medical team, we
6 looked after the medical patients and the surgical team
7 looked after the surgical patients, so very occasionally
8 a member of the surgical staff would have asked myself,
9 maybe, as a middle-grade SHO, for advice or maybe
10 support or maybe they needed a hand with doing bloods or
11 whatever, but that was just occasionally. So sometimes,
12 yes, it would have happened that you would have been
13 asked, but I ... I wasn't aware of the number of
14 surgical children in the ward because I looked after the
15 medical patients.
16 Q. Yes. It may be that you can't help us by commenting on
17 this. I'm just wondering where they got their support
18 in dealing with paediatric cases. We can see how, from
19 what you have said and what Dr Johnston said, that the
20 paediatric SHOs would be looking to their registrars
21 because this is an area for which they don't have the
22 level of expertise that would otherwise go with that
23 grade. And if one thinks about it from the surgical
24 side, they're perhaps seeing even less paediatric cases
25 because the main burden of their work might be with



1 adult cases. So were you aware of where the surgical
2 SHOs were getting their support from when they came to
3 the ward to deal with the surgical patients?
4 A. I assume the surgical SHOs, if they had queries or
5 questions, then they should have went up their ladder as
6 in asking maybe a more senior surgical SHO or surgical
7 registrar and then up to consultant level if there was
8 any queries.
9 Q. So there wasn't a sense of any sort of team about the
10 two disciplines on Ward 6?
11 A. Well, we could be asked and we were asked on occasions,
12 if a surgical doctor, be it SHO, registrar, consultant.
13 If the paediatric team were asked for advice or support
14 doing bloods or if there was a query, we would have
15 assisted as best we could. So it wasn't that there was
16 no communication between the two teams, like there was.
17 If they asked for help --
18 THE CHAIRMAN: But it was limited?
19 A. Yes. If they asked for assistance, we would have
20 offered it.
21 MS ANYADIKE-DANES: Thank you. I just want to ask you
22 briefly about the induction and training when you came
23 to Altnagelvin. You have said in your second witness
24 statement for the inquiry, at 030/2, page 3, that you
25 remember attending some form of induction when you first



1 came to Altnagelvin as an SHO; would that be right?
2 A. I remember because it was my first time working in
3 Altnagelvin Hospital. Whenever it was your first
4 attachment to the hospital you had to go to the hospital
5 induction, which happened the first Wednesday that you
6 arrived, and there also was a paediatric induction then
7 up on the ward as well.
8 Q. So you had to go to that induction?
9 A. Yes, you had to go to the hospital induction and then
10 there was a paediatric induction upstairs with the
11 paediatric consultants.
12 Q. You arrived in August?
13 A. Yes.
14 Q. And as we have heard evidence from others involved in
15 Raychel's care who have arrived at differing times, some
16 arrived in February, some in May -- is this induction
17 something that's held whenever a new entrant comes or is
18 it only held at, say, the August time of year; do you
19 know?
20 A. Back then, I can't remember what exactly -- what way it
21 was exactly. I know the first Wednesday in August,
22 whenever it was, was a big changeover for the majority
23 of people, there was that induction. Back then in
24 2000/2001, I can't recall whether there was an induction
25 six months down the line or if the new doctors came.



1 I honestly can't recall.
2 Q. For comparison purposes, do you happen to know what
3 it is now as you're a consultant there? Do you have
4 induction days at different times during the year?
5 A. Yes. I know that, say, there's -- you know, junior
6 doctors come at different stages and there is
7 induction -- there is induction for them through the
8 hospital induction, and then whenever they come to
9 paediatrics, then there is a paediatric induction as
10 well.
11 Q. Thank you. When you came, were you aware of the
12 Altnagelvin Junior Doctors' Handbook? Would you have
13 heard of such a thing?
14 A. I can't recall hearing about it back then. That's not
15 to say that I didn't see it or didn't receive a copy,
16 but I can't recall it.
17 Q. Just while we're there, before we pass entirely from the
18 induction, can I just pull this up and you tell me if
19 this bears any relation to what you remember from your
20 induction? 316-004f-018. That's for August 2001. It
21 may be that it has changed a little bit having regard to
22 Raychel's case.
23 If you can see the sort of talk or lecture that is
24 being given, along with the written notes that are being
25 provided, and that's one of the reasons why I asked

1 about the handbook. There's a case note standards
2 that is said to be provided, there's the Junior Doctors'
3 Handbook, there's the antibiotic policy from the
4 formulary and a list of contact numbers and so on. Does
5 that look like something that you might have attended
6 when you came?
7 A. No, I can't remember. I do remember the first Wednesday
8 in August, whenever I started in Altnagelvin, I do
9 remember we went up to the ward first of all to the
10 paediatric ward, we were then sent down to attend
11 induction and then we came back up to the ward for
12 further paediatric induction. But I can't remember
13 exactly what was covered.
14 Q. Thank you. Were you aware of the fact that there was
15 a lecture programme -- lectures may be putting it too
16 high -- seminars and talks and so forth that were
17 available to the doctors, which the trainee doctors were
18 supposed to attend when they could, subject to their
19 duties? Were you aware of that?
20 A. I know in paediatrics we had our own meetings as well.
21 We had weekly perinatal meetings with the obstetricians
22 and there was also a Friday teaching session. Now,
23 I can vaguely remember that there was other talks and
24 lectures down in the clinical education centre, but
25 I can't recall how often I was able to attend or



1 whether -- what was actually discussed at those, but
2 I know that there was other ongoing talks and lectures.
3 Q. When you say that there was something for the
4 paediatricians which would typically have been on
5 a Friday, what sort of thing are you talking about?
6 What sort of thing would be covered?
7 A. The Friday teaching sessions, it varied. It could have
8 been maybe whenever a new doctor started talking about
9 conditions that would be commonly seen now in
10 paediatrics like febrile convulsions, maybe a child with
11 an infection. It just varied.
12 Q. Could you do a case note review? If a case had happened
13 where there was learning to be taken from it, as opposed
14 to dealing with that during a teaching ward round, could
15 a case be presented at a session like that?
16 A. Yes, it probably could have been, yes.
17 Q. Raychel's case could? I'm not saying it was, but
18 Raychel was a case, which I think even shortly
19 afterwards people realised there was lessons to be
20 learned from it. Is that a case that could be?
21 A. It could have been, but now I don't remember it being
22 presented.
23 Q. Thank you. Just while we're on that, I know I'm leaping
24 ahead, but since I've introduced it, as a result of
25 Raychel's case, Dr Nesbitt, who was a paediatric



1 anaesthetist, produced a talk. Were you aware of the
2 fact that he'd done that?
3 A. I wasn't aware of that. I then moved on to a different
4 hospital in August 2001, so now I don't know when he did
5 his talk or when the talk was first given. I wasn't
6 aware of that, but as I say I then moved on back to
7 Belfast in the August.
8 Q. Thank you. Then I wonder if I can ask you a little bit
9 about the condition of hyponatraemia itself. In your
10 first witness statement for the inquiry -- which we
11 don't need to pull up, but it's 030/1, page 3 -- you
12 said that you had knowledge of hyponatraemia from your
13 medical training at Queen's University and that you'd
14 also had those three years of experience in paediatrics.
15 So you knew about hyponatraemia; is that right?
16 A. Well, I knew hyponatraemia meant that the sodium was
17 low.
18 Q. So you knew about dilutional hyponatraemia?
19 A. I hadn't heard tell of the word dilutional
20 hyponatraemia. I knew that hyponatraemia meant a low
21 sodium.
22 Q. Yes.
23 A. But back then, I don't recall hearing about dilutional
24 hyponatraemia.
25 Q. Well, you were aware of electrolyte imbalance generally?



1 A. Yes. Well, in undergraduate training in physiology and
2 biochemistry talks, the likes of water balance and fluid
3 balance were talked about. But that was sort of between
4 1991 and 1996. I can't recall what exactly I learnt
5 then. I was aware that you could get problems with
6 electrolytes, but I had never, until Raychel's case,
7 come across a sodium so low.
8 Q. Yes, but you'd come across children whose sodiums were
9 low, I presume?
10 A. Sorry?
11 Q. You had come across children whose sodiums were low.
12 A. Yes. In the three years before Raychel's case I would
13 obviously have been involved in writing up fluids and
14 seeing a lot of children's electrolytes. Some of their
15 sodiums could have been below the normal range of 135,
16 but I can't recall how low or how often I had seen it,
17 but I know I definitely had never come across a sodium
18 of 118 before.
19 Q. We asked you some questions about your training and you
20 said, at 030/2, page 3, that you were aware of how to
21 prescribe fluids.
22 A. Yes.
23 Q. And that:
24 "Children on fluids needed at least one daily
25 electrolytes."

1 I presume that means "electrolyte test".
2 A. Yes, urea and electrolytes.
3 Q. So you were aware of the need to do that?
4 A. Yes.
5 Q. And why would you need to do that?
6 A. Yes. I can never remember any specific training on how
7 to prescribe fluids. Whenever I started off in
8 paediatrics in 1998 in the Children's Hospital,
9 throughout the first few years you sort of learnt on the
10 job. So the first time you needed to do bloods, you
11 needed the help of a registrar to show you how to take
12 bloods and it would have been the same, I assume, for
13 fluid prescribing. I don't remember any formal talks
14 about how to prescribe fluids, but whenever I started
15 prescribing fluids in Belfast I would have had the help
16 of some of my seniors, who would have taught me how to
17 do the 4-2-1 rule for prescribing fluids and also back
18 then it was stressed the importance of once a day
19 electrolytes if you were on fluids and that's just what
20 I had always been used to.
21 Q. So to test that they're still within their normal
22 parameters?
23 A. Yes.
24 Q. And if they're not, that needs to be addressed?
25 A. Yes.



1 Q. Not necessarily by you, but it needs to be addressed?
2 A. Yes, I always knew that if there was something I wasn't
3 sure about, to ask for advice.
4 Q. So when you spent that period of time in the Children's
5 Hospital in 1998 to 2000, which is one of the places you
6 say that you became familiar or had your training in
7 this --
8 A. That's probably where I started writing up fluids in
9 those two years.
10 Q. What fluids were they using there at the Children's
11 Hospital?
12 A. I honestly cannot remember what fluids they were using
13 back then. It's a long time ago.
14 Q. You also had some experience on the surgical side when
15 you were at the Children's Hospital. Were you aware of
16 post-operative nausea and vomiting as a condition?
17 A. Whenever I was in the Children's Hospital covering
18 surgery -- I can't recall exactly how long I was
19 covering surgery, but it might have just been six weeks
20 or an eight-week period. I know the likes of the
21 community was six months and Royal Maternity and
22 neonatal intensive care was six months, but I think that
23 covering the surgery and neurology and A&E was maybe
24 just a two-month block. Whenever I was in surgery we
25 went on ward rounds and were involved in taking bloods



1 and following up on results, but I don't recall knowing
2 very much about post-operative nausea and vomiting.
3 Q. But did you know that children could do that, vomit
4 after surgery?
5 A. Yes.
6 Q. And even if you weren't thinking specifically about
7 post-operative vomiting, you would know, wouldn't you,
8 that if a child is vomiting in a prolonged and severe
9 way, that they're likely to be losing electrolytes?
10 A. They could be, yes.
11 Q. And that vomit is, leaving aside anything else, richer
12 in sodium than other bodily fluids might be, and so they
13 might be losing a significant amount of sodium unless
14 that's addressed in some way?
15 A. Yes.
16 Q. You would appreciate that?
17 A. Yes, and a lot of times the children I've come across
18 who have been doing a lot of vomiting, a lot of times
19 it's the potassium that they run into trouble with, and
20 the potassium drops.
21 Q. In any event, if they are doing it then you need to test
22 to see where they stand now, have they lost too much so
23 they're no longer within normal parameters and that
24 needs to be addressed or have they not?
25 A. Yes.



1 Q. So if you have a child who is vomiting in a prolonged or
2 severe way, then you alive to the fact that it can have
3 those sorts of implications and their bloods need to be
4 checked?
5 A. Yes.
6 Q. So even if they are on Solution No. 18, which is
7 essentially water, basically, is it not?
8 A. Yes.
9 Q. So if that's what they're receiving, then that in and of
10 itself is not going to be adequate to replace the likely
11 potassium and sodium that they're losing?
12 A. You would have to review just how much vomiting that
13 they're having and review -- you would need to review
14 their input/output charts.
15 Q. Of course.
16 A. It just wouldn't be as straightforward as -- you would
17 have to review the fluid balance, how much have they had
18 in, how much vomiting, what's their urine output.
19 You have to take the whole clinical picture into
20 account.
21 Q. Of course. That level of vomiting, as you say, requires
22 review, some thought --
23 A. Yes.
24 Q. -- to consider what the implications of it are and once
25 you know what the results are and what the possible

1 implications might be, what to do about it. So some
2 thought has to go into that?
3 A. Yes, you have to look at the whole clinical picture.
4 Q. Did you know that, just as a response to stress and
5 trauma, that post-operatively there can be the hormone
6 antidiuretic hormone released in such a way as to
7 restrict the loss of water? Did you know that that is
8 something that happens?
9 A. Yes. Now, because I wouldn't have been -- because I'm
10 not commonly involved in the management of
11 post-operative children, back in 2000 I do not know if
12 I was aware of that. I know medical conditions --
13 I would have been more concerned about medical
14 conditions that can cause syndrome of inappropriate ADH.
15 Q. I'm going to take you to something that the inquiry's
16 expert, Dr Ledwith, who produced a paper for us on
17 doctors' training and education over the period that the
18 inquiry's concerned with, but leaving that aside you
19 were aware of the secretion of ADH and its implications
20 in terms of fluid balance within the body?
21 A. Yes, for medical problems.
22 Q. Yes. Just since I've mentioned it, I will pull that up.
23 It's 303-046-519 and 520.
24 MR LAVERY: Just before my learned friend deals with that
25 point, Ms Anyadike-Danes put it to the witness,



1 Mr Chairman, that Solution No. 18 was essentially water.
2 That's not quite correct, Mr Chairman. There's also
3 dextrose and sodium in Solution No. 18. So it's not
4 quite correct to say that it's essentially water. There
5 are other components in Solution No. 18.
6 THE CHAIRMAN: The specific reason for using it, as opposed
7 to others, is that there is dextrose in it.
8 MR LAVERY: Indeed.
9 MS ANYADIKE-DANES: I apologise. It has been so often
10 referred to as essentially just increasing the free
11 water, but dextrose, yes -- but the context I was asking
12 Dr Trainor about that was to do with electrolytes and
13 the sodium content, as I think we all know by know, is
14 less than that amount that would be being lost in the
15 fluids through vomiting. So I was putting it in that
16 context that it is not ...
17 Would you accept that Solution No. 18 does not have
18 within it the level of sodium that would be lost in
19 those gastric juices and so forth in vomiting?
20 A. Yes, there'd be 30 millimoles of sodium in
21 Solution No. 18 and some dextrose as well.
22 Q. Thank you. So if we can pull up 303-046-519 and 520
23 alongside it. If we see right down at the bottom:
24 "It was during these years ..."
25 And the years that Dr Ledwith is talking about are



1 those three years, really, the first pre-med year and
2 then the pre-clinical years, which is -- you can see
3 that from his middle paragraph. He says:
4 "It is during these years that medical students
5 would learn about the physiological relevance of sodium,
6 its absorption during digestion, its distribution within
7 bodily fluids and its elimination in the urine. The
8 vital role played by anti-diuretic hormone (ADH) and
9 other hormones, their secretion from the hypothalamus,
10 and their effects upon the re-absorption of sodium from
11 the renal tube tubules would also have been addressed."
12 And so on. Then he goes on to deal with the
13 clinical years in the next page, which is the years 3 to
14 6. He goes on to say, if you scroll down just past
15 halfway, that middle paragraph:
16 "It would be during this year that the basic
17 physiology and pathophysiology of the syndrome of
18 inappropriate antidiuretic hormone would be taught and
19 the situations in this might occur, the consequences of
20 inappropriate retention of salt by the kidneys and the
21 clinical signs caused by this phenomenon would be
22 covered in detail. Some understanding of the use of
23 intravenous fluids in clinical settings may also have
24 been learned in this year."
25 So what Dr Ledwith was asked to do was to look



1 at the teaching of doctors from roughly 1975 to 2012 or
2 thereabouts. There was a companion one done for nurses,
3 but Dr Ledwith was focusing on the doctors. If you look
4 on the website, you will see that this went through an
5 English expert as well to see how this stood with
6 what was being taught in England. In his view, this is
7 what would have been being taught and this is what the
8 students should have appreciated. And that's why I was
9 putting it to you because you seemed unsure of the
10 issues to do with SIADH and the circumstances in which
11 they might arise and were really answering, I think,
12 from the perspective of what you thought you might have
13 been taught on the ward or in the hospital setting, if I
14 can put it that way.
15 Now I've shown you this, does that ring a bell with
16 you at all?
17 A. I'm afraid it doesn't.
18 Q. Okay. Then I think you had said earlier when I was
19 asking you, that when you were at the Royal you would
20 have learned something about the calculation of fluids
21 and you would have been taught a basic formula. Does
22 that mean that you would have learnt from the
23 Holliday-Segar formula?
24 A. Yes.
25 Q. And in fact, when later on you come to calculate the

1 reduced fluids for Raychel, you have her fluid rate,
2 before you apply the reduction, at 65 ml an hour.
3 A. Yes.
4 Q. And that's calculated by reference to that sort of
5 formula, having regard to her body weight of
6 25 kilograms.
7 A. Yes.
8 Q. So you would appreciated, would you not, that a rate of
9 80 ml an hour running over many hours -- which in
10 Raychel's case was running from about 10 o'clock in the
11 evening of the Thursday, Thursday the 7th -- and you
12 first saw Raychel, as I understand it, in the early
13 hours at 4/4.30-ish, on the Saturday, the 9th. So that
14 was running all that time with a break only for the
15 theatre when she was on Hartmann's at that same rate, at
16 80, and you would have appreciated that that was too
17 high or not for you?
18 A. No, the first time I met Raychel and had to calculate
19 her maintenance fluids and using the 4-2-1 rule, got
20 65 ml an hour, and then obviously I was fluid
21 restricting her. If I had been asked to calculate her
22 maintenance fluids -- well, I did calculate her
23 maintenance fluids there and I got 65 ml an hour. I do
24 not know -- you would have to ask the surgeons why they
25 prescribed 80 ml an hour. They maybe had some other



1 reason why they wanted her to be on 80 ml an hour and
2 not 65 ml an hour. So I can't comment why they put her
3 on 80 ml an hour.
4 Q. We'll come to that in a minute when we get to the stage
5 when you're calculating it. If you had not been alerted
6 to any specific reason where you felt that there was
7 a necessity to administer above the normal basic rate
8 using the formula, would you have been wanting to
9 question why it was 80 ml?
10 A. Yes, well, whenever I calculated her maintenance fluids
11 I got 65 ml an hour.
12 Q. No, I appreciate that. But if earlier on you had been
13 dealing with Raychel, would you have wanted to question
14 why it was 80 ml an hour?
15 A. Yes, well, I would have to have seen whoever prescribed
16 her fluids at 80 ml an hour, why they had wanted 80 ml
17 an hour and not 65.
18 Q. I understand. Then can I pick you up on something that
19 you said before, right at the beginning, when you were
20 talking about the surgical patients on the paediatric
21 ward, and essentially the surgeons dealt with that,
22 apart from occasions when they might ask for
23 a paediatrician's input or advice?
24 A. Yes.
25 Q. So far as you were aware, who was dealing with the fluid



1 management of those surgical patients?
2 A. The surgical team.
3 Q. And had that always been so?
4 A. Whenever I was there in 2000, it was the surgical team.
5 I wasn't responsible for prescribing fluids for the
6 surgical team -- for surgical patients, sorry.
7 Q. Yes. The reason I ask that is because you're probably
8 aware by now that there are differing views as to who
9 had that responsibility or how that was managed. Some
10 have said that was done jointly, if I can put it that
11 way, with the paediatricians; others have said that
12 they'd have expected the paediatricians to have done
13 that. In fact, Mr Zawislak, who was a surgeon, was of
14 the view that he wouldn't prescribe fluids for
15 a post-operative patient. He would be looking very much
16 to the paediatricians to do that and regarding that as
17 something far more in their domain than his.
18 Were you aware that there was a lack of clarity, if
19 I can put it that way, as appears now as witnesses give
20 their evidence over who was responsible for prescribing
21 post-operative fluids?
22 A. I know the fluids for the surgical patients were --
23 I was under the impression that it was members of the
24 surgical team who were responsible for them, not members
25 of the paediatric team.



1 Q. And why were you under that impression?
2 A. Because it was -- we looked after the medical patients,
3 the surgical doctors looked after the surgical patients.
4 We prescribed fluids for our medical patients and the
5 surgical team prescribed fluids for their surgical
6 patients.
7 THE CHAIRMAN: Does that mean that if it was the position
8 that paediatricians were responsible for the fluid
9 management of surgical patients that you would have been
10 regularly involved in that fluid management, not just
11 for Raychel but for other surgical patients on Ward 6?
12 A. Sorry, can you repeat?
13 THE CHAIRMAN: If Mr Zawislak is right and it wasn't the
14 surgeons who were responsible for fluid management of
15 children on Ward 6 but it was the paediatricians, then
16 it would follow, wouldn't it, that you and your
17 colleagues would regularly be involved in --
18 A. Yes, writing up a lot of fluids which we weren't.
19 THE CHAIRMAN: Thank you.
20 MS ANYADIKE-DANES: You in your second witness statement for
21 the inquiry, 030/2, page 3, said that during your on
22 call in the Children's Hospital and Altnagelvin as
23 a medical SHO, you would occasionally be asked to review
24 surgical patients. Can you help us with what you mean
25 by "review"?

1 A. It could have been for a variety of things. It could
2 have been that maybe a surgical child was difficult,
3 a blood sample needed done and the surgical team had
4 difficulty getting bloods from that child. So we might
5 have been asked to assist, could we take a blood sample
6 on a surgical child, maybe a surgical child needed a new
7 Venflon for IV access, we might have been asked to
8 assist for that. Sometimes a surgical child maybe had
9 a temperature that couldn't be explained and the
10 surgical team might ask us for a paediatric opinion, why
11 this child could have a temperature. So there was
12 a variety of reasons you could have been called to ask
13 us to see a surgical child.
14 Q. Yes. That's what -- I wanted to tease out with you
15 whether you meant anything specific by "review", and it
16 may just be that that's a medical term of art and I have
17 misunderstood what you mean, but I wouldn't immediately
18 have understood the expression "review" to mean if
19 somebody had difficulty getting bloods. You as
20 a paediatrician who were more used to doing that from
21 children might be asked to do that, I wouldn't
22 necessarily consider that as a review. Whereas when you
23 said you might be asked for an opinion as to why a child
24 had a temperature that they were experiencing difficulty
25 in bringing down, I could understand that as a review.



1 Perhaps you could help us.
2 A. That would be classed as a review. I probably, in my
3 statement, should have put in that sometimes you were
4 asked to assist them with blood taking or getting IV
5 access.
6 Q. And you wouldn't mean that as a review?
7 A. No.
8 Q. If you were asked to do anything, really, with
9 a surgical patient, what was your response to doing
10 that? I ask you that in particular because Dr Johnston
11 expressed some concerns about being asked to intervene
12 in a patient who wouldn't be his and was really the
13 patient of the surgical team and not a paediatric
14 patient. So he expressed some reservations, concerns
15 perhaps, about doing even something as one-off as
16 replacing an IV fluid bag; do you share those?
17 A. Are you talking about back now in 2000?
18 Q. Yes, I beg your pardon. Unless I say otherwise, I am
19 really meaning 2001.
20 A. It's hard to remember back in 2000 how often you would
21 have been asked or what you were asked to do. It would
22 have depended what you were asked on sort of what
23 happened next. If it was that they had trouble getting
24 a blood sample, you would have went and assisted them
25 with getting the blood sample and then they would have



1 sent it off and followed up on results. The surgical
2 patients were looked after by the surgical team. If
3 we were asked for assistance, we did do our best to
4 assist, but I suppose it depended what the situation was
5 what happened next.
6 Q. I put to him a situation as to replacing a bag of IV
7 fluid. He said effectively, I'm not quoting him, but
8 effectively, even though that seems a relatively
9 straightforward thing, one would be concerned about it
10 because you don't know the history, you don't know
11 anything, and you're in there and providing further
12 fluids without perhaps necessarily appreciating things
13 like rate, type of fluid and just the general context in
14 which you're being asked to do something, and he
15 expressed his concerns about doing that. Obviously you
16 want to help if somebody's asked you to, but nonetheless
17 he had those sorts of professional clinical concerns.
18 Do you understand that?
19 A. Yes, I can understand his concerns.
20 Q. Would you have a similar attitude, if I can put it that
21 way?
22 A. Yes, I suppose it's difficult to remember back in 2000,
23 like how often I would have been asked or whether
24 it would have been the SHOs would have been more likely
25 to have been asked. I was on the registrar rota so



1 I can't recall how often I was asked or what exactly
2 I would have been asked to do.
3 Q. He says he can't actually remember being asked to do
4 something like that, but he was expressing a view as to
5 what his attitude might be if he was. In fact,
6 Dr Butler was asked to intervene, as you probably know
7 by now. She was asked to replace a bag of IV fluid at
8 about noon on the Friday, 8 June. And she has given her
9 evidence and explained that she asked certain questions
10 or got certain information, if I can put it that way,
11 from the nurses that would have meant that she wouldn't
12 have those concerns, although I think she understood
13 precisely what Dr Johnston was saying.
14 So it happened in Raychel's case that
15 a paediatrician was asked to intervene and, of course,
16 you did come after she had suffered her seizure --
17 A. Yes.
18 Q. -- both Dr Johnston and yourself. Maybe it's this word
19 "review" that I have picked up incorrectly. When you
20 were giving your evidence in the inquest -- let's put
21 this up. 012-035-169. It starts off:
22 "The surgical doctors on the ward [four lines down,
23 but one word in] would be responsible for prescribing
24 fluids. Paediatricians may be involved if asked to
25 assist. That did not happen with Raychel."

1 Do you know what you meant at that stage when you
2 said that that did not happen with Raychel?
3 A. It's hard to remember back in 2003 what I meant by that.
4 I suppose that's what Mr Leckey has written down that he
5 had taken from the conversation. All I can think was
6 that I wasn't asked before about assisting with
7 prescribing fluids for ...
8 Q. Oh, you meant you weren't asked to do that?
9 A. Mm-hm.
10 Q. I'm just trying to see if I can help you because we have
11 a slightly longer note of what happened. We do have
12 a longer note, counsel was making notes and that has
13 been typed up, but I can't see any further development
14 of that. So you can't help us with what that meant?
15 A. No.
16 Q. But you will accept that paediatricians were asked in
17 Raychel's case?
18 A. Yes, but I didn't -- I hadn't realised that.
19 Q. Not you to prescribe, but that did happen?
20 A. I know that now.
21 Q. Did you know that at the time of the inquest that
22 Dr Butler had been asked?
23 A. I can't recall whether I knew that back then or not.
24 Q. Thank you. The nurses have given their evidence
25 particularly Staff Nurse Gilchrist, as she was then, to



1 say that if they did ask a doctor's assistance, and
2 sometimes they did because the paediatricians were more
3 often on the ward than the surgeons were, that if they
4 did ask they expected a doctor to carry out an
5 examination and form a view, even if the nurses had
6 communicated what they thought was appropriate to
7 happen. Can you comment on that, what you expect
8 a junior doctor or junior paediatric doctor to do if
9 asked to assist a nurse?
10 A. It depends what you are being asked for. It depends
11 what the query is or in what way you're asked to assist
12 and what then you would do.
13 Q. Well, the first way -- and this specifically involved
14 a paediatrician -- was to, as I told you before, in Dr
15 Butler's case, to replace the bag. Then two more junior
16 than she, JHOs but on the surgical side, were asked to
17 administer anti-emetics. And in all those cases, the
18 nurses were of the view that even though they had a firm
19 view of what they would like to happen and thought was
20 appropriate, they nonetheless expected the doctor to
21 carry out his or her own examination and satisfy
22 themselves that that was appropriate. Do you have
23 a view as to what you think a junior doctor should do in
24 those circumstances?
25 A. I suppose it is difficult for me to say. You would need



1 to ask those individuals themselves what they were
2 thinking at the time. It depends on what you're being
3 asked to do and the situation that you're in at that
4 time, what exactly I would do.
5 Q. Yes, but you were a more senior doctor then and you're
6 a consultant now.
7 A. Yes.
8 Q. Even if we go back to then, you were acting as
9 a registrar. That is something that a junior doctor
10 could ask you about, "What should I do? What's the
11 guidance?" Carry out your examination and form your own
12 independent view, or you have experienced nurses there,
13 if that's what they think is appropriate, get on with
14 it.
15 A. Yes, but I suppose it depends what the junior doctor's
16 been asked to do then what advice I would give them.
17 MR LAVERY: It's very difficult for this witness to
18 speculate about what might happen in a hypothetical
19 situation.
20 THE CHAIRMAN: I should also say, Ms Danes, I'm reticent
21 about accepting a general proposition that the nurses
22 were all of a certain view on this because that is not
23 clear on the evidence that I've received. So let's move
24 on to deal with the specifics.
25 MS ANYADIKE-DANES: Yes, Mr Chairman.



1 Just before I pass on from slightly more general
2 questions about the ward, I wonder if you could help us
3 about the amount of discussion perhaps that goes on
4 about maybe concerns of accessibility in terms of
5 doctors responding to nurses for the patients there.
6 Were you aware that the nurses had any concerns about
7 doctors, surgeons, not always being available to respond
8 to them in terms of the surgical patients?
9 A. No.
10 Q. You would have perhaps a greater relationship with those
11 nurses because they're essentially nurses that you are
12 meeting all the time.
13 A. Yes, the paediatric doctors would be on the paediatric
14 ward most of the time.
15 Q. Yes. And in that time, you never heard any concern
16 being expressed in that way?
17 A. What concern?
18 Q. The concern is -- I can tell you specifically --
19 surgeons are unable to give commitments to children in
20 Ward 6 unless they're acutely ill and are bleeped.
21 That's a specific concern that relates back to
22 a document at 022-097-308. This is something that
23 obviously happens after Raychel's death, and you can see
24 that it is an update in relation to the critical
25 incident meeting which took place on 12 June. If you

1 look right down at the bottom of the note:
2 "There is a concern by nursing staff that surgeons
3 are unable to give a commitment to children in Ward 6
4 unless they are acutely ill and are bleeped. Could
5 paediatricians maintain overall responsibility for
6 surgical children in Ward 6?"
7 I'll ask you that about that second bit later on
8 when we deal with issues to do with the aftermath of
9 Raychel's death. I was giving you that so you see the
10 context in which that concern was being expressed.
11 That's a concern, as I understand it, because the
12 surgeons, not surprisingly, are more often involved --
13 well, they are involved in theatre and so on, and
14 therefore less on the ward, less accessible, and that
15 was a concern that the nurses were expressing, that when
16 they needed them they couldn't always -- this is not
17 a criticism of the surgeons, but they couldn't always
18 respond perhaps as quickly as they would have liked them
19 to and certainly weren't always in a position to be
20 proactive. Is that anything that you were aware of?
21 A. I know that there was always usually paediatric staff
22 around Ward 6. I know that members of the surgical team
23 could have been in theatre or could have been in A&E.
24 But I can't recall anybody saying to me specifically
25 that they had major concerns about that, but I know that



1 the surgical team weren't always on the ward because
2 they had patients in other areas.
3 Q. Yes. And so far as you were aware, did that lead to --
4 even if you may yourself not have been the recipient of
5 that kind of communication from the nurses, did it lead
6 to the paediatric doctors being called upon more often
7 by the nurses who weren't able to reach the surgeons?
8 A. And for what sort of things are you talking about?
9 Q. Well, I'm looking at it in the context of this comment
10 that's made by the nurses, so I'm asking you if that
11 therefore means that nurses were calling upon the
12 paediatricians because they couldn't reach the surgeons;
13 were you aware of that?
14 A. Whenever I was there, I wasn't personally aware of that.
15 I don't know whether any other members of the paediatric
16 team had that experience, but I wasn't --
17 Q. Yes.
18 MR LAVERY: [Inaudible: no microphone] she's going to be in
19 a position to answer that.
20 MS ANYADIKE-DANES: The reason why I'm asking this
21 paediatrician, Mr Chairman, is because that might have
22 been something that was an issue between the
23 paediatricians and the surgeons, and when we come on to
24 deal with aftermath and matters more directly relating
25 to governance, that might find expression there.



1 THE CHAIRMAN: Well, we have got a very clear answer from
2 this doctor that she wasn't aware.
3 MS ANYADIKE-DANES: Exactly.
4 THE CHAIRMAN: And she'd only been there for 10 months
5 at the time.
6 MS ANYADIKE-DANES: When you were there, how often would
7 blood tests be carried out on the patients?
8 A. What sort of patients, medical or surgical?
9 Q. Let's start first with the medical ones. How often
10 would their electrolytes be checked if they were on
11 IV fluids?
12 A. If they were on IV fluids, the medical patients had
13 electrolytes done every day.
14 Q. Was it done at a particular time?
15 A. I can't recall whether there was a particular time.
16 Q. For example, would it be done so that you would have the
17 results ready for a ward round?
18 A. That would have been ideal, but I don't know back then
19 whether that was always the case. That would be ideal
20 to have the results for the ward round but I know they
21 would have been done on a daily basis. Usually you
22 would have aimed for the morning time to get the bloods
23 done.
24 Q. Were you aware of what the position was in relation to
25 the surgical patients?



1 A. I wasn't.
2 Q. If we come to the early hours of the morning on 9 June,
3 you'd come into work or started work at 9 o'clock on
4 8 June; is that right?
5 A. Yes. Back then we were doing 24 hours shift, so I would
6 have started at 9 o'clock on the Friday morning.
7 Q. You were covering the paediatric ward, the neonatal
8 unit, the day-case unit and providing emergency cover
9 for the labour ward and A&E.
10 A. Now, I probably wouldn't have been covering all of those
11 during the day. I can't recall. We would have had
12 a weekly rota for 9 to 5. So on Friday 9 to 5, I would
13 either have been based in the ward or in the neonatal
14 intensive care unit or in outpatients. I can't recall
15 what area exactly. But after 5 o'clock there was one
16 registrar, myself, on the reg rota, an SHO and
17 a consultant on call. So after 5 o'clock I would have
18 been covering the ward and neonatal intensive care.
19 There would have been no clinics on then after 5.
20 Q. And can you remember being contacted by Dr Johnston?
21 A. Yes.
22 Q. Do you remember how he contacted you?
23 A. Yes. There's some things about that night I do remember
24 and there's other things I can't recall. I was busy
25 in the neonatal unit, which was then the -- the

1 children's ward was on the sixth floor and back then the
2 neonatal unit was on the fourth floor. I was busy
3 in the neonatal unit doing different things and
4 I remember he came down to find me at approximately
5 4.15.
6 Q. Do you recall what he told you?
7 A. I remember him saying that there was a sick surgical
8 child upstairs who had just had a seizure. I think my
9 first -- I asked him first of all where he'd been and he
10 said he was up in the children's ward, there was a sick
11 surgical girl who had just had a seizure, and he was
12 dealing with that. And she looked sick and he said
13 I needed to go up and see her because she looks sick.
14 Q. When Dr Johnston gave his evidence, he said he had been
15 called very, very shortly after Raychel had had her
16 seizure -- he fortuitously happened to be on the spot as
17 it were -- and he said he spent perhaps 10 minutes or so
18 stabilising her, which required two administrations of
19 medication. When he had done that and he had bleeped
20 Dr Curran because he wanted bloods done -- and the
21 reason for that is because, in his view, he had an
22 electrolyte imbalance as a differential diagnosis.
23 That's what was in his mind. So he very much wanted to
24 get the blood results back to see what her electrolytes
25 were. He had that in his mind as he went to see you.



1 Did he tell you that?
2 A. He didn't. That I can recall, he didn't.
3 Q. Could he have and it is one of the things that's not so
4 clear with you or do you remember the exchange pretty
5 clearly and he didn't mention it?
6 A. I would say I remember the exchange fairly clearly and
7 I didn't hear about an electrolyte imbalance. I do
8 remember asking him -- because it was unusual to hear
9 that a surgical child had had a seizure and I do
10 remember saying, "Has she got epilepsy?", and he said,
11 "No, there's no history of epilepsy or fits". I do not
12 remember him saying that there was an electrolyte
13 problem.
14 Q. Did he tell you that he'd asked for more senior surgical
15 input?
16 A. No, not that I can recall.
17 THE CHAIRMAN: But would you have assumed that he had sought
18 more senior surgical input since Raychel was a surgical
19 patient?
20 A. At the time I didn't sort of query whether he had or
21 hadn't.
22 THE CHAIRMAN: Okay.
23 MS ANYADIKE-DANES: Did he give you a sense of when this had
24 happened?
25 A. I don't know now if he did. I just knew that I had been



1 busy in the neonatal unit for a period of time and
2 he wasn't around and I was wondering sort of where
3 he was.
4 Q. Because that's where he would be?
5 A. If knew if there had been something happening in A&E or
6 if there had have been someone sick in A&E, I would have
7 heard that there was somebody in A&E, so I assumed he
8 was in the children's ward, but I just didn't know what
9 he was doing or what was happening.
10 Q. Presumably when you're told that a post-surgical child
11 has had a fit, your mind is going through all the
12 various possibilities of what it might be, even as
13 you're gathering yourself to go down and respond to it.
14 Would you have wanted to know when she'd had the fit?
15 A. As far as I can recall, the only question I asked him
16 was, "Does she have epilepsy?", because I knew it was an
17 unusual story for a surgical child to have a seizure.
18 I didn't ask a lot of details because I knew I had to go
19 straight upstairs to Ward 6 to see her. So I don't
20 recall asking him a lot of other questions.
21 Q. Was it in your mind that you might want to alert, even
22 at that early stage, your senior colleague?
23 A. I knew I needed to go and see her first of all
24 because -- to ring the consultant before I had even seen
25 the child ... I knew the first question Dr McCord would



1 ask me, like, "How is she?". So I knew I had to go and
2 see her first of all, but very quickly after I saw her
3 then I knew I needed Dr McCord's assistance, so I did
4 call him.
5 Q. Yes. So you respond and you go up and you see Raychel.
6 In your first statement for the Trust at 012-011-110,
7 you say:
8 "When I arrived on Ward 6, a surgical JHO was
9 checking Raychel Ferguson's blood results on the
10 computer and I noted that her sodium was low at 119 and
11 her potassium was 3. No other results were available."
12 And you then say that you had asked whether the
13 blood for those results had been taken from the same arm
14 where the drip was running in. So whether it was an
15 artefact, I presume, is what you were concerned with.
16 That surgical JHO was Dr Curran, and you'll have seen
17 his evidence. He assured you that it hadn't been.
18 I take it from what you said before that you never had
19 an experience of a sodium that low.
20 A. No.
21 Q. That that was very low so far as you were concerned.
22 A. Yes.
23 Q. That's hyponatraemic.
24 A. Yes. I'd never seen a sodium as low.
25 Q. And coupled with the fact that you knew she had had

1 a fit, at that stage, when you got there and you saw the
2 result, was anybody telling you, almost as you're
3 looking at that and digesting it, what had happened?
4 Did a nurse fill you in, did Dr Curran, as to what had
5 happened?
6 A. I remember whenever I first saw that result, I did ask
7 Dr Curran had the blood been taken from the drip arm and
8 he said it hadn't. But I also checked with the nurses
9 that the blood hadn't been taken from the drip arm
10 because it was so low and very abnormal. They said, no,
11 it definitely wasn't taken from the drip arm. I then
12 took out her surgical notes because her notes were
13 in the trolley and had a very quick -- because I knew
14 nothing about this 9-year-old girl that I was going to
15 see. So I had a very quick look, quick flick through
16 the chart and saw in the notes that she was a 9-year-old
17 girl, previously well, no history of seizures, day 1
18 appendix. Then I saw doctor -- I knew then what
19 Dr Johnston had given to her. Now, I don't know whether
20 I read that in the notes or whether some of the nurses
21 looking after Raychel filled me in on what exactly had
22 happened.
23 Q. Yes. We've been trying to find out when people say they
24 looked at notes, which were at the bedside and so forth,
25 we've been trying to identify exactly what people had to



1 look at, if I can put it that way. If I pull up
2 020-007-011 and put alongside it 012. That's Dr Makar's
3 note. Is that what you were looking at?
4 A. I can't now remember exactly what I looked at in 2000.
5 I can see from my own notes that I have made that I knew
6 she was a 9-year-old surgical patient, day 1
7 post-appendicectomy, and I do remember looking at her
8 medical notes, but I can't remember what pages exactly
9 I saw, what notes I saw.
10 Q. You knew she was on fluids at that time?
11 A. Yes.
12 Q. You can see that?
13 A. I knew whenever I went into the room that she was
14 attached to fluids.
15 Q. Did you know she had been vomiting? Did anybody tell
16 you that?
17 A. I see in my medical notes -- my medical notes weren't
18 made until 6.20 in the morning, whenever I was in the
19 CT scanner. I see in my medical notes that I have
20 written that she had vomited post-op and somewhere -- in
21 a statement, I think -- I wrote "seven times". But I do
22 not recall whether I was told that she had vomited so
23 many times or whether I'd looked at the fluid balance
24 sheet myself. I knew I had to go in and see a child
25 that had been reported to be sick to me. So I don't



1 know how much detail I looked in the notes or the fluid
2 balance or whether I looked at the fluid balance or
3 whether I was just told that she had been vomiting.
4 Q. Would you have wanted to look at the fluid balance?
5 A. If you had a lot of time and it depended, you know, if
6 the fluid balance was at the bottom of her bed. I knew
7 once I went in and saw Raychel that she was very sick,
8 so I don't know whether I looked at it or if I did look
9 at it, in how much detail.
10 Q. Let me approach it from a different way, instead of
11 asking you whether you looked at this document or that
12 document, which you may not now remember. Perhaps you
13 can help us with this: what is the information that you
14 would have wanted to know? You've got to make some sort
15 of assessment of what has happened, what is happening,
16 and what to do, and also, for that matter, what
17 information to convey if you're going to forward this on
18 to your senior colleague, your consultant. What are the
19 salient things to tell him so that you can be being
20 assisted? So you've seen that she's got a very low
21 sodium level, which doesn't appear to be, on the face of
22 it, an artefact. You know that she had a seizure and
23 that your SHO is very concerned about her. You can see
24 how she looks immediately when you look at her. What
25 other information would you want to have?



1 A. Now, the sodium you were saying about the sodium of 118.
2 Because her sodium previously had been 137, that is why
3 I asked for that repeat sodium because the 118 was such
4 a difference, such a change from the previous result.
5 Q. Can I ask you this: did you know what that previous
6 result -- when it was taken?
7 A. Well, if you look in the medical notes that I have
8 written, I have written in them that her U&E, her sodium
9 on 7 June was 137.
10 Q. The reason I didn't take you to your note then is
11 because by that time you may have had an opportunity to
12 consider things that you haven't necessarily considered
13 at this point in time. In any event, if you had known
14 that about when her U&Es were taken, you would have
15 known that they were taken before her surgery on the
16 Thursday evening, and you're now there in the early
17 hours of the Saturday morning. So yes, there is
18 obviously a fall from 137 to 119, I think it was
19 actually, the first time you saw the low sodium, but in
20 between then a lot may have happened. Her surgery has
21 certainly intervened and that's why I'm asking you for
22 what information would you want to have about what had
23 happened to Raychel to help you assess what was going
24 on.
25 A. Yes, well, you have to assess the child and go through

1 your airway, breathing, circulation, assess the clinical
2 condition of the child at that time, and then whatever
3 other past history that you have and observations you
4 would want to look at. But this here was a very ill
5 little girl. Whenever I first went into the room to see
6 her, I knew once I saw her that I needed further
7 assistance. That is why I asked Staff Nurse Noble to
8 contact Dr McCord once I had done my examination because
9 I knew that I needed assistance with Raychel.
10 Q. You knew she was hyponatraemic?
11 A. I was rechecking that result because the sodium -- that
12 first sodium, yes, I had queried whether it was from the
13 drip arm, I heard it wasn't. But I had never seen such
14 a low sodium. That is why I wanted it urgently repeated
15 because I, at that stage, didn't know -- is this a true
16 result, is this a lab error, and that is why I had asked
17 Dr Curran to urgently repeat the sodium.
18 Q. I understand.
19 A. Because at that time I didn't know whether we definitely
20 were dealing with a low sodium or whether there was
21 something else going on.
22 Q. Yes. Let me put it this way: if one just looks at her
23 fluid balance chart -- if we pull up 020-018-037 -- if
24 you had been given any of that information, so her first
25 vomit is at 8 o'clock in the morning of the Friday, and



1 leaving aside whether there might be any other vomits
2 that aren't recorded here, there is vomiting that
3 carries on through that day and towards the end of the
4 day it's being characterised as coffee grounds.
5 Do you see that?
6 If you'd been told that, that that's what had been
7 happening, there's a large vomit there, the first record
8 of passing urine is at 10 o'clock. Can I pause there
9 and ask this, just so that we're clear about it?
10 What was the practice on recording urine output so far
11 as you were aware on Ward 6? Was an effort made to
12 record every instance so far as you could do it when
13 a child had passed urine, or was it simply to record the
14 first time it happened?
15 A. I can't recall that far back what the practice was.
16 Q. But in any event, you would have seen that so far as
17 this was concerned, there seems to be only one recorded
18 instance of it. You might have been told that there had
19 been two anti-emetics to try and address the vomiting
20 later on in the evening.
21 A. I don't know whether that -- whether I was told or not.
22 Q. I'm trying to see. When you say that it was such a low
23 sodium that you were concerned whether it was an
24 accurate result, I'm trying to see the information that
25 might have been given to you or you could have read to



1 see whether that would have made a difference in your
2 view as to whether it was likely to be an accurate
3 result or not.
4 A. Whenever we would get any abnormal result, the first
5 thing we've always been taught is to repeat it.
6 Q. Yes, I understand that. But the result you have is low
7 sodium, okay? And so what I'm looking at is if any of
8 these things would provide an explanation, as far as
9 you're concerned, for why her sodium might have been
10 low. So at the moment what we've looked at is
11 prolonged, possibly severe vomiting, perhaps you might
12 have taken that from the two recorded instances of
13 coffee-ground vomiting. That kind of vomiting, might
14 that not have produced a low sodium result?
15 A. At that time, I can't recall exactly what my thoughts
16 were. Yes, whenever the next sodium came back and it
17 was low, then the fluids were changed. But I was also
18 concerned that there could be something else going on
19 with Raychel. She had petechiae and I was worried that
20 she could have meningococcal septicaemia and I also had
21 queries in my notes and differential was there some
22 other intracranial lesion. There were a lot of things
23 to consider. Whenever you have a sick child, a lot of
24 times, there's not just one clear-cut diagnosis.
25 Q. I understand that and I'm going to ask you about that



1 differential in a minute. Perhaps we can pull up your
2 witness statement, 030/2, at page 6, where you
3 considered that the seizure may have been due to an
4 electrolyte abnormality. Do you see the top paragraph?
5 A. Yes.
6 Q. "My impression was that she possibly had a seizure
7 secondary to an electrolyte problem or had a cerebral
8 lesion."
9 Was that a view that you had formed before you got
10 back her second set of results?
11 A. No, the notes I made in Raychel's chart were the notes
12 that I made whenever we were in the CT scanner at 6.20
13 in the morning. So that was two hours after I had first
14 met her and the repeat sodium had come back at 118, so
15 we had two low sodiums. She also had the petechiae so
16 I was worried, could she have meningococcal septicaemia
17 or some other intracerebral lesion. So whenever I wrote
18 that, my impression was "Seizure secondary to an
19 electrolyte problem". I knew at that stage that the
20 sodium was low and the magnesium was low. There's
21 a lots of different reasons why children can have
22 seizures and I didn't know at that stage just how big
23 a part the low sodium had played because I had also
24 given her antibiotics because I was worried about
25 infection.

1 Q. I understand that, but just staying with the low sodium
2 for a moment, could it be that the incidents of vomiting
3 could have reduced her sodium levels?
4 A. It depends how much vomiting you do and every child is
5 different. Some children will vomit and might not drop
6 their sodium and some might drop their sodium, but it
7 depends on how many vomits and things like that.
8 Q. The number of vomits that are being indicated, some are
9 being shown as "large" on her fluid balance sheet.
10 Could that kind of vomiting have reduced her sodium
11 level?
12 A. But at that time I don't know if I had looked at her
13 fluid balance chart to see how many vomits or their
14 severity.
15 Q. I appreciate that, and I haven't put it to you in that
16 way. If you had that information, could that kind of
17 vomiting have reduced her sodium level?
18 A. It could.
19 Q. Yes. If you had known or been told that not only had
20 she been vomiting in that way, but towards the latter
21 part of the evening she'd had a headache, would that
22 have predisposed you to linking the low sodium with some
23 sort of an electrolyte problem?
24 A. Because I'd heard about the headache?
25 Q. The headache, yes.



1 A. Children can have headaches for a lot of different
2 reasons. If a child has a temperature, they can have
3 a headache. So there's a lot of different reasons for
4 a child complaining of a headache. Back then, I can't
5 say what I was exactly thinking at that stage. Whether
6 I would have linked it or not, I can't say in
7 retrospect.
8 Q. I appreciate that and I am not asking you to look at
9 these things in isolation. Any one of things in
10 isolation -- there could be any number of different
11 factors that might give rise to it, but these things
12 didn't happen in isolation. So this is the information
13 that was available. Although Dr Johnston, when he first
14 attended her, immediately after her seizure, his
15 thinking was that there was an electrolyte abnormality
16 and, in fact, he thought that without really considering
17 very much about the vomiting. It was because he could
18 not see a very obvious reason, she was afebrile -- so
19 there was nothing of that sort going on -- and I presume
20 she still was when you saw her. So she didn't have
21 a temperature. He couldn't see any obvious reason once
22 he had ruled out a possible history of epilepsy why she
23 would have a fit like that and that was in his mind.
24 You say you can't remember, but on balance you think
25 he didn't mention that to you. His evidence is that he



1 would have because that's what he was concerned about,
2 but leaving that aside, can you explain why he might
3 have had that in his mind and you wouldn't have had that
4 in your mind, even with the low sodium result, because
5 he didn't have the benefit of that? At the time he was
6 thinking that, there were no sodium results available to
7 him.
8 A. No, I don't know why he thought that it was an
9 electrolyte problem.
10 Q. But it's not something that occurred to you at that
11 stage?
12 A. Not at that stage whenever I just had the first sodium
13 of 118. Yes, whenever the repeat or 119 -- sorry,
14 whenever the repeat one come back and the low sodium had
15 been confirmed, then yes, I knew that the sodium was low
16 as well as was the magnesium.
17 THE CHAIRMAN: Do I understand you, or is this taking it too
18 far, that when you get a sodium reading of 119, which is
19 lower than you'd ever seen, is your instinct to think,
20 "That can't be right"?
21 A. That is correct and because I knew that -- yes, albeit
22 36 hours beforehand the sodium had been normal -- I had
23 never seen a sodium so low. I didn't know that a sodium
24 could drop so fast. If we got any result in the
25 hospital that were unusual or different, like if we get



1 a sample back from the lab with a very high glucose, you
2 wouldn't act on it and give a child insulin, you'd
3 repeat the sample to check is the glucose really high
4 before you would act. And it's the same with
5 electrolytes, sodiums, potassiums, calciums, magnesiums.
6 Sometimes you get potassiums back from the lab that are
7 higher than you expect and you repeat them, so you would
8 always repeat an abnormal sample.
9 THE CHAIRMAN: And how abnormal at first blush was this one?
10 A. Very abnormal. I had never seen a sodium of 118.
11 MS ANYADIKE-DANES: Did you know that a very low sodium
12 could produce seizures?
13 A. It is difficult to say what I knew 12 years ago.
14 12 years ago I was a lot more junior than I am now. So
15 12 years ago I wasn't aware that you could get such
16 a low sodium and I wasn't aware then the consequences
17 that you could have a seizure and what could happen.
18 Nowadays, everybody knows more now about hyponatraemia.
19 Q. I understand that. When you were just answering the
20 chairman then and you said it was an abnormally low
21 result and you would always want to check something like
22 that, in fairness to you, the inquiry's expert,
23 Dr Scott-Jupp, who is a paediatrician, says something
24 similar and we'll come on to what the other experts say
25 about it.

1 The reality of it is from how you've answered me
2 when I was pressing you a little on the vomiting,
3 actually there might have been information available to
4 you for that result, seen in the context of those
5 results, to be explicable, if I can put it that way. So
6 although it was abnormally low, in the context of what
7 had been happening to her over that day and that
8 evening, there might have been a clinical explanation
9 for it?
10 A. But you have to remember at that time, as I say, I can't
11 recall whether I saw the fluid balance, whether I knew
12 she had been vomiting so much, but she also had
13 petechiae and I was worried about infection or whether
14 there was something else going on.
15 Q. I am going to ask you about that, but the point that I'm
16 trying to get you to see if you can help with is that
17 whether you knew that or not, before you reach a view
18 that this is an abnormal result and therefore should be
19 repeated -- to repeat a blood result, according to
20 Dr Johnston, one is looking at about -- even pressing
21 them and saying this is really urgent, his view is that
22 could take somewhere between 30 minutes and 45 minutes
23 to get a result back. So if you ask for a repeat, there
24 is a time lag in that. So why I'm asking you and
25 pressing you a little bit is that before one -- well, at



1 the same time, maybe, as one takes that step, do you not
2 also see whether the information to hand in the child's
3 notes is such that could actually explain why the result
4 is the level that it is? Would that not be a prudent
5 thing to do?
6 A. Yes, but whenever I went into the room and saw how
7 unwell Raychel was, you're trying to deal with a very
8 sick child on the spot and, in hindsight, you could
9 say: did I look at the medical notes enough, how well
10 did I review the fluid balance? I just knew that
11 whenever I saw Raychel in room I, she was extremely sick
12 and we had to move into her the treatment room and
13 I needed further assistance. I can't -- I knew
14 something serious had happened, but to try and tie it
15 all together once you first see a child, I wasn't able
16 to do that because I thought there could be a few things
17 going on here.
18 Q. I do understand that and I'm not wishing to minimise the
19 situation of extremis that you might have found yourself
20 in and tried to help what appeared to you to be a very,
21 very sick child. So I'm not trying to minimise that at
22 all and I am not even suggesting that you yourself
23 should have been poring through the notes, but you had
24 experienced nurses there who had been nursing that child
25 and would have been able to tell you if you'd simply



1 said, "What's been going on?", they should have been
2 able to tell you, "What's been going is that this child
3 has been vomiting during the day and into the evening,
4 she has had two anti-emetics and the last vomiting that
5 she was producing had coffee grounds in them, that's
6 what has been going, she's had a headache and we're
7 just -- it's not within our experience what is happening
8 here". It's not what was projected when they did the
9 ward round. What was projected is that she might be up
10 on her feet and on her way out the next day.
11 So that could have been told to you as you're there
12 looking at the results. I'm not suggesting that you
13 start poring through the notes yourself, but there were
14 people there who had that information and could have
15 given it to you. What I'm trying to see if you could
16 accept is, if you had that information, then the low
17 sodium result of 119 might have been explicable in that
18 context.
19 A. If I had have been given that information, looking back
20 then, as I say, I still don't know what my opinion would
21 have been, because it's very hard to say 12 -- there's
22 some things I remember about 12 years ago and other
23 things that you just can't remember, like what you were
24 told or what your thoughts were. Everybody involved
25 knew we had a sick child.



1 Q. Yes, I understand that. What you do is you want to have
2 the tests re-done.
3 A. Yes.
4 Q. And you also want to address some other differential
5 diagnoses that you might have. Am I right in
6 understanding you that the tests being re-done, you get
7 a fresh set of lab results back and you also have the
8 blood gas tests done?
9 A. Yes.
10 Q. And just for the benefit of those who might not
11 appreciate it, what will the blood gas tests show or
12 what can it show?
13 A. The blood gas test would be the check the pH of the
14 child, so you can check a -- a normal pH would be 7.35
15 to 7.45. It would check whether the blood had too much
16 acid in it and also it would give you a measure of the
17 child's bicarbonate or base excess. If you have a sick
18 child, the bicarbonate level could be down and the base
19 excess can be elevated.
20 Q. Some blood gas analysers can tell you, as a by-product
21 of all that, a sodium.
22 A. Yes.
23 Q. Will that produce that?
24 A. The blood gas machine, back then in 2000, was in the old
25 neonatal unit on the fourth floor. There is a printout

1 of the blood gas in the notes, but I think it has faded
2 through time. I can't recall --
3 Q. Sorry, let's see if we can pull that up. I think it's
4 020-015-025.
5 A. Yes, that's it, because that's my writing, "R Ferguson",
6 and that's "04.30". That's my handwriting.
7 Q. So is there anything on there that would give you any
8 assistance with what her sodium levels were?
9 A. No. Back then, I don't recall that the blood gas
10 analyser gave us electrolyte results. I know nowadays
11 there is more up-to-date blood gas machines that can
12 give you electrolytes, but I can't recall 12 years ago
13 that the blood gas analyser in the neonatal unit did
14 give you electrolytes because if it had given me
15 electrolytes, it would be printed out as well. But
16 I don't recall that we could get electrolytes from the
17 blood gas machine 12 years ago.
18 Q. When you say "printed out", would it be something that
19 would come out automatically or would you have to
20 programme it to do that? The reason I ask you that is
21 in the Children's Hospital in 1995 when Adam, the first
22 child I mentioned, was having his surgery done, they had
23 a blood gas analyser that could produce his sodium
24 levels. In fact, that's how they knew his sodium level
25 was as low as it was during the course of his surgery.



1 So is it that you have a different kind of machine or
2 you have to programme it to produce that result for you?
3 A. You would probably need to ask the people who look after
4 the blood gas machine what way the blood gas machine was
5 set up back then because I honestly -- I can't remember
6 us getting electrolytes from blood gases back then.
7 Q. So if you're wanting to have a repeat blood test done,
8 would you accept what Dr Johnston says, that it might be
9 any time up to half an hour, maybe slightly longer,
10 before you got a result back?
11 A. It depends the time of the day you're sending the blood.
12 The bloods back then would have went in the --
13 Q. Let's talk about when it was being sent for Raychel.
14 A. It was being sent at night-time. It would have been
15 sent down in the chute. The way it used to work -- and
16 the way it still works -- is if you're sending an urgent
17 blood overnight, you ring the man or woman in
18 biochemistry and say that there is an urgent sample
19 coming and you would like a result as soon as possible.
20 Q. And in your experience, how quickly could you get it
21 back if you did that?
22 A. It depends. It depends how quickly the lab get it and
23 how quickly the lab process it. Then if you've asked
24 for an urgent result, the way it used to work as far as
25 I can recall is biochemistry, rather than waiting to put



1 it up on the computer, a lot of times, if you were
2 waiting on a very urgent result, they would have rung
3 back with the results. But it could have been anywhere
4 from 5 minutes onwards. You did always push them if it
5 was very urgent that you wanted it as soon as possible.
6 Q. Are you aware how quickly it came for Raychel?
7 A. As far as I can see, her repeat, second set of repeat
8 bloods, were done, I think, on the lab sheet, it says
9 04.35.
10 Q. Yes.
11 A. And I do remember that the second sodium, the 118
12 sodium, came back just after Dr McCord had arrived
13 in the hospital and he came into the treatment room.
14 Q. About 5 o'clock? Thereabouts?
15 A. Somewhere between 4.45 and 5.
16 Q. It has been difficult, not surprisingly, to be precise
17 about all those timings. Because there were others who
18 came roughly at the same time as he did, there seems to
19 be some suggestion that it was perhaps closer to 5, but
20 anyway. In any event, what it looks like is it took
21 somewhere perhaps around half an hour to get those
22 results back.
23 A. Maybe slightly short, but I can't say for sure.
24 Q. If in fact Raychel's problem was very low sodium result
25 produced by hyponatraemia and an abnormally low one at



1 119, then time was of the essence for treating her, was
2 it not?
3 A. Yes.
4 Q. If one of your differentials was some sort of perhaps
5 meningitis or something of that sort, the sort of
6 treatments that you would provide for a child with a
7 very low sodium, hyponatraemia, like for example
8 changing perhaps the fluids, perhaps changing the rate
9 at which fluids were administered, maybe also
10 administering something like mannitol and so on, what
11 would be the effect of doing that for a child who you
12 thought might have meningitis? What could be the
13 detrimental effect?
14 A. Sorry, I don't understand the question.
15 Q. At that time, you weren't sure what was producing that
16 low sodium result. There were a number of contenders so
17 far as you're concerned. Meningitis might have been one
18 of them or some sort of meningococcal infection might
19 have been something and you thought that perhaps because
20 of her rash. She was hyponatraemic, but what was the
21 effect of that hyponatraemia, whether that was causing
22 raised intracranial pressure and so forth and that was
23 what was producing the fit and so on, that's perhaps
24 another contender. If you're going to --
25 MR STITT: Mr Chairman, I say this with the greatest of

1 respect, and counsel should not interrupt in the middle
2 of a question and I apologise for that. But the first
3 question was a long and difficult question and the
4 witness said she didn't understand it. The second
5 question is even more complex and long and I have to
6 interrupt in ease of the witness. I know the witness
7 wants to help the inquiry, but I'm having difficulty
8 with the question and I suspect the witness is also.
9 THE CHAIRMAN: Okay, thank you.
10 MS ANYADIKE-DANES: Okay, I can help you in this way if
11 you are having difficulty with it. You were not sure
12 what Raychel's problem was. You had different
13 possibilities for what was her problem.
14 A. Yes.
15 Q. What I'm trying to ask you is: if you addressed the
16 possibility in relation to the hyponatraemia, which has
17 certain things that you do in terms of perhaps changing
18 the fluids, perhaps changing the rate at which fluids
19 are administered, perhaps introducing medication such as
20 mannitol, those are the sorts of things you would do if
21 you were going down the line of hyponatraemia producing
22 a raised intracranial pressure on to cerebral oedema,
23 that sort of thing; would you accept that?
24 A. Yes.
25 Q. If you were to do that, what would be the effect of



1 doing that if in fact your alternative, your
2 differential diagnosis of meningitis, proved to be
3 correct? What would be the detrimental effect of having
4 done that?
5 A. I wouldn't be aware of any detrimental effects.
6 Q. That's why I was taking you there. Because --
7 THE CHAIRMAN: That's a comment. "That's why I'm taking you
8 there" is a comment. Let's keep to a questions.
9 MS ANYADIKE-DANES: So if you're not aware of there being
10 a detrimental effect of doing that, then why not do it?
11 A. Because I waited on the repeat sodium. I still -- the
12 first sodium of 119 ... We have always been taught you
13 do not act on your first abnormal result, you always
14 repeat it, and that is why I did not act on the first
15 sodium of 119. I waited until the repeat sodium came
16 back, which was 118, and once we saw that result,
17 Raychel's fluids were changed to normal saline and she
18 was fluid restricted.
19 Q. Yes, you have explained that that's what you were doing,
20 you were going to wait until you got the second result.
21 The reason why I have pressed you a little bit about
22 that is because there's a delay factor in waiting. And
23 if in fact there was a hyponatraemia producing a raised
24 intracranial pressure leading to a cerebral oedema with
25 all the consequences that might flow from that, then



1 time was not on Raychel's side. And even though
2 normally, the teaching might be, "Be safe, get a second
3 result", maybe there are certain circumstances in which
4 the safe thing to do is not to do that, but actually to
5 do something more aggressive, if I can put it that way,
6 to try and address what might be the problem.
7 A. Because I thought the first sodium of 119 -- because it
8 was such a dramatic change from the previous one and
9 I queried whether it was going to be a lab error,
10 I didn't want to start changing fluids then because if
11 the repeat sodium had come back high for some reason,
12 then changing the fluids would have been the wrong thing
13 to do. So that is why I still say I waited for the
14 second result.
15 Q. Yes.
16 A. And the second sample was taken at 04.35 and it was back
17 quicker than the first U&E, looking through the notes,
18 because I do know that the second result did come back
19 just after Dr McCord had come into the treatment room.
20 Whenever Dr McCord arrived, Raychel had taken a turn for
21 the worse and the anaesthetists were there and she had
22 been intubated and ventilated. But as far as I can
23 recall, Dr McCord did arrive some time between 4.45 and
24 5, so the repeat sample, in my opinion, was processed
25 quicker than the first one.



1 THE CHAIRMAN: You know what these questions are coming to.
2 There's a suggestion by one or more of the experts that
3 it might have been appropriate to change the fluids
4 earlier. Right? Your answer to that is, first of all,
5 it's not a consistent approach by the experts -- some of
6 them are not critical -- and to the extent there's any
7 criticism, the amount of delay involved was in the
8 region of 30 minutes?
9 A. Yes.
10 THE CHAIRMAN: Thank you.
11 MS ANYADIKE-DANES: Since I have mentioned an expert, let
12 me, in fairness to you, put up what the expert says.
13 It's the Trust's own expert, Dr Warde. Dr Warde is a
14 consultant paediatrician. Have you read Dr Warde's
15 short report?
16 A. Yes.
17 Q. Let's pull it up. 317-009-012. About four lines down:
18 "One could question why, upon receipt of the initial
19 electrolyte results revealing sodium of 119, Dr Trainor
20 did not immediately alter the IV fluid therapy to
21 0.9 per cent sodium chloride, but instead asked for
22 a repeat estimation."
23 He does, of course, query what the result would have
24 been in terms of the overall outcome for Raychel, but
25 then he goes on to say:

1 "Some would argue that faced with a symptomatic
2 patient faced with a severe hyponatraemia, it would have
3 been appropriate to be more aggressive and to commence
4 treatment with hypertonic 3 per cent sodium chloride
5 combined with a diuretic such as frusemide."
6 I had mentioned mannitol to you, and then he talks
7 about whether that would have been readily available to
8 you. In any event, you see what his comment is. He is
9 from the same discipline as you, he's also a consultant
10 paediatrician. Apart from that which you have already
11 explained to the chairman, do you wish to comment on
12 this specifically?
13 A. What part of his statement?
14 Q. Do you wish to comment on the points that Dr Warde is
15 making here specifically?
16 A. I suppose, first of all, then, I still stand with what
17 I say about why I didn't act on the first sodium of 119,
18 because I would always ask for a repeat --
19 Q. Yes.
20 A. -- just to make sure that there wasn't lab error.
21 Q. Yes. Pausing there when you say that, and I know that
22 you have said that's your training -- I'm sure that must
23 be so because, apart from anything else, Dr Scott-Jupp
24 also thinks that that was a reasonable thing that you
25 did in seeking that -- but have you had very much



1 experience of getting a very low sodium -- I think you
2 said you haven't had the experience of getting a very
3 low sodium result, but maybe of potassium, a low
4 potassium result, repeating the blood test and then
5 getting a very high one? Have you had any experience of
6 that?
7 A. A lot of times it would be more maybe a potassium being
8 high and you would repeat it maybe because the sample
9 has been slightly haemolysed. You would repeat it and
10 the repeat would be lower than the first one.
11 Q. But still abnormal?
12 A. It depends. Every case is different. I can't say
13 exactly.
14 THE CHAIRMAN: I presume, doctor, apart from the points
15 you've already made, Dr Warde, to the extent he is
16 critical at all, says five lines up:
17 "Some would argue that it would have been
18 appropriate to be more aggressive."
19 On Dr Warde's approach, there is an argument, but
20 it's not an argument that would carry everybody.
21 A. Yes.
22 MR QUINN: Mr Chairman, could I ask one question at this
23 stage? Could the witness be asked, in her experience to
24 date, has she ever seen a sodium reading so low as 118
25 or 119?



1 THE CHAIRMAN: You mean since 2001?
2 MR QUINN: Yes. She had five years' experience then, she
3 hadn't seen anything like this. I'm just wondering
4 statistically what it's like as a paediatrician
5 practising in Altnagelvin now. Has anything like this
6 come up again?
7 THE CHAIRMAN: Can you help us on that?
8 A. I have seen low sodiums since 2000. Is that what you're
9 asking?
10 THE CHAIRMAN: Yes.
11 A. Yes.
12 THE CHAIRMAN: As low as 118 or 119?
13 A. I have had one other child who's had a sodium of 118.
14 THE CHAIRMAN: Thank you. We take it that that's one more
15 child as low as that in 12 years subsequently?
16 A. Yes.
17 MS ANYADIKE-DANES: And just in fairness, since we've
18 mentioned it a couple of times, I'm not going to read
19 out what Dr Haynes says, suffice it to say he's the
20 consultant paediatric anaesthetist and his view is at
21 220-003-018. He would have expected you to have taken
22 steps to obtain a hypertonic solution and to have made
23 some attempt to correct the electrolyte abnormality. He
24 also, like Dr Warde, obviously can't possibly say what
25 the result and the overall outcome would have been had



1 you done that, but that was his view as to something
2 that he thinks that you might have done.
3 Then Dr Scott-Jupp, and in fairness to pull this up
4 and show it, it's 222-004-014. He says:
5 "It was clearly appropriate to do the second blood
6 test and it was appropriate to wait until the repeat
7 results came back before acting upon it due to the risks
8 of taking action on a false result and appropriate steps
9 were taken after the receipt of the repeat results."
10 That is his view, which accords with what you
11 actually did.
12 You have said that fairly quickly after you saw
13 Raychel, you realised that you were dealing with a very
14 sick child and actually what you required was some
15 senior assistance --
16 A. Yes.
17 Q. -- your consultant, in fact. And I think from the way
18 you gave your evidence, that would have happened within
19 a very short period of time indeed.
20 A. Yes, after I went in to see Raychel and quickly assessed
21 her, I knew that I needed assistance of my consultant,
22 who at that time was Dr McCord.
23 Q. Yes. Can you help with this? When you say "quickly
24 assessed her", what did that involve?
25 A. If you look in the notes that I made, obviously whenever

1 you're faced with a very sick child you don't then take
2 time afterwards to sit and write good notes because your
3 main priority is the child and we are always taught on
4 APLS courses "airway, breathing, circulation". So you
5 can see from my notes, whenever I went in to see
6 Raychel, what exactly I looked at. I don't know whether
7 I was told she had no temperature or whether I looked at
8 the chart, I'm not sure about things like that, but
9 I know I listened to her chest, examined her abdomen,
10 lifted up her limbs, checked her plantars, checked her
11 pupils. After doing that, I can't say how long that did
12 take me, but it would have been a quick assessment as
13 was noted down. I then knew she was very sick and
14 I needed assistance.
15 Q. Let's put that up, 020-015-023 and 024.
16 MR STITT: May I just go back to one point before we come to
17 this document? I'll put the point to you, Mr Chairman,
18 and if you wish me to come back to it at another time,
19 I will. Ms Anyadike-Danes had very properly and fairly
20 put two or three reports to the witness in a balanced
21 manner, dealing with this repeat test.
22 THE CHAIRMAN: Yes.
23 MR STITT: And I would have thought for completeness
24 it would have been helpful to have put the Foster
25 report, which deals specifically with this.



1 THE CHAIRMAN: Okay. Do you have the reference to hand?
2 MR STITT: Yes, 223-002-024. It's the penultimate
3 paragraph.
4 THE CHAIRMAN: "Dr Trainor enlarged upon her clinical
5 notes"?
6 MR STITT: Yes, and if one looks at the --
7 MS ANYADIKE-DANES: "She asked the house officer to repeat
8 the electrolytes. This is a standard procedure when a
9 result is very abnormal."
10 Was that the point?
11 MR STITT: If that was put to the witness and I missed it,
12 I apologise. I didn't think it was. I think, in
13 fairness, the inquiry's expert is saying that that's
14 standard procedure when the result is very abnormal.
15 It's exactly what the witness had said.
16 MS ANYADIKE-DANES: Yes. Well, I apologise for not putting
17 that. I hadn't gone to every part of all the expert
18 reports, but it's right that a fresh expert also
19 expresses a view like that, that that part of the report
20 ought to be put as well.
21 MR STITT: I entirely accept that Ms Anyadike-Danes has been
22 entirely fair throughout, but I obviously have a duty --
23 THE CHAIRMAN: Yes.
24 MS ANYADIKE-DANES: If we can go back to the two pages from
25 the medical notes and bring up 024 alongside it.



1 Thank you. When you say the notes that you made or the
2 entry that you made in Raychel's notes, that's what
3 you're referring to, is it?
4 A. Yes.
5 Q. That comes immediately after the entry that Dr Johnston
6 made. You obviously would have seen that before you put
7 in your own.
8 A. Well, I know I wrote my notes whenever we were down in
9 the CT scanner. I can't recall 12 years ago whose notes
10 I had read in the notes whenever I flicked through them.
11 Q. Yes. What I was going to ask you is if you had any
12 sense -- and it may be that you can't, it's just so long
13 ago and so much has intervened -- of how long you were
14 with her before you formed the view "I'll get the nurse
15 to contact or to bleep Dr McCord"?
16 A. Whenever I went in to see Raychel there was a nurse with
17 me. I can't recall exactly who that nurse was. But you
18 can see there, my first line is, "Looks very unwell",
19 and that there is the examination I performed. I can't
20 say now how long it took me to perform that examination,
21 but I would say it wasn't like 10 or 15 minutes, if you
22 know what I mean. Whenever you're dealing with a sick
23 child, you do airway, breathing, circulation, check all
24 those are okay, notice the petechiae, I noticed she was
25 unresponsive, checked her plantars. So I went through



1 my examination and by the time I got to the end of my
2 examination, but I don't know how long that was, I knew
3 that I needed Dr McCord's assistance and I asked, as far
4 as I can recall, Staff Nurse Noble to contact Dr McCord,
5 to get Dr McCord on the telephone for me, please, and to
6 move Raychel into the treatment room.
7 Q. Staff Nurse Gilchrist, I think in her evidence
8 yesterday -- I wasn't in the chamber when that was being
9 given, so I hope I will be corrected if I have got it
10 incorrect -- her view was that at the stage when you
11 were being called, Raychel's pupils were sluggish.
12 At the time -- it may just be that she was fast
13 deteriorating and so by the time you get to examine her,
14 they've moved from sluggish to being fixed. In fact,
15 you say, "Unresponsive, pupils dilated and
16 unresponsive". Is that the same thing as saying her
17 pupils were fixed and dilated?
18 A. Yes, she herself looked very unwell, was unresponsive
19 and the pupils then were dilated and not responding.
20 Q. And that presumably is an extremely serious sign --
21 A. Yes.
22 Q. -- so you have asked the nurse to contact your
23 consultant?
24 A. Yes.
25 Q. And is that while you are carrying on examining her?

1 A. I can't recall exactly how long it took me to examine
2 her, but it wouldn't have been a long, long time. You
3 can see there what I actually did do. I noticed that
4 her face was flushed, that she had a widespread red
5 rash, she had the petechiae. There was a monitor on
6 her, so that is obviously where I got the heart rate and
7 saturation level from. I'd have listened to her chest,
8 examined her abdomen, her limbs were flaccid and then
9 I just checked her plantars. I don't know how long that
10 took me. And I checked her pupils. I then knew I
11 needed further assistance because we were dealing with a
12 very sick child.
13 Q. And in fact, Dr McCord was reached --
14 A. Yes.
15 Q. -- and you spoke to him.
16 A. Yes.
17 Q. What would you have wanted to tell him?
18 THE CHAIRMAN: I'm sorry, let's go first. What do you
19 remember telling him? Or do you remember the
20 conversation that you had with him?
21 A. I remember Staff Nurse Noble saying that Dr McCord was
22 on the phone. I went out to speak to him on the phone
23 as Raychel was being moved to the treatment room.
24 I can't remember my exact words, but I do remember
25 saying, "Dr McCord, there's a very sick surgical girl



1 here, could you please come in?".
2 MS ANYADIKE-DANES: Okay, that's what you remember saying?
3 A. That's what I remember saying.
4 Q. Presumably it's going to take a period before Dr McCord
5 actually reaches the hospital; he's not on the hospital
6 premises.
7 A. No, he's not on the hospital site, but I knew he would
8 be in quickly.
9 Q. Of course. Presumably, if he had any guidance to give
10 you as to what to do in the interim, you would want to
11 receive that.
12 A. Yes.
13 Q. So bearing that in mind, what would you have wanted to
14 tell him about Raychel?
15 A. It's very hard in hindsight because looking back now,
16 you know what ideally -- in an ideal situation you would
17 want to say to a consultant to give them as much
18 information as possible. At the time, I cannot recall
19 what exactly I did say to him. I just knew that
20 I needed Dr McCord now.
21 Q. I understand that. That's why I put it in that way
22 because the sorts of things that you could have had in
23 your mind as to what to tell him, I'm trying to see what
24 that might be at your level of experience at the time.
25 What sort of thing would you have wanted to tell him so



1 that he could be possessed of as much information as he
2 reasonably could to guide you as to what to do, if
3 anything, before he arrived?
4 A. To start, you would want to tell somebody the past
5 history about the child, what had happened, what had
6 happened acutely, what had been done. But to start
7 telling somebody that sort of information whenever you
8 have a very sick child on the way to the treatment room,
9 it depends how long it would have taken me to tell him
10 that sort of -- that there I thought was delaying
11 Dr McCord getting in. I can't remember whether I told
12 him that Raychel had had a seizure, I can't remember
13 whether I told him about the sodium or whether I told
14 him about petechiae. I just remember telling him that
15 I had a very sick surgical girl and could he please come
16 in.
17 Q. If you were to distil out from the information that you
18 had at that time the most important things to be told --
19 A. Would be that she'd had a seizure, she had petechiae.
20 Q. And was her low sodium an important thing to tell him?
21 A. I was waiting on the repeat result. I didn't know
22 whether the low sodium was going to be a true result,
23 and obviously her pupils as well, but 12 years ago is
24 a long time ago and it is very hard to remember an exact
25 conversation.



1 Q. I understand. The reason why I'm asking you about
2 that is because Dr Haynes -- I've already explained his
3 position for the inquiry -- has said that when Dr McCord
4 was contacted by telephone, and assuming that he was
5 informed about the abnormal electrolyte results from the
6 first test, he could have instructed you to make an
7 attempt to administer hypotonic saline. So although,
8 of course, you don't want him to delay coming, but there
9 were some very discrete things that you could have told
10 him quickly. He could have been told that: she had
11 a seizure, her pupils were now fixed and dilated, she
12 had got an abnormal serum sodium result, which I am
13 having re-tested, and she had petechiae. He could have
14 been told that. As I understand it from what the
15 inquiry's expert says, if he had got that -- certainly
16 the combination of the seizure, fixed and dilated pupils
17 and the low sodium -- he could have been telling you,
18 even if in your experience you might not have been
19 willing, if I can put it that way, to start treatment in
20 those circumstances, your consultant could have been
21 telling you to immediately deal with the low sodium and
22 that's why I was asking you what could be in your mind
23 or might have been in your mind to tell Dr McCord. But
24 you don't recall anything of that sort?
25 A. I cannot recall exactly what I informed him of or didn't

1 inform him of.
2 Q. Thank you. In any event, Dr McCord comes. In relation
3 to --
4 THE CHAIRMAN: It is 11.55. Shall we give the stenographer
5 a break for a few minutes? We'll come back and, doctor,
6 I think if you have been following the inquiry you know
7 we break every couple of hours for the stenographer for
8 a few minutes. I'm hoping that we'll get your evidence
9 finished around lunchtime. Okay?
10 A. Thank you.
11 MR STITT: Mr Chairman, I've received considerable
12 assistance from the chief executive officer of the
13 Western Trust, Ms Way, who's in court today again. You
14 had specifically asked that someone in authority be
15 present yesterday and that was why she came. In fact,
16 mainly thanks to her offices and working late last night
17 with her assistants, we've got the documentation sorted.
18 She has asked me to enquire whether you require her
19 presence any longer before you today.
20 THE CHAIRMAN: No, not at all. When you told me yesterday
21 she was coming again today I thought that was because
22 she was coming to observe the inquiry because she would
23 have a natural interest in it as chief executive, rather
24 than I specifically asked her to be here again. I don't
25 think it is necessary to continue and I have to say I'm



1 not sure if there are any outstanding issues. But if
2 there are, can I assume Ms Way would be available at the
3 end of a phone to you at some point later on today or
4 tomorrow?
5 MR STITT: Yes.
6 THE CHAIRMAN: Then thank you very much for coming.
7 (11.59 am)
8 (A short break)
9 (12.22 pm)
10 MS ANYADIKE-DANES: Dr Trainor, can you help us with, if
11 you have a recollection of this, whether the second set
12 of results came back before Dr McCord arrived or
13 afterwards?
14 A. As far as I can remember, we were in the treatment room
15 with Raychel, she had taken more unwell whenever she
16 went into the treatment room and had been intubated and
17 ventilated. Dr McCord had arrived after that stage and
18 then as far as I can remember, the second set of results
19 then came through, just after he arrived.
20 Q. What did you say to him as soon as he arrived, so far as
21 you can remember?
22 A. Well, whenever Dr McCord arrived he saw for himself the
23 situation. The anaesthetist was there and she had been
24 intubated and was being ventilated so he saw for himself
25 that we were dealing with a very unwell child. I can't



1 remember exactly what I told him. My normal practice,
2 if somebody did come in to see a sick child, would be to
3 give them a run down on what had happened. I can't
4 remember what I told him, what I said, but I'd say he
5 saw for himself that we were dealing with a very sick
6 child and I do remember, just shortly after he arrived,
7 maybe a minute or two later, the repeat electrolytes
8 came back and that is when we said about stopping the
9 No. 18, putting up normal saline and I did that
10 calculation to work out what two-thirds of maintenance
11 was.
12 Q. At whose instigation was that? Did you, as soon as you
13 saw that result, know what you were going to do as
14 a result of that or was it that Dr McCord said, "This is
15 what we ought to do"?
16 A. It was 12 years ago, I can't remember, I can't remember
17 whose decision it was. Obviously, if I got the sodium
18 result back, everybody else in the room I'm sure knew
19 about the repeat sodium as well, so I can't say exactly
20 whose decision it was, but the decision was made to
21 change the fluids.
22 Q. And then when you say "he would have seen the situation
23 himself", I take it one of the things he'd be looking at
24 is to see the state of her pupils?
25 A. It wouldn't happen very often. I actually can't recall



1 any other times that -- that up to that time there would
2 have been a child intubated and ventilated in the
3 treatment room. So once he came through the door he
4 would have realised the seriousness of the situation.
5 I think he made notes about examining Raychel's pupils
6 as well.
7 Q. And when you had examined her a little while earlier,
8 her pupils were fixed and dilated?
9 A. Yes, and unresponsive.
10 Q. And they were when he examined them, I take it?
11 A. I'd have to remind myself of his notes.
12 Q. He didn't tell you that they had started responding?
13 A. No, no.
14 Q. Can I ask you in this way: we have heard from the
15 clinicians and nurses and our experts that one carries
16 on treating a child right until either the child dies or
17 there is a decision made in the light of a brainstem
18 death test, one just carrying on treating a child,
19 that's just what one does. But when Dr Johnston was
20 giving his evidence, his view was it was very unlikely
21 that there was going to be a good outcome, I think his
22 expression was, in the light of how she presented and
23 the fact that her pupils were fixed and dilated. Would
24 you share that view?
25 A. Yes. Everybody in the room was aware just how unwell

1 Raychel was, but we weren't exactly sure what all was
2 going on. As I say, she'd recently received antibiotics
3 for query -- you know, had she meningococcal
4 septicaemia, meningitis. We were -- whenever she was in
5 the treatment room we were still trying to organise a CT
6 brain so things were ongoing and we were still working
7 to -- I had the differential diagnosis list recorded in
8 my notes. So even though we knew she was very unwell,
9 we still continued on with everything that I have
10 documented.
11 Q. I understand that. What I'm trying to ask you is that
12 once a child has reached the stage where the pupils are
13 fixed and dilated, have you personally had any
14 experience of a child recovering from that situation?
15 A. Well, I haven't personally, but the sick children would
16 be managed in the likes of a paediatric intensive care
17 unit, so you might be better asking their opinions. But
18 in my opinion, I haven't seen recovery from that
19 situation.
20 Q. Thank you. And in fact, part of the response to
21 treating Raychel is to change her fluids?
22 A. Yes.
23 Q. And you changed them to two-thirds of the maintenance
24 amount, so that's 40 ml an hour, you restrict them to
25 that. And you change the nature of the fluids so they



1 go from Solution No. 18 to 0.9 per cent normal saline.
2 A. Yes, No. 18 was stopped and the normal saline then was
3 put up and I did the calculation and got 40 ml an hour.
4 So the fluids were started at that rate.
5 Q. And the reason for doing all of that is to recognise the
6 fact that she might have too much fluid in her of
7 a low-sodium nature and to try and restrict that fluid
8 and increase the amount of sodium in her system --
9 A. Yes.
10 Q. -- basically?
11 A. Yes.
12 Q. And a CT scan was also arranged.
13 A. It was being organised. Whenever Raychel was taken to
14 the treatment room, there was -- it was a very busy
15 time. In the period I was called from when I was first
16 called at 4.15 until then, Raychel went down to the
17 CT scanner. I recollect roughly about 5.30, there was
18 an awful lot of the things happened in that hour and 15
19 minutes. One of the things that was being organised was
20 a CT scan of her brain. I'm not sure who made the phone
21 calls about that or who it was organising that, but we
22 knew it was under way and that that was going to be
23 performed as soon as possible.
24 Q. Were you aware of who else was there at the time?
25 A. 12 years ago is a long time ago and it is very --



1 there's certain things I remember, there's things
2 I can't remember. There obviously were a lot of people
3 about and a lot of people in the treatment room.
4 I remember Dr Johnston, I remember Staff Nurse Noble,
5 I remember Dr McCord. I vaguely remember other people
6 but I cannot remember who, and I remember -- yes.
7 Q. I understand. In terms of Raychel's parents, were you
8 aware of where they were at any time really when you
9 were there treating Raychel?
10 A. Whenever Raychel was first in room I, in Ward 6,
11 I remember whenever I went in to examine her somebody
12 was with me, but I do think that was a nurse. Now,
13 Raychel's parents could have been there at that time,
14 I cannot remember. I do remember in the treatment room
15 whenever Raychel was moved into the treatment room and
16 was in our treatment room there's a bed sort of in the
17 middle of the floor up against the wall. I do remember
18 whenever Raychel was in the treatment room before
19 anaesthetics had been called, I remember her dad being
20 there. And I do remember having a conversation with her
21 dad and I think Staff Nurse Noble was there as well
22 whenever I said to Raychel's dad that there was
23 something seriously wrong, I think was -- now I'm trying
24 to remember my words. I think I remember saying that
25 there was something seriously wrong with Raychel and my



1 consultant was coming in to see her. And then after
2 that, as far as I can recall, Raychel's dad, you know,
3 left the room and then a very, very short time after
4 that I know Raychel's condition deteriorated and we had
5 to call the anaesthetists -- call the anaesthetic
6 doctor.
7 Q. By deteriorating, do you mean she was starting to
8 desaturate?
9 A. Yes, her saturations started to drop and her respiratory
10 effort became poor, so I had to start bag-valve-mask
11 ventilation and the anaesthetists then had been the
12 anaesthetic doctor -- Dr Date, I think -- had been fast
13 bleeped, and then whenever she arrived she took over the
14 airway and breathing and intubated Raychel.
15 Q. When a child is ill, as Raychel appeared to you to be,
16 before she desaturated, so you know she's had the
17 seizure, her pupils are fixed and dilated, she's
18 flaccid, she's unresponsive in any way, in your
19 experience -- and tell me if you haven't had it -- is
20 desaturation a normal part of a downward trajectory in
21 condition?
22 A. Well, it's one of the things that you would worry about.
23 Whenever you have a very sick child there's different
24 ways they can deteriorate. But a child who has been
25 maintaining their saturations -- she had oxygen on the

1 whole time, but if the saturations start to fall and the
2 respiratory effort reduces, then you know you need
3 anaesthetic support as well.
4 Q. You may not have the experience maybe even now to say
5 what that means, so just say if you don't. But what is
6 going on in terms of deterioration that leads to the
7 desaturation? What brings it about?
8 A. Well, I suppose with Raychel, whenever she was initially
9 in the treatment room -- all this here happened within
10 a very, very short space of time. You know, Dr Johnston
11 had come back up and I was asking him to repeat other
12 bloods in view of meningococcal septicaemia and give
13 antibiotics. So there were a lot of different things
14 going on. I was still worried that she had
15 meningococcal septicaemia, I was worried about some
16 intracranial lesion. The repeat sodium wasn't back at
17 that stage, so there's a lot of different reasons why
18 children can deteriorate. But if you have a sick child
19 who's deteriorating, you need further assistance and
20 that's why we called anaesthetics.
21 Q. What was the cerebral lesion you thought? What would
22 that be?
23 A. I didn't know. A child who has previously been well who
24 has had a seizure, we had asked already was there
25 a history of epilepsy. Children can have seizures for



1 lots of different reasons, they can have temperatures
2 which can cause seizures, they can have infections like
3 meningococcal septicaemia, meningitis, I was just
4 thinking if there could be anything else going on.
5 Could she have had a bleed in her brain, was there
6 something else intracranial going on that I obviously
7 couldn't see until I got the CT scan.
8 Q. Yes. In terms of some sort of infection of the type
9 that you were concerned might be present, could that
10 happen in the absence of any fever?
11 A. Usually, most children would have temperatures, but
12 sometimes not all children, whenever they become sick
13 read the textbooks, so sometimes you could have children
14 who have infections and don't have a temperature, but
15 usually they would have. But for Raychel being so sick,
16 we wanted to cover all possibilities.
17 Q. Yes. And so I think you actually accompanied Raychel to
18 the scanner at about 5.30.
19 A. Yes, and I wrote my notes whenever I was down there.
20 Q. You say you did that with the anaesthetist. Does that
21 mean Dr Nesbitt?
22 A. I remember the anaesthetic doctor, Dr Date, being fast
23 bleeped and whenever she came into the treatment room
24 I know she took over from -- I was doing the
25 bag-valve-mask ventilation. I know she took over and



1 she did intubate Raychel. I honestly can't remember
2 then whenever we went to the CT scanner what anaesthetic
3 doctor was with us.
4 Q. I understand. Then you went with Raychel to intensive
5 care; is that right?
6 A. After she had the scan done, then I accompanied her with
7 other -- there was other people there.
8 Q. Yes.
9 A. We went to intensive care and then I went back, I can't
10 remember whether I went back to Ward 6 or whether I went
11 back to the neonatal unit.
12 Q. And then it's in the intensive care, in your first
13 witness statement for the inquiry, that you say you had
14 a brief conversation with Raychel's parents?
15 A. Yes. I can't recall that 12 years --
16 Q. Let me pull it up for you in fairness to you. It's
17 030/1, page 3. Right at the top:
18 "In intensive care, I had a brief conversation with
19 Raychel's parents and explained that Raychel was very
20 ill and the anaesthetists were looking after her."
21 A. Yes. If I wrote that down, then that did happen.
22 I can't remember having the conversation or what I said,
23 but I don't know if you're familiar with the intensive
24 care unit in Altnagelvin. The parents' room where the
25 parents or relatives sit is on the way into intensive



1 care. So whenever I would have been coming back out of
2 intensive care, I would have left Raychel with the
3 anaesthetists and the intensive care nurses. So on my
4 way back out, what I am assuming from that there is
5 I passed the room where the parents were sitting and
6 obviously Raychel's parents were very upset and anxious
7 and probably what has happened is as I was passing then
8 I spoke to them and explained that she was still very
9 ill and that the anaesthetic doctors were looking after
10 her. I just have to go by what I've wrote down there as
11 I can't remember what I said.
12 Q. I understand you can't remember what you said. Do you
13 recall the exchange with them even if you can't remember
14 what you said?
15 A. I can't really, sorry. There's certain things
16 I remember and there's other things I can't remember.
17 Q. That's all right. Were you aware of whether anybody
18 else had spoken to Raychel's parents to try and give
19 them information as to Raychel's condition, what they
20 were doing for her and what might happen in the next
21 short period of time? Were you aware of any of that?
22 A. I wasn't aware of who said what or what exactly was
23 said.
24 Q. Well, not necessarily what was said. Were you aware as
25 to whether any clinician, really, had spoken to

1 Raychel's parents?
2 A. I'm not sure. I spent -- whenever she was up on the
3 ward, I spent all of my time in the treatment room.
4 I can't recall then whether Dr McCord spoke to the
5 parents or any of the relatives. You would have to ask
6 him that, or whether any of the anaesthetic staff said
7 anything. I'm not sure.
8 Q. And your response to the parents was a human one,
9 I presume, because you've just been in with their child
10 who's very ill, you see them there by themselves,
11 I presume --
12 A. I don't know now if there was anybody else. I know
13 Raychel's dad had phoned Raychel's mum to come in.
14 I assume both of them were down in intensive care at
15 that stage. As I say, I can't remember, but they were
16 obviously very, very upset -- naturally so -- and very
17 anxious.
18 Q. In the general scheme of things in your experience, who
19 did you expect would be the person to explain matters to
20 Raychel's parents?
21 A. Whenever a child is sick, there would always be somebody
22 who would speak to the parents and let the parents know
23 what's going on. But whenever you're dealing with
24 a child acutely, I know what I said to the dad initially
25 before we had to get anaesthetic staff. After that,



1 some member of the team would be speaking to parents or
2 relatives, but it all sort of depends on the situation
3 who that would be and what they would say.
4 Q. Yes.
5 A. We wouldn't leave parents not knowing what was going on.
6 Q. Yes. Then a decision is made for Raychel to be
7 transferred to the Children's Hospital.
8 A. Yes.
9 Q. Do you know who makes that decision, how that comes
10 about?
11 A. Well, I know that the only paediatric intensive care
12 unit in the province is in Belfast, so if you have
13 a child who is intubated and ventilated, in my
14 experience I know that that's where they would be
15 transferred to. But now I don't know who made the call
16 to paediatric intensive care or how that came about.
17 But I know that sick children who are intubated and
18 ventilated, that is where they would be cared for.
19 Q. You, in fact, wrote up the transfer letter.
20 A. I did.
21 Q. We can pull that up. 063-005-010. I think there are
22 two pages of it, so if we can pull up the 011 next to
23 it. This is your transfer letter. You've got
24 a summary. Is that what you're trying to provide as to
25 what's happened, her current state, the results of any



1 immediate tests that have been carried out?
2 A. Yes. This is -- I finished work that morning at
3 approximately 9 o'clock and then, before I went off
4 duty -- I was off duty, but before I left the building
5 I went down to see how Raychel was. And while I was
6 there, because I knew what had happened from 4.15 in the
7 morning until she went to intensive care, then
8 I volunteered to write the transfer letter for her
9 transfer.
10 Q. Yes. Is that letter accompanied by the transfer
11 referral sheet?
12 A. I don't know now. I just did that letter because I knew
13 then the doctors in Belfast would have an account of
14 what happened with us. I don't know what other
15 documentation went with her.
16 Q. You've recorded her electrolyte results and therefore
17 the low sodium. Can we see if there's a 012?
18 063-005-012. That's the other half of it. The
19 immediately preceding page showed the sodium result of
20 118. And then this is what's happened, you indicate the
21 fluids have been changed and so on.
22 There's no reference that I could see to
23 hyponatraemia in that. We've got her serum sodium
24 results but you have not mentioned specifically
25 hyponatraemia.



1 A. No, I didn't put the word "hyponatraemia", but they
2 could see the sodium was 118.
3 Q. Was hyponatraemia anything that you can recall having
4 discussed with Dr McCord?
5 A. Dr McCord knew the repeat sodium result was 118. So, by
6 definition, hyponatraemia is where the sodium is below
7 135. I don't know whether the word was mentioned, but
8 we knew that the sodium was low at 118.
9 Q. When she came back from the scan, cerebral oedema was
10 clear on the scan. There was, at one point, thought
11 that there might be some sort of haemorrhage that would
12 be shown on it.
13 A. I can only go by what is written down from back then.
14 I have down there:
15 "Initially subarachnoid haemorrhage found with
16 evidence of increased pressure."
17 And then I have got the last line, "Repeat CT
18 requested". The fact that I haven't wrote in the result
19 of the second CT to me now means that I didn't know the
20 result of the second CT when I did that letter. I was
21 off duty at that time and I had went down to see how
22 things were and had volunteered to do the letter out of
23 helpfulness.
24 Q. Yes. So it may be that at that stage you didn't
25 appreciate that the haemorrhage, the thought that there

1 might be one, had been ruled out by the second --
2 A. No, because I havent recorded the result of the second
3 CT.
4 Q. Can we pull up 020-024-052? This is the transfer
5 referral sheet. Is this something you've seen before?
6 A. No, it wouldn't be a document that I would have been
7 used to seeing.
8 Q. You wouldn't be used to seeing a transfer referral
9 sheet? There's a number of different hands who seem to
10 have written it. If we look at the principal diagnosis,
11 "Initial: appendicitis". I'm not sure what that first
12 query is or whether it has been struck out, but there's
13 a "query meningitis", a "query encephalitis". There
14 doesn't seem to be any reference on that to
15 hyponatraemia, but you didn't see this sheet.
16 A. No, I just did the transfer letter and my handwriting is
17 fairly obviously so I know that --
18 Q. Thank you. And I take it from how you said that this
19 isn't something you would typically see that you weren't
20 asked for your view as to how the transfer referral
21 sheet might be completed accurately?
22 A. No, I just did the transfer letter for the doctors in
23 Belfast. That was my sheets.
24 Q. Thank you. Leaving aside the suggestion of a bleed, was
25 there any thought that the hyponatraemia might have



1 caused the cerebral oedema so far as you're aware?
2 A. Back then, I can't recollect what exactly my impression
3 was or -- because there was several things that we were
4 worried about.
5 Q. I understand. So Raychel is duly transferred to the
6 Children's Hospital. When do you learn that she has
7 died?
8 THE CHAIRMAN: Sorry, just before you answer that, when she
9 was transferred to the Royal, doctor, did you think her
10 position was hopeless?
11 A. I knew she was a very, very sick child.
12 THE CHAIRMAN: But did you think there was any chance that
13 she was going to survive?
14 A. It's very hard now to think back. I think what I was
15 thinking 12 years ago -- I knew the fact that her pupils
16 were fixed and dilated was a very bad sign and I knew
17 that she was extremely unwell.
18 THE CHAIRMAN: Okay, thank you.
19 MS ANYADIKE-DANES: If we just complete that. All the time
20 that you had been with her, there had been no indication
21 of any change in her condition, if I can put it that
22 way, apart from a deterioration when she started to
23 desaturate.
24 A. Yes, at that time there she deteriorated, yes. Then
25 after that, no, she -- what exactly do you mean?



1 Q. What I was asking you is apart from that period of
2 actual deterioration, there had been no real change in
3 her condition all the time you'd been with her.
4 A. Do you mean like in general or observation-wise --
5 Q. Well, she hadn't improved --
6 A. No.
7 Q. -- and she had a period where she actually got worse.
8 A. Yes.
9 Q. And then if you can help me with when you first learnt
10 that Raychel had died and how you learnt that.
11 A. I can't honestly remember when I heard or when I first
12 learnt. I would have been -- I had done the 24-hour
13 shift on the Friday and I would have been back again on
14 the Sunday to do a further 24-hour shift, but I don't
15 recall whether I heard on the Sunday or the Monday.
16 I don't recall who told me or I don't recall that I'd
17 heard what had happened or what the outcome was.
18 I can't remember that.
19 THE CHAIRMAN: It would have been a natural thing for you to
20 ask at some point when you came back in, wouldn't it?
21 A. I'd have been working a 24-hour shift on a Sunday, but
22 I don't know on that Sunday how much time I spent on the
23 ward, how much time I spent in neonatal, what sort of
24 a day it was. I'm sure I did hear at some stage, but
25 I don't know when or how.



1 THE CHAIRMAN: Thank you.
2 MS ANYADIKE-DANES: And did you hear that there was going to
3 be a critical incident review, a meeting, to try and
4 establish what had happened and to see what lessons
5 might be learnt; did you hear that?
6 A. I can't remember whether I heard about that or not
7 because I then would have been on Sunday 24 hours, would
8 have went off on the Monday morning, 9 o'clock, and
9 actually I was on that Tuesday again for a further
10 24-hour shift. So I don't know whether I had heard
11 about the meeting or not.
12 Q. Well, did anybody contact you to find out what you knew
13 about what had happened with a view to trying to
14 establish the facts and to see what lessons might be
15 learnt?
16 A. I can't remember that.
17 Q. Let me see if I can pull up something for you.
18 Dr Fulton, who was the medical director, as I'm sure you
19 know, at that time in Altnagelvin, made a statement to
20 the PSNI. He has since said that what he has said in
21 here isn't necessarily accurate as to who actually
22 attended this meeting, but in this statement he lists
23 out those who, in his view at that time, did. If we can
24 go to 095-011-049.
25 There's a list. The critical incident enquiry

1 started at 4 pm. He had been asked to establish that,
2 as you can see right at the top. The chief executive,
3 Stella Burnside, had asked that the Trust move into its
4 protocol for how to deal with critical incidents.
5 Can I just pause there: were you aware that the
6 Trust had a protocol for how to deal with critical
7 incidents?
8 A. At that time I wasn't aware.
9 Q. In any event, the enquiry started at 4 pm on the
10 Tuesday. And he lists out who the staff were who were
11 to be there to establish the critical facts, and you can
12 see that your name, albeit incorrectly spelt, is there,
13 "Dr Bernie Trainor", and you can see all the others who
14 are there, who are part of the nurses and clinicians who
15 treated Raychel over the period of her admission. Do
16 you remember being at a meeting like that?
17 A. I don't remember being at that meeting. Now, I'm not
18 saying that I wasn't at the meeting, but I cannot recall
19 anything about being at that meeting or what happened.
20 So I don't know if I was there or not. I know I was on
21 a 24-hour shift that Tuesday, 12 June, so if that
22 meeting was at 4 o'clock, I would have been taking over
23 emergency work, you know, at 5. So I don't know whether
24 I would have been there or not, but I have absolutely no
25 recollection of being asked or being at the meeting.



1 Q. If you had been at a meeting like that, where they were
2 going to discuss in frank terms what had happened, why
3 it had happened, with a view to seeing what could be put
4 in place to reduce the chances of that happening again,
5 do you think you're likely to have remembered that?
6 A. It's very hard -- as I've said before, 12 years ago is
7 a long time ago. You would hope you would remember
8 something, but I remember nothing from that meeting. So
9 I don't know whether I was there or not.
10 Q. That's why I was framing it in terms of whether you
11 think you are likely to recall something like that. For
12 example, can I ask you this: was Raychel the first child
13 who you'd treated who had died?
14 A. As far as I can recall, whenever I was in children's,
15 I had come across ... I can think of at least one child
16 who had died, but that was a very different case. This
17 other child had a very different diagnosis. So it
18 wouldn't have been the first child that I had come
19 across who had died.
20 Q. Were you aware that such a meeting happened even if you
21 don't recall actually being part of it, that there was
22 a meeting like that amongst clinicians and nurses to try
23 and, in the aftermath of Raychel, see what had happened?
24 Were you aware of that?
25 A. I can't recall being aware of the meeting, but then with



1 being on the 24-hour shift on the Tuesday, I would have
2 went off again on the Wednesday morning at 9 o'clock.
3 Q. Yes. Well, did it come to your attention that certain
4 changes were being proposed as a result of Raychel's
5 death?
6 A. I knew that the surgical patients -- I think it was
7 maybe the next day or later on in that week -- I know
8 then that there was a decision made that the surgical
9 patients weren't to get No. 18 Solution any more.
10 I remember that happening.
11 Q. Yes. We can pull up a notice, 095-011-059j; do you
12 recall seeing that notice anywhere?
13 A. I don't recall seeing that notice exactly. That doesn't
14 mean to say it wasn't up or I didn't see it, but I know
15 that the surgical patients then weren't prescribed
16 Solution No. 18.
17 Q. I'm going to pull up something else and see if you were
18 aware of this happening. 095-010-046ab. It is a letter
19 where Dr Nesbitt, who was the clinical director of
20 anaesthesia and critical care, writes to Mr Bateson,
21 who's the clinical director of the surgical directorate.
22 He writes that fairly shortly afterwards, 3 July 2001.
23 He says that he's asked his anaesthetic colleagues to
24 prescribe Hartmann's solution instead of No. 18. He has
25 been asked as part of that review to do some research



1 work on Solution No. 18. You can see in the middle
2 paragraph:
3 "The problem in the children's ward seems to be that
4 even if Hartmann's was prescribed, it was changed to
5 No. 18 by default. I therefore asked Sister Millar to
6 change this policy so that for surgical children the
7 default solution became Hartmann's. With agreement, it
8 may also be possible for paediatricians to undertake the
9 fluid management of surgical children. Obviously this
10 impacts on surgical care and needs your support."
11 Pausing there for a minute, were you aware of any of
12 that that's being discussed in that middle paragraph?
13 Well, first up, that Solution No. 18 was the default
14 solution so even if a child was actually prescribed with
15 Hartmann's, it would be changed to Solution No. 18 on
16 Ward 6. Were you aware of that?
17 A. But that there would be then for the surgical patients.
18 I wasn't involved in the prescribing of fluids for
19 surgical patients. I know that the medical patients,
20 whenever I was there in Altnagelvin in 2000, got No. 18,
21 but I can't comment when the surgical patients' fluids
22 were changed from Hartmann's to No. 18 because I wasn't
23 involved in looking after the surgical patients' fluids.
24 Q. And you never heard any discussion about that?
25 A. No, I just knew that the medical patients got No. 18

1 Solution.
2 Q. And was it ever appropriate, for clinical reasons, for
3 a medical patient to get something other than
4 Solution No. 18 that you were aware of?
5 A. I cannot remember 12 years ago what other fluids --
6 there would have been other fluids in the ward and in
7 pharmacy, but I know that I was familiar with No. 18.
8 I'm not saying that other fluids weren't used or weren't
9 prescribed. There was babies who needed dextrose and
10 sodium and potassium additives. There was a variety of
11 fluids. But the most commonly one used in paediatrics
12 was No. 18, but other ones could have been used at
13 different times. I cannot remember.
14 Q. Yes. So I know that you say that you can't remember,
15 but would your assessment of it be that it wasn't
16 entirely rigid that it had to be Solution No. 18?
17 A. I say I remember No. 18, but I can't remember any -- I'm
18 not saying that there wasn't other occasions that other
19 fluids weren't used because I know there was other
20 fluids available.
21 Q. Okay. Then if we go to the penultimate sentence in that
22 paragraph:
23 "With agreement, it may also be possible for the
24 paediatricians to undertake the fluid management of
25 surgical children. Obviously, this impacts on surgical



1 care and needs your support."
2 Were you aware of that suggestion at any time?
3 A. No. Well, you see I never -- you know, at that time in
4 2001, I never saw that letter and I was in Altnagelvin
5 as a middle-grade SHO for the month of July and
6 then August I would have moved back to Belfast. But
7 in the time I was in Altnagelvin, you know, I was still
8 under the impression that the surgeons were still
9 prescribing fluids for the surgical patients and the
10 medical doctors were prescribing fluids for the medical
11 patients.
12 Q. So if there was any discussion about a possible change
13 in practice, it's not one that you became aware of
14 before you left; is that what you're saying?
15 A. No, but I was junior whenever I was there, I was
16 a middle-grade SHO, so I don't know, if there were any
17 discussions, whether I was part of it or not.
18 THE CHAIRMAN: Or if those discussions led to agreement,
19 that agreement took effect before you left. You don't
20 know that.
21 A. No, whenever my time in Altnagelvin -- I say I, you
22 know, wasn't involved in routinely writing up fluids for
23 surgical patients.
24 THE CHAIRMAN: Thank you.
25 MS ANYADIKE-DANES: Then if I ask you finally in relation to



1 this letter, you see the penultimate paragraph:
2 "Some clinicians evidently feel that Solution No. 18
3 is a fluid they wish to prescribe and have disagreed
4 with the regime suggested. Obviously, clinical judgment
5 is important and I am sure that there is a place for
6 No. 18 Solution, but I am concerned that my attempt to
7 put in place a safe policy has met with resistance so
8 quickly."
9 Were you aware of any of what is being discussed
10 there?
11 A. No.
12 Q. Altnagelvin is not a very big hospital, I presume, and
13 Ward 6 is not a very big ward.
14 A. It's fairly big.
15 Q. Well, if there's a child who has died, not too big for
16 that not to be the subject of discussion, both
17 in relation to the ward and possibly the hospital in
18 general. But were you aware of any discussion about
19 Raychel after her death?
20 A. I can't remember when exactly I heard that Raychel had
21 died and obviously, having met her in the early hours of
22 Saturday morning, it was very upsetting for all
23 involved. But I cannot remember what other
24 conversations there were or what was discussed and then,
25 in August, then I moved on to a different hospital.



1 Q. I appreciate that. But Raychel has died in June. Would
2 it not be unusual for people not to be discussing that,
3 particularly as nobody thought that this child would
4 die? She came in to have a fairly -- if there is such
5 a thing -- straightforward appendicectomy. And nobody
6 thought that anything serious would happen to her. Even
7 at the ward round and the following day from her
8 surgery, it was thought that she was making fairly
9 standard progress towards being discharged possibly the
10 next day. So when a child then deteriorates in the way
11 that she did and dies, it wouldn't be unusual to suppose
12 that there'd be some discussion about that.
13 A. No. You would assume that there would be some sort of
14 discussion, but I cannot remember being involved in any
15 of the discussions or what was discussed.
16 Q. Did you want to know, given that you had come in towards
17 the end of it, really to respond to a crisis, did you
18 not want to know what had happened even from the point
19 of view of your own medical knowledge, what had happened
20 to her?
21 A. Whenever Raychel was transferred to Belfast, initially
22 we were under the impression that she had a subarachnoid
23 haemorrhage and I know then it came to light later that
24 that was wasn't the case. But I don't know when I --
25 I knew then whenever No. 18 was not being prescribed for

1 the surgical patients that there was obviously an issue
2 with that. But it was probably -- you know, because
3 I don't know how quickly post-mortem results came out or
4 how I heard about those sort of results. As I say,
5 I can't remember.
6 Q. Can I just ask you one final question subject to
7 anything anyone else may want to ask you? When you say
8 there was a thought that she had had a subarachnoid
9 haemorrhage and she was going to the Children's
10 Hospital, was there any thought that she was going to
11 the Children's Hospital for that to be treated?
12 A. I can't recall whenever we were in the CT scanner
13 when -- you know, who was involved in the discussions
14 with, you know, the neurosurgeons or whatever. So ...
15 Q. Sorry, I'm probably phrasing it badly. I'm not asking
16 you to recant exactly who said what to whom about it.
17 Was your sense that she was being sent to the Children's
18 Hospital so that something in relation to that could be
19 treated?
20 A. No, well, I knew she was going to intensive care in
21 Belfast because she needed the support of paediatric
22 intensive care. I didn't know what exactly she was
23 going for and then she'd had the repeat CT, which
24 I didn't have the result of, so I wasn't aware of
25 whether she was going for any procedures. I knew she



1 needed paediatric intensive care support and had to be
2 transferred to Belfast for that.
3 Q. Yes. All the time that you were there towards that end,
4 after she'd had the first CT scan, was there any
5 discussion about the possibility that surgery might be
6 something that could relieve that kind of bleeding?
7 A. I can't recall the conversations after the scan was
8 done, what was discussed or what Belfast had advised.
9 MS ANYADIKE-DANES: Thank you very much.
10 Mr Chairman, I have no further questions.
11 THE CHAIRMAN: Thank you.
12 Doctor, you then went to the Royal from August 2001
13 to August 2002; is that right?
14 A. Yes.
15 THE CHAIRMAN: When you got to the Royal, did you find that
16 Solution No. 18 was no longer used there?
17 A. I can't remember. You know, that's 11 years ago, and I
18 can't ... I know it stopped in Altnagelvin for the
19 surgical patients just after Raychel died and then
20 I know it stopped a short time later for the paediatric
21 patients. But I can't remember, whenever I went to
22 Belfast, what their fluid policy was.
23 THE CHAIRMAN: Well, maybe this is even more difficult. Do
24 you remember it being used when you were in the Royal
25 from 1998 to 2000?



1 A. I can't remember.
2 THE CHAIRMAN: Okay, thank you.
3 Mr Quinn, do you have anything?
4 MR QUINN: I have a couple of issues I want to ask about,
5 Mr Chairman.
6 Given what we have heard about Raychel's demeanour
7 after 4 o'clock in the morning in particular, was she
8 moving about? Was she able to move about or was it
9 observed that she was moving? Or was she, as it was,
10 comatose?
11 THE CHAIRMAN: Was there any movement from Raychel?
12 A. I can only go from the medical notes that I have wrote.
13 I think I have down that she was unresponsive and her
14 limbs were flaccid.
15 MR QUINN: And would you expect then that Dr Nesbitt would
16 tell the parents that when he was in the back of the
17 ambulance with her on the way to the RBH that there was
18 plenty of movement, which was a good sign?
19 A. I can't comment on that.
20 THE CHAIRMAN: Well, if there was movement, that is
21 something which you didn't see during your involvement
22 after 4 o'clock.
23 A. No, she was unresponsive whenever I saw her.
24 THE CHAIRMAN: Okay.
25 MR QUINN: That's the first point. The second point is: was



1 there a doctor, or perhaps a senior nurse, with a beard
2 who would have given the parents advice or spoken to the
3 parents just before she was transferred to Belfast?
4 A. A doctor or a nurse?
5 MR QUINN: A doctor or perhaps a senior nurse with a beard
6 who would have communicated with the parents just before
7 her transfer to Belfast. I'm asking this question
8 because both parents clearly recollect that this person
9 told them that she was being transferred for an
10 operation, as one parent called it, and surgery as the
11 other parent called it.
12 A. I can't recall who else the parents would have been
13 speaking to.
14 MR QUINN: In your mind, was there any hope for Raychel
15 in relation to a surgical procedure?
16 A. Well, I suppose that sort of wasn't for me to say
17 because I was very junior at that time and that's where
18 neurosurgeons and whatever would have become involved.
19 I wouldn't have any sort of thoughts about that.
20 MR QUINN: In your career, from 2001 to date and given your
21 relatively senior position now, have you attended any
22 other critical incident reviews?
23 A. Um ... I'm trying to think over the last number of
24 years. No, no other critical incident reviews.
25 MR QUINN: So would be it fair to say had you attended this

1 one, it would have stuck in your mind?
2 A. You have to remember 12 years ago ... I am not saying I
3 wasn't at it. I might have been at it, but I have
4 absolutely no recollection.
5 THE CHAIRMAN: Thank you. Mr Campbell, Mr Stitt? Okay.
6 Doctor, unless there's anything you want to add
7 before you leave, that brings an end to your evidence
8 at the inquiry. Thank you for coming. You're free to
9 go.
10 (The witness withdrew)
11 Ladies and gentlemen, Mr Zafar has come back this
12 afternoon to complete his evidence. In order to make
13 sure we get through it this afternoon, we'll resume at
14 1.45.
15 (1.08 pm)
16 (The Short Adjournment)
17 (1.45 pm)
18 (Delay in proceedings)
19 (1.50 pm)
20 MR MUHAMMAD ZAFAR (continued)
21 Questions from MS ANYADIKE-DANES (continued)
22 THE CHAIRMAN: Mr Zafar, thank you for coming back again.
23 You're still under oath from when you started your
24 evidence last time.
25 A. Thank you, sir.



1 MS ANYADIKE-DANES: Good afternoon, Mr Zafar. Mr Zafar,
2 have you discussed your evidence with anybody since
3 you were last here giving evidence?
4 A. No, I was in England.
5 Q. Thank you. I want to take you back to where we were
6 last time, which is at the time of the ward round that
7 you carried out. On the last occasion, I was asking you
8 about the documents that you saw when you were carrying
9 out that ward round. Since then, we've had quite a bit
10 of evidence from other witnesses, indicating the charts
11 that are available by the bed and those documents or
12 records that may be kept elsewhere.
13 If we just pull this up quickly, 020-007-013. So
14 you've made your notes in the general clinical notes.
15 A. Yes.
16 Q. And those notes would have started with Mr Makar's
17 surgical note; is that correct?
18 A. Right.
19 Q. And that surgical note is one that would have been
20 entered into on 7 June. You then write your ward round
21 note on 8 June.
22 A. Right.
23 Q. And if you're writing your note in that document,
24 you will have seen that there is no note between when
25 Mr Makar makes his entry and when you make yours;



1 is that correct?
2 A. Yes. I didn't see anything, yes, that I can remember.
3 Q. So that was clearly available to you.
4 A. Yes.
5 Q. One of the things I was asking you about is whether you
6 saw the fluid balance chart. Let me pull it up because
7 some people refer to it in a different way. If I can
8 pull up 020-018-037. When you are seeing Raychel,
9 there's probably only one entry on there, which is that
10 which would have been at 8 o'clock --
11 A. Yes.
12 Q. -- and the entry that you would have seen is "vomit".
13 A. I haven't remember -- I don't remember and I have seen
14 that vomit or not, no one has told me at that time.
15 I did the round around -- between 8 and 9, I don't know
16 exactly the time, but I don't remember. At that time
17 fluid entry was -- I don't remember as well how much was
18 there.
19 Q. I understand. So you don't remember whether you looked
20 at this chart. Can we start with that first?
21 A. No, well, charts were there, but I don't remember that
22 it was -- because it was start of there that I
23 couldn't -- I couldn't memorise now how much was fluid
24 there or not.
25 Q. So you have accepted the chart was there.



1 A. Yes.
2 Q. Sister Millar, who was present there as you conducted
3 your ward round, her evidence was that she told you that
4 there was a vomit, but in any event -- if you wait and
5 just bear with me a minute -- she says that the vomit
6 was recorded on the fluid balance sheet and therefore
7 was there so that you could see it.
8 A. Right. I don't remember that because it's so far, and
9 it was there or not there, and I don't remember that she
10 has told me that, that there was vomit.
11 THE CHAIRMAN: How important would it have been at this ward
12 round if you had been told that Raychel had vomited?
13 A. Well, it was important for me, then I have to look in
14 other sides as well. It's only one vomit, how big is,
15 and which kind of that vomit is --
16 THE CHAIRMAN: Let's assume for the moment that the record
17 was there or it was drawn to your attention, and it was
18 the only vomit and that there was no measurement of it,
19 you had no indication whether it was small, medium or
20 large. If you had been told that Raychel had vomited
21 once, had vomited quite recently perhaps, but nobody had
22 an idea of how large the vomit was, how important would
23 that be for your assessment of how she was and how the
24 day might progress?
25 A. Well, I have gone on my examination, what I have done,

1 that she was feeling very well at that time, apyrexial.
2 She didn't show me any signs of any deterioration at
3 that time. I have gone on that side. And I have just
4 asked the nurse, please could you observe her further
5 and see that if there's any problem or not.
6 MS ANYADIKE-DANES: Yes. But in answer to the chairman, you
7 would have wanted to know that she had vomited.
8 A. I haven't noted that.
9 Q. No, no, you would have wanted to know that.
10 A. Yes, would like to.
11 Q. Thank you. You knew that she was, at that time, on
12 IV fluids.
13 A. She was. That's why I stopped that -- reduced the
14 fluid, not stopped.
15 Q. Bear with me a minute. You knew she was on IV fluids.
16 A. Yes.
17 Q. Did you know those IV fluids were Solution No. 18
18 fluids?
19 A. That, I don't recall that.
20 Q. Would it not have been important to find out what the
21 type of fluid is that she's on?
22 A. Well, I mean, my intention was that -- reduce the fluid
23 and stop the fluid.
24 Q. Yes, I understand that.
25 A. That's why I haven't gone that direction to find out



1 which kind of fluid is, how much is going on at that
2 stage, and why. I mean, I don't know that. Because my
3 all attention was gone towards the direction of that
4 that she is so well enough she doesn't require further,
5 within, one or two hours any further fluid.
6 Q. But would it not be part of a normal assessment to
7 see -- sorry, excuse me -- what she was on, how long she
8 had been on it, and what rate it had been administered?
9 Would that not be a normal part of an assessment of
10 a child?
11 A. This is a normal part of that assessment, but my
12 question is here that -- I mean, if she is doing well,
13 my consultation is not going that side that what fluid
14 she is taking. And that's why I haven't thought that,
15 that's something I need to know which fluid she is
16 taking.
17 Q. Yes. Did you know at that stage whether she had had an
18 electrolyte test done for that day?
19 A. I don't know that.
20 Q. If you had known that she had vomited, would you have
21 wanted an electrolyte test done?
22 A. Well, it depends on the vomit. First of all, if -- one
23 vomit will not indicate to do immediately electrolyte
24 tests if there's no deterioration. If there's some sort
25 of deterioration is coming out, then you are going to do



1 their electrolytes.
2 Q. Okay. You said that you can't remember looking at this
3 fluid balance sheet. This is the one that starts on
4 8 June. There was one for 7 June and there is
5 a prescription for her fluids. Okay? The prescription
6 for her fluids is a prescription that was written up by
7 Mr Makar. He wrote that up for her pre-surgical
8 condition, if I can put it that way.
9 A. Right.
10 Q. When she came out of surgery and got back on the ward,
11 she was put back on that pre-surgical prescription. If
12 you had been told that, would it have surprised you?
13 A. No, but I -- definitely I thought questioning myself,
14 why it is that starting. I mean, I can't predict now,
15 at this stage, that at that time what I have done.
16 Well, naturally, I have thought that, why it is pre
17 prescription and continuation is there. When she
18 doesn't need any further fluid, she has no deterioration
19 at that time, and I definitely -- I think about that at
20 that time. I can't say what I was thinking at that
21 time.
22 Q. No, I appreciate that. I'm simply asking for your
23 response to it. Mr Makar's own response is that he
24 would not have thought that it was appropriate for
25 a prescription that he had written up with a rate that



1 was suitable for her pre-surgical condition to have been
2 reinstated post surgery without any further review as to
3 whether it continued to be appropriate.
4 A. No, I agree with that, but the question is mine -- that
5 I have stopped that fluid, further reduced that fluid,
6 don't carry on that fluid, she doesn't need that.
7 That's why I didn't feel at that time to look about that
8 all documents.
9 Q. I'm going to come to that in a minute. What I'm really
10 trying to get at, if you like, is to get some
11 understanding of what the practice was on Ward 6.
12 Because there are some witnesses who have said that the
13 practice on Ward 6 is, unless there was any indication
14 to the contrary, what had been prescribed before surgery
15 would simply be started up again once the child had got
16 back on to the ward. Mr Makar expressed his surprise at
17 that or his concern about that. I'm asking you whether
18 you were aware that that was something that happened in
19 Ward 6.
20 A. I don't remember that. I don't know that.
21 Q. You don't remember or you don't know?
22 A. No, I don't know as well I don't remember.
23 THE CHAIRMAN: If that was the practice, would you agree
24 with Mr Makar that that practice was wrong?
25 A. It's now or at that time?

1 THE CHAIRMAN: At that time. The question is this,
2 Mr Zafar: there is some evidence that after children had
3 surgery and if they had to go on IV fluids, the
4 pre-surgical IV fluid and rate would be what they would
5 go back on to after the surgery. Mr Makar says that
6 should not happen because a child's needs have to be
7 reassessed after surgery: you decide what fluid she
8 needs and you decide the rate of the fluid which she
9 needs. Do you agree with Mr Makar or would you have
10 been content that the pre-surgical fluid and rate then
11 became the post-surgical fluid and rate?
12 A. No, I will go on the -- I mean, the fluid, how much she
13 required, according to her body weight at that time
14 after surgery and the calculation of that will be on the
15 insensible losses during the surgery and the
16 anaesthetists have to assess that, how much fluid, how
17 much rate is going after how many hours after that
18 surgery.
19 THE CHAIRMAN: So you expect the fluid to be recalculated in
20 light of the surgery?
21 A. In light of the surgery, yes.
22 THE CHAIRMAN: Thank you.
23 MS ANYADIKE-DANES: And can you help with this: the actual
24 rate that was being administered to Raychel was 80 ml
25 an hour. That is a rate that Mr Makar prescribed and he



1 did so for reasons that he has already explained. So
2 although he recognised that perhaps a more normal rate
3 would be 65 ml, in those circumstances 80 ml was
4 appropriate. So can I ask you this: if you had known
5 that after her surgery, and without any further review,
6 the rate was being continued on at 80 ml an hour, would
7 you have considered 80 ml to be too high a rate?
8 Assuming nothing untoward happens that requires a slight
9 increase, would you have considered 80 ml of itself to
10 be too high?
11 A. During the surgery, the losses are not much and the
12 anaesthetists are agreed with that, that entirely
13 depends on that circumstances. Under normal
14 circumstances, IV fluids should be go according to her
15 body weight and the formula which is started since long,
16 Bush formula, and Mr Bush, he prescribed very nicely in
17 his papers that -- I mean, her body weight and plus ...
18 If someone is above 25 kilograms, just one half litre
19 plus 20 ml per kilogram added that and then start. It
20 all depends on that formula. I will consider that
21 formula, I will not go -- first of all, I will take the
22 ideas and views after surgery from the anaesthetist, who
23 was anaesthetising, and he knows how much fluid has gone
24 there and he knows how much fluid is lost there. And
25 then after that I will go on that side -- according to



1 the body weight. I'll go.
2 Q. The witnesses that we have had calculated, according to
3 the Holliday-Segar formula, have reached a rate of
4 somewhere between 65 and 67 ml an hour on the basis that
5 Raychel weighed 25 kilograms. Does that sound roughly
6 correct to you?
7 A. According his body weight is correct.
8 Q. Thank you.
9 THE CHAIRMAN: Sorry, there's another point. When you were
10 giving your answer a moment ago, you had said you would
11 take what the anaesthetist has decided after surgery.
12 A. I mean, there's initial one or two hours, definitely,
13 yes.
14 THE CHAIRMAN: Okay. So what you expect to happen is that
15 Mr Makar has prescribed fluids before the surgery.
16 A. Yes.
17 THE CHAIRMAN: The anaesthetist has then controlled the
18 fluids during surgery.
19 A. Yes.
20 THE CHAIRMAN: The anaesthetist has then prescribed the
21 fluids for the hours following surgery.
22 A. Four hours or 12, whatever, how might they consider
23 that ...
24 THE CHAIRMAN: What happens after the number of hours for
25 which the anaesthetist has prescribed the fluid and the



1 rate of fluid? Who takes over responsibility after
2 that?
3 A. Well, again, it's debatable here. An anaesthetist, if
4 she's not in intensive care category or not in an HDU
5 category and if she's going back to the ward, then the
6 responsibility is coming to the doctors who are looking
7 after her in the ward.
8 THE CHAIRMAN: And is that you coming round on the ward
9 round on the Friday morning?
10 A. Yes.
11 THE CHAIRMAN: Right. And your position is then it did come
12 back to being your responsibility the ward round --
13 A. Yes --
14 THE CHAIRMAN: -- but if I understand you correctly, you
15 were not particularly concerned about the fluid because
16 your approach was that because Raychel was well --
17 A. Yes.
18 THE CHAIRMAN: -- the rate of fluid which she was receiving
19 was going to be reduced --
20 A. Yes.
21 THE CHAIRMAN: -- and stopped --
22 A. And stopped.
23 THE CHAIRMAN: -- as the day went on.
24 A. Yes.
25 THE CHAIRMAN: So whether she was receiving 80 ml an hour or

1 65 ml an hour or something less, since your plan was to
2 stop it anyway --
3 A. Yes.
4 THE CHAIRMAN: -- and it was likely to be reduced probably
5 within a few hours, then you weren't very worried about
6 the amount of fluid she was getting; is that fair?
7 A. Yes, that's fair. Correct.
8 THE CHAIRMAN: If that summary is not fair, please correct
9 me.
10 A. Yes, yes.
11 THE CHAIRMAN: Thank you.
12 MS ANYADIKE-DANES: Your view was that you were going to
13 have the fluids reduced --
14 A. Yes.
15 Q. -- and ultimately stopped, as you've just agreed with
16 the chairman --
17 A. Yes.
18 Q. -- and that was because she appeared quite well to you
19 --
20 A. She was.
21 Q. -- not because you'd formed a view that she was actually
22 getting too much fluid, but just on her presentation.
23 A. Yes, her presentation was very good and at that time she
24 doesn't require anything IV.
25 Q. At that time, you would have known that she had not



1 anything by mouth at that stage. So she had had no oral
2 intake --
3 A. She was nil by mouth at that time as well, yes.
4 Q. The first point: would you want to know that she could
5 tolerate fluids before you actually stopped her
6 intravenous fluids?
7 A. This is naturally a practice in a post-op surgical
8 patients.
9 Q. So then given that you don't want to stop abruptly her
10 fluids --
11 A. I didn't.
12 Q. -- until you know she can tolerate oral fluids, what is
13 the direction you give to the nurses about fluids?
14 A. Well, again, it's a debatable area here. How much fluid
15 you want to -- I mean, reduce, depends on the --
16 I mean ... Observational nursing staffs, that what they
17 are thinking. Okay, go back on half or 25 per cent or
18 50 per cent or 60 per cent, reduce that and then go back
19 and stop it. It all depends on that. I can't really
20 say exactly, "Okay, I want a 20 ml, 30 ml or 80 ml off",
21 I was not in that --
22 Q. No, what I'm asking you is: what is the direction you
23 give to the nurses? When you were giving your evidence
24 last, you said that after the ward round you were going
25 to go off into theatre, so you were going off to do your



1 normal surgical duties, if I can put it that way, and
2 the people in large part who would have care of Raychel
3 are the nurses.
4 A. Yes.
5 Q. So they need to be clear on what it is that you want to
6 happen to Raychel, who's a surgical patient. So what is
7 the direction you give to the nurses?
8 A. My direction was I have to at that time explain: look,
9 she is doing very well, reduce the fluid and start oral
10 sips; as soon as she would tolerate, please stop the
11 fluid.
12 Q. And when you say "as soon as she tolerates", how much
13 would you want her to be taking on board by oral fluids
14 before you thought it was appropriate to stop it?
15 A. Sips, starting the sips. Okay, if you -- I don't know
16 how I can go forward that sips mean. What you're
17 expecting that that, sips, means a little bit of fluid
18 give her and if she is doing well, I mean that's fine.
19 Q. Is there any reason why you didn't include that in your
20 note in Raychel's charts?
21 A. Not really. I mean, just as far as -- I mean, quick
22 round, I have written that, and we always do that --
23 Q. Sorry?
24 A. We always on the round some advice give all available,
25 face-to-face I work, and you carry on like this and



1 this, and at that time it was not a practice to write
2 everything on the notes. And I understand it's not now,
3 it's totally changed. That was the reason that I didn't
4 wrote that.
5 Q. Is that not quite an important direction because without
6 that --
7 A. I agree.
8 Q. -- looking at your notes, then anybody coming to see
9 would assume that what you had thought was appropriate
10 was that those IV fluids simply carry on at that rate
11 and at that type because there's absolutely nothing in
12 the notes to show any different.
13 A. No, no, I agree that, I haven't written that -- I mean,
14 one more line ...
15 Q. Yes.
16 A. But I have explained to her, attending nurse, and I have
17 gone back to my other assignments.
18 Q. So leaving aside the present day when notes, as I think
19 you said, are written in more detail --
20 A. More detail.
21 Q. -- leaving that aside entirely, but even at 2001, would
22 you accept that it would have been appropriate to
23 include a line like that for the benefit of anybody
24 coming afterwards to see what your direction was?
25 A. No, no, I agree with that, it should be, but it was

1 a very quick round, honestly, and that's ...
2 Q. I understand that. You expected, I think you told the
3 chairman this last time, that given how Raychel appeared
4 to you and given that the surgery had been
5 straightforward and had not really lasted very long --
6 A. Yes.
7 Q. -- that you really expected Raychel to make a very good
8 recovery.
9 A. That's true.
10 Q. In fact, I think you thought that she would be having
11 a light diet some time that day --
12 A. Yes.
13 Q. -- with a view to going home the next day.
14 A. Day or two, yes. That's true, yes.
15 Q. Presumably, you'd want to know if anything happened that
16 made it look as if there was a different path for her
17 progress.
18 THE CHAIRMAN: You mean as Friday went on?
19 MS ANYADIKE-DANES: Yes. Even as Friday went on, you would
20 want to know if something happened that appeared
21 different from what you thought should be her normal
22 progress.
23 A. This is a normal practice in the ward. If something is
24 going wrong with the patient, that nurse has always
25 informed a surgeon or on-call surgeon or a consultant



1 who is there. I mean, I -- really, I was not expecting
2 that, that they will not inform me. I mean that's why I
3 haven't take interest as well to find out on the day how
4 she is because my point of view was that she is going
5 well. I didn't hear anything about her.
6 Q. Yes. I think from what you've just said that you
7 expected that if anything was untoward that somebody
8 would be contacted, so you don't need to take a note
9 saying, "Please contact me if anything untoward
10 happens". But who would you expect is the person to be
11 contacted if something as happening that wasn't quite as
12 you had expected it would be?
13 A. From the nursing -- from the ward?
14 Q. Yes.
15 A. I mean, nurses are the first -- who are looking after --
16 Q. Yes. Who would you expect they would contact, would it
17 be you or would it be the JHO?
18 A. I mean, on-call team, they can contact any person
19 on-call team. When on-call team contacted, they know
20 each other very quickly I think.
21 Q. I'm sorry, Mr Zafar, I know they could do that. Who
22 would you typically expect that they would contact?
23 A. Mostly on surgical side, there was a JHO, SHO and the
24 registrar and the consultant.
25 Q. Yes. So who would you expect --



1 A. And JHO is the -- easiest source was for them to call
2 him and then carry on further. If the JHO is not
3 responding, they can call to SHO as well. If SHO is not
4 responding, they can call to registrar as well. If
5 registrar is not responding, they can directly call to
6 consultant.
7 THE CHAIRMAN: So you'd expect them to go up
8 that hierarchical line --
9 A. They can. Yes, Mr Chairman.
10 THE CHAIRMAN: -- unless their concerns were more
11 significant, in which case they could jump over the JHOs
12 and go to the SHO or the registrar?
13 A. Mr Chairman, nowadays it's happening. I mean, they
14 don't care about --
15 THE CHAIRMAN: We're not talking about nowadays, Mr Zafar.
16 Let's just be careful about this. I know from some of
17 the evidence that we've heard that things are quite
18 different now and that nurses are more assertive and
19 they will jump lines and also within the hospital things
20 have changed. But at that time, is my impression
21 correct that if the nurses were concerned that the
22 nurses would almost inevitably call a surgical JHO and,
23 if that JHO was concerned, he would call the SHO and
24 it would go up the ladder; is that fair?
25 A. It is fair, yes. I will add up at that time also there



1 was procedures when nurses can call not only JHO if they
2 will feel the JHO is not confident and competent doing
3 things, they can call directly to either SHO or
4 a registrar or a consultant.
5 THE CHAIRMAN: Okay. That would depend on how concerned
6 they were about the child?
7 A. Yes.
8 THE CHAIRMAN: And the extent to which they were worried
9 about the youth or inexperience of the JHO?
10 A. Their own observations, yes.
11 THE CHAIRMAN: Thank you.
12 MS ANYADIKE-DANES: I think you said you felt you were with
13 Raychel five to ten minutes on that ward round.
14 A. That might be, I don't remember.
15 Q. So you would have left there, having given the nurse an
16 instruction or guidance -- "direction" perhaps is
17 a better expression -- for what you wanted to happen,
18 which is to introduce oral fluids. When you're
19 satisfied she can tolerate those, then start to reduce
20 and ultimately stop IV fluids.
21 A. Yes.
22 Q. And if you then have expected that if anything did not
23 go in the normal way that you had regarded her progress,
24 that somebody would contact a member of the surgical
25 team?

1 A. That is true.
2 Q. It's not entirely clear whether you saw or spoke to one
3 of Raychel's parents. The person who would have been
4 there is her father and he may not literally have been
5 there at the bedside when you were there. But did you
6 think it important that your view of Raychel's condition
7 and the development towards going home be communicated
8 to her family?
9 A. Well, exactly I don't remember, but when I'm going
10 back -- I'm thinking that I have spoken with someone who
11 was there with her bed. I have spoken with her as well.
12 She was smiling.
13 Q. You have said that.
14 A. There was someone, I don't know who was there. I have
15 spoken, I think. And then I asked the nursing staff how
16 she is feeling. I have a positive response from the
17 nursing staff. And after that I ...
18 Q. In fairness to you, people's memories fade. It's not
19 entirely clear whether Mr Ferguson remembers you
20 speaking to him, but --
21 A. I don't remember.
22 Q. -- if I can put it this way, would this be fair: it
23 would have been your intention --
24 A. Yes.
25 Q. -- to explain their daughter's condition --



1 A. True.
2 Q. -- and your view as to how she might progress?
3 A. Yes.
4 Q. That's what you would have wanted to do?
5 A. Yes.
6 Q. Thank you. So then you then go on about the rest of
7 your day and you're on duty for the rest of that day;
8 isn't that right?
9 A. Yes.
10 Q. And you're on call in the evening; is that correct?
11 A. I was on [inaudible] as well. I was 24 hours.
12 Q. You were 24 hours.
13 THE CHAIRMAN: That's starting at 8 am?
14 A. Until next 8 am, yes.
15 THE CHAIRMAN: Thank you.
16 MS ANYADIKE-DANES: I don't know if you've heard or if you
17 know as a result of anything that you've subsequently
18 read, but the next interaction that Raychel has with
19 a doctor is about noon, 12 noon that day. At that
20 stage, the IV bag has finished and the nurse wants
21 another bag put up. And a paediatrician, Dr Butler, is
22 asked to do that. And that's what happens at that
23 stage. If Raychel was going to be given another bag of
24 fluid by noon, would that have fitted in with how you
25 thought she would progress during the day or would



1 you have expected her to be off her IV fluids by that
2 time?
3 A. I'm expecting that. I mean, should be off at that time.
4 Even before that, should be off that fluid.
5 THE CHAIRMAN: Sorry, completely off?
6 A. No. Because I have seen at 8.30, two, three hours, you
7 can observe that is more than enough if she is eating or
8 she's doing well, and then you can carry on. I mean,
9 why we need a fluid when she has --
10 THE CHAIRMAN: Sorry. This is my misunderstanding.
11 I thought that what you had expected was if she
12 maintains her progress and was still well over the next
13 few hours that the rate of fluid would be reduced.
14 A. Yes.
15 THE CHAIRMAN: And it would be much later in the day before
16 the fluid stopped completely.
17 A. Later on the day is a completely stopped.
18 THE CHAIRMAN: But that would mean that if the fluid ran out
19 at about midday, she might need some more fluids, even
20 at a reduced rate from a new bag.
21 A. Mr Chairman, here again the condition is that if she
22 required another bag, it would need to be asked someone
23 to assess that, definitely she needs that fluid or not.
24 When I saw her, she was in that stage where she was
25 quite good and she can -- if she have started drinking



1 and light food ... I don't think she needed
2 a continuation of IV maintenance until 12 further hours.
3 MS ANYADIKE-DANES: That is why I asked you the question in
4 that way. From what you saw and how she would progress
5 during the day, would it have surprised you to know she
6 was having a new bag of IV fluid put up at 12 noon?
7 A. If I know that, I would be surprised at that. What is
8 the problem? Why is she need the fluids? She was okay
9 at that time when I saw her, she doesn't need that.
10 Q. So if a new bag was being put up, am I right in
11 understanding that you would expected her situation to
12 be reviewed to see why she needed it?
13 A. Yes.
14 Q. Because, from your perspective, she wouldn't have needed
15 it from what you could see early in the morning?
16 A. Yes.
17 Q. If that was happening, given the view that you would
18 have formed and if you had had a opportunity to, would
19 have conveyed to the family, would you have wanted to be
20 told that the position is that we're now putting up
21 a new bag of fluid for Raychel?
22 A. I would need to address to the family why we are going
23 to put another bag, a bag of fluid.
24 Q. Yes. What I'm trying to get at is slightly different,
25 but thank you for that. Would you have wanted somebody

1 in the surgical team to know that, whatever it is --
2 A. Yes.
3 Q. -- that happened, that somebody thought she needed
4 another bag of IV fluid at noon?
5 A. No, I mean surgical team --
6 Q. Yes.
7 A. -- is expecting that. I mean if some changes are going
8 why she need another bag of fluid, I mean
9 [OVERSPEAKING].
10 Q. That's what I'm asking you. Would you have expected to
11 be told that?
12 A. I was, yes.
13 Q. Thank you.
14 THE CHAIRMAN: I am sorry, Mr Zafar, I don't get this. If
15 her fluid bag runs out at noon --
16 A. Yes.
17 THE CHAIRMAN: -- and a new bag is put up, that doesn't mean
18 to say that she's going to get fluid non-stop for the
19 next 10 to 12 hours, sure it doesn't. It might mean
20 that she needs a reduced amount of fluid for the next 2
21 or 3 or 4 hours; isn't that right?
22 A. Well, 3 or 4 hours already Mr Chairman, already from
23 9 o'clock until midday is 3, 4 hours. Her condition
24 should be very much different than to ...
25 THE CHAIRMAN: So just to get it clear then: when you saw



1 her at -- let's suppose it was at about 8.30 -- you
2 thought that she would be off fluids completely by noon?
3 A. I mean, according to my plan, it is that -- noon, 2,
4 3 o'clock there should not be any fluid because she was
5 doing very well.
6 THE CHAIRMAN: I'm sorry, that's the point. When you say 2
7 or 3 o'clock, that means you anticipated her getting
8 some reducing amount of fluid into the early afternoon.
9 A. Yes.
10 THE CHAIRMAN: And for her to get a reducing amount of fluid
11 into the early afternoon, if the bag runs out at midday,
12 a new bag has to be put up, doesn't it? You might not
13 use very much of it, but a new bag has to be put up for
14 a short time?
15 A. Right, yes. Yes. Well, at least surgical team is
16 supposed to be know about that: look, fluid is finished
17 and we can put another -- a bag, but we have reduced the
18 fluid. We have no information about that.
19 THE CHAIRMAN: Yes.
20 MS ANYADIKE-DANES: Sorry, I'm just being asked for
21 clarification at the risk of making it any less clear.
22 When you say 2 or 3, are you talking about, just to be
23 clear about this, you would have expected her to be off
24 fluids completely within two or three hours of when you
25 saw her or --



1 THE CHAIRMAN: He said 2 or 3 o'clock.
2 MS ANYADIKE-DANES: He said actually both and that's why I'm
3 being asked to clarify.
4 Or are you saying you would have expected her to be
5 off fluids completely by 2 or 3 pm?
6 A. No, no, not 2 or 3 pm. It's daytime, please.
7 THE CHAIRMAN: Sorry, 2 or 3 pm is the daytime.
8 A. Sorry. It's daytime. Noon time you can consider that
9 midday.
10 MS ANYADIKE-DANES: So off the fluids by midday?
11 A. I mean, according to how she is feeling I was expecting
12 that. If there's going worse with her, it should be
13 informed to the doctors ...
14 Q. So your reference to 2 or 3 hours means 2 or 3 hours
15 from when you saw her?
16 A. Sorry, here is a confusion, right. I saw her at 8.30.
17 Then 12 o'clock is coming, right? It's three-and-a-half
18 hours, three hours like that and after that two hours.
19 Five hours, you can assess very nicely any patient who
20 is in a difficult situation or on a good situation or in
21 a bad situation.
22 Q. This point is actually quite a precise one. If we can
23 get this right: when you saw her at 8.30, did you expect
24 her to be off the IV fluids completely by about 12 noon?
25 A. 12 noon?



1 Q. Yes.
2 A. Yes. I mean, you can consider yes, if she has started
3 already taking good food orally, right?
4 Q. I'm asking you for your expectation.
5 A. Yes, my expectation is if she is taking good amount of
6 fluid, not only from the sips, she has gone, okay, a bit
7 more drinking, she is okay, she could be stopped. If
8 she is not at that level, then give her one or two more
9 hours and observe her if she is okay and then stop it.
10 Q. Right. So then, if I go back to a question I asked you,
11 when a new IV bag was put up at 12 noon, is that
12 something which you would have expected to have been
13 told to either you or another member of the surgical
14 team?
15 A. It is nice if they will let us know, surgical team, that
16 okay we are changing the bag of fluid -- is finished, I
17 mean, how much is, but she required further fluid or she
18 is not drinking enough, then ...
19 Q. And if at that time they had contacted you and said,
20 "The IV bag is empty, we're going to put up another
21 one", are you saying you would expect them to be telling
22 you about her condition, which is what is requiring her
23 to have a little bit more IV fluid?
24 A. Yes. I would like to know that at that stage. Okay,
25 why she is requiring that IV fluid and I will consider.

1 I was expecting that someone call about this.
2 Q. Sorry, you were expecting somebody to call?
3 A. I will consider that someone will let me know at that
4 stage that she required another bag of fluid and what's
5 going on with her.
6 Q. Yes. And does that also mean that you would have
7 expected, before that bag of fluid was actually erected,
8 that somebody would have reviewed Raychel?
9 A. No, it depends on how -- which kind of information
10 we are getting from the nursing staff. She is
11 deteriorating or not.
12 Q. Sorry, a different question. Whoever comes to put the
13 IV fluid bag up, would you expect that that person at
14 that stage would carry out some sort of review of
15 Raychel's condition in relation to the requirement for
16 further fluids?
17 A. It's only entirely his observation, but if I am there
18 I am writing up fluid, then I have to do that, why she
19 is needing that fluid.
20 Q. You would have done that?
21 A. I have done that. Okay, just to have to see why she is
22 requiring that fluid and how much she has taken of
23 fluid.
24 Q. Yes, okay. Then if we move on. The next intervention
25 by a doctor happens at about 6 o'clock.



1 A. Evening?
2 Q. In the evening. That same day, but 6 o'clock in the
3 evening.
4 A. Right.
5 Q. In fact, the nurses might have wanted somebody to come
6 a little earlier than that, but that was the earliest
7 that a member of the surgical team could come. And what
8 the nurses are wanting is an anti-emetic. And the
9 reason they're wanting that is because Raychel is
10 vomiting. Now, would you have expected to have been
11 told that that is what was happening?
12 A. Yes.
13 Q. The person who responds to the nurses is a JHO.
14 A. Right.
15 Q. And that JHO administers the anti-emetic. But are you
16 saying, so that we're clear on that, that you would have
17 expected that JHO to let you know that that's what they
18 were doing?
19 A. Well, it all depends on the protocol, JHO's confidence
20 and the JHO, what he thinks at that time.
21 Q. Sorry, Mr Zafar you have just said that you would have
22 expected to be told that.
23 A. I am expect it, but I am explaining that now. I mean, I
24 am expecting.
25 THE CHAIRMAN: Sorry, you asked him a further question and



1 then he's answering it. You can't interrupt his answer
2 because it's not quite the same as the first answer he
3 gave.
4 Mr Zafar, the question to you was: would you have
5 expected the junior house officer, at about 6 o'clock,
6 to let you know what he was doing in giving an
7 anti-emetic to Raychel?
8 A. I mean, it's entirely his observations. I would like
9 that, if there is something happened with her that he
10 has to discuss with me or my colleague, yes.
11 MS ANYADIKE-DANES: And do you say that because JHOs are
12 quite junior and inexperienced and that's why you would
13 want to know, or is it because it's something happening
14 to a patient who you had thought was on a very good road
15 of recovery and you would have wanted to know about
16 something that seems like a departure from that?
17 A. Here is the two questions. One is the JHO's teaching
18 and the second is the patient. Patient is important
19 than JHO's teaching at that stage. It's nice there to
20 know both sides that. He will understand why I was
21 interested to see and why I was interested to know about
22 her as well as I was concerned about that patient and
23 her -- I mean, the progress assessments.
24 Q. Yes. Do I take it then from what you saw at the ward
25 round, a vomiting that would have required a doctor to



1 be called to administer an anti-emetic is not what you
2 thought would be happening?
3 A. Vomit -- I was not thinking that she is vomiting.
4 THE CHAIRMAN: I think it goes further than that. When you
5 saw Raychel at about 8.30, you did not expect that at
6 6 pm, nine-and-a-half hours later, she would still be
7 receiving the same amount of fluid by IV as she was
8 getting at 8.30 in the morning.
9 A. Yes.
10 THE CHAIRMAN: And if you had known that she was still
11 getting that rate of fluid and that she was repeatedly
12 vomiting and that she was being given an anti-emetic,
13 you must have wanted to know about that.
14 A. Yes, yes.
15 THE CHAIRMAN: And who should have told you about that at
16 6 o'clock that night, because you're still in the
17 hospital and you're still available? So who should have
18 told you about that at 6 o'clock on Friday evening?
19 A. Well, here is a JHO -- if JHO knows that, he's supposed
20 to call me and discuss. And as well as if nursing staff
21 thinks that need to be a call senior medical help or
22 senior SHO or registrar, they can directly also call to
23 me or my senior colleague on call.
24 MS ANYADIKE-DANES: Well, the JHO who, I think you've
25 accepted, is very junior and not very experienced --

1 A. No, I agree. I am --
2 Q. -- may not realise the significance of that, may not
3 have appreciated what you had thought would be her
4 natural progress and may not realise that carrying on
5 with fluids at that rate and vomiting at 6 o'clock is
6 something that would alert you.
7 A. Yes.
8 Q. So would you accept that a JHO may not appreciate that?
9 A. If the JHO is there for that reason, his duties are --
10 his duties are that if there is something serious
11 happen, he has to talk with SHO or a registrar. That's
12 why he is always available in the ward for that reasons.
13 Q. Correct me if this is a wrong characterisation, but does
14 that mean that you'd have expected him to either know
15 that himself --
16 A. Yes.
17 Q. -- or be told that by more senior nurses and then
18 communicate that to you?
19 A. I mean, he's supposed to be that's communicate with me
20 and naturally, yes.
21 Q. Would you have expected a JHO to have appreciated that
22 that was a significant situation that should be
23 communicated to you?
24 A. Well, if she has already up to that time -- two, three
25 times she had a vomit of more than that, I don't



1 remember now. I mean it is a serious situation when she
2 is vomiting and an IV fluid is going on and I am need to
3 be informed that.
4 Q. At that stage, she had four --
5 THE CHAIRMAN: She had many more vomits than two or three by
6 6 o'clock.
7 A. About that vomits, no one has --
8 THE CHAIRMAN: Your point is that nobody told you.
9 A. No one told me.
10 THE CHAIRMAN: And you say you should have been told, not
11 just because she's vomiting, but because she's still on
12 the full rate of IV fluid that she was on at 8.30 in the
13 morning.
14 A. Morning, yes.
15 THE CHAIRMAN: I've seen the doctor, he gave evidence,
16 he was quite young, quite inexperienced. There was
17 a debate about how much he had learned from the nurses
18 or about how much he found out from the nurses. So
19 you have made the point about the doctor and what you
20 might have expected the doctor to do. What might you
21 have expected the nurses to do given Raychel's condition
22 at 6 o'clock on the Friday evening? Might you have
23 expected the nurses to contact you directly or not?
24 A. If they are worrying about any condition, her condition,
25 they could contact me directly as well.



1 MS ANYADIKE-DANES: Can I put it in a different way, leaving
2 aside the worrying point? When you discussed with the
3 staff nurse, the sister -- sorry, Sister Millar is the
4 person who was there at your ward round, you had been
5 pleased with Raychel's current condition.
6 A. Yes.
7 Q. You'd explained to her, as I understand it, what you
8 thought would be the normal course for Raychel and how
9 that would involve a gradual weaning off of her
10 IV fluids and so on and so forth. So that's how you
11 thought Raychel would progress.
12 A. That I was thinking.
13 Q. And that's a discussion or an exchange you'd have had
14 with Sister Millar. Would you have communicated with
15 Sister Millar how you thought Raychel would progress?
16 A. I explained to her that she is doing well.
17 Q. Yes. So if that was the case, to follow up from the
18 chairman's question to you, what had actually happened
19 by 6 o'clock did not fit any of that because her fluids
20 were carrying on, not only were they carrying on but
21 they were carrying on at a rate which you thought was
22 rather high, but you weren't troubled about it because
23 she was going to be off it fairly soon, but she's not
24 off it fairly soon, and she's vomiting --
25 A. Yes.



1 Q. -- sufficient vomit for the nurses to want an
2 anti-emetic to be administered. So none of that is how
3 you thought Raychel's progress would actually proceed.
4 A. Yes.
5 Q. So since this is something that you had discussed with
6 the sister, would you have expected the nurses to have
7 let you know, "Doctor, the patient isn't quite as you
8 thought she would be and this is what has happened"?
9 A. I was expecting that someone will let me know, nursing
10 staff or JHO. No one has spoken with me, no one has
11 informed me.
12 THE CHAIRMAN: Can I also ask you this, Mr Zafar? I have
13 been given evidence which I find very hard to believe,
14 which is that Raychel had a perfectly standard
15 appendicectomy, there were no complications to it, she
16 came in on the Thursday evening, she was assessed as
17 needing the operation, the operation went fine, quite
18 smoothly, and she was back on Ward 6 in the early hours
19 of Friday morning --
20 A. Yes.
21 THE CHAIRMAN: -- and she did not vomit apparently until
22 about 8 am.
23 A. Yes.
24 THE CHAIRMAN: So her initial post-operative period was
25 normal.

1 A. When I saw her, yes.
2 THE CHAIRMAN: I now know -- and the staff in Altnagelvin
3 knew -- that she vomited regularly throughout Friday,
4 starting at 8 am, was vomiting in the morning, was
5 vomiting in the afternoon and vomiting again in the
6 evening. It has been suggested to me that that's not
7 unusual. Do you say that's not unusual?
8 A. Well, I mean, it is not unusual when she is continuing
9 vomiting. It's not unusual. Post-op patients do vomit,
10 but not like that, that continues for four, five, six
11 times vomits.
12 THE CHAIRMAN: So it is unusual that she was vomiting so
13 often during the day?
14 A. It is not unusual. This is very unusual. I haven't
15 seen that ...
16 THE CHAIRMAN: Sorry.
17 MS ANYADIKE-DANES: A double negative.
18 THE CHAIRMAN: "It's not unusual", "it's very unusual".
19 There's a clash between our cultures, so let's just make
20 it clear because this is fundamentally important to
21 Raychel's case. I'll hear more evidence, I'll hear what
22 the experts say, but it seems to me at the moment that
23 it is hard to believe that the amount of vomiting which
24 Raychel endured throughout Friday was usual. And it
25 seems to me that if it was my daughter who was in



1 Altnagelvin after an operation and she was vomiting six,
2 seven, eight or nine times, that that is something which
3 would be very unusual. Do you agree that it would be
4 very unusual or have I got this wrong?
5 A. No, this is very unusual --
6 THE CHAIRMAN: Thank you.
7 A. -- with post-appendicectomy.
8 MS ANYADIKE-DANES: Thank you. If you had been contacted
9 at the time when Dr Devlin responds to administer the
10 anti-emetic, so that's 6 o'clock in the evening that
11 same day -- it doesn't matter whether you were contacted
12 by him or contacted by the nurses -- you had been
13 contacted and had been told what had been happening,
14 what would have been your response?
15 A. I came myself and saw her.
16 Q. You would have visited her?
17 A. Yes. And first I did that and then I reviewed her
18 everything: IV fluid if she is on IV fluid, IV fluid how
19 much is going in and which kind of fluid is, and how
20 much vomits are, how many vomits are, which kind of
21 vomits are, all that, and her general observations. And
22 after that, I will ask her do the bloods for her.
23 Q. Electrolyte testing?
24 A. Electrolyte tests. If they are giving still sips,
25 I will stop it, don't give oral sips, stop that, nil by



1 mouth, and I will discuss with my senior as well. This
2 is the situation where I need to intervene and ask
3 senior advice as well.
4 Q. Let's break that down. The first thing is that you'd
5 want to visit her if you'd been told that?
6 A. Yes.
7 Q. Can you say why you'd have wanted to do that?
8 A. Already they have indicated to me that she has since
9 morning continuing IV fluids plus vomiting. That's
10 a major indication for me -- I mean, why she is
11 vomiting? If it's one or two, that's okay. But if it
12 continues, four, five, six, they're saying, then I have
13 to go and see her. Why she has a vomit after a simple
14 operation when it's not complicated, it's not a
15 peritonitis, it's no a perforated appendix site, it's
16 a normal appendix site. I mean, I have a bit of
17 inflammation maybe and it's taken out and there is no
18 other problems. If I couldn't see that why it is, then
19 I have to go and review her on that.
20 Q. So you would want to go and assess her and see what was
21 happening?
22 A. Yes, and then I will inform to my senior.
23 Q. And if you were assessing her, would that involve not
24 just examining her, but now reviewing all her records
25 now because she's no longer well and in the state you



1 thought she was at 8 o'clock?
2 A. I have already re-review her. I mean, re-review mean
3 everything. You have to go through that and assess her
4 operation notes, before operation what was there, as
5 well as -- I mean, after that, how much she has taken of
6 fluid, which kind of fluid and the how much vomits,
7 which kind of vomits. Everything. Bloods.
8 Q. And then I think you said you would order some blood
9 tests.
10 A. Yes.
11 Q. And I think you said that you would contact your senior.
12 A. I would, yes.
13 Q. And is that because you would have regarded a situation
14 like that as sufficiently serious that you would want
15 some senior guidance on what to do?
16 A. No, I will -- there are two reasons here as well as
17 this. Cover me, that's I am [inaudible] I'm SHO there,
18 right? And let them know what's going on with the
19 patient, okay? The second is to get a guidance from
20 them, what I am going to do further, what I am doing
21 that is right or not.
22 Q. Yes. Would the senior you had in mind be your
23 registrar?
24 A. Registrar. If registrar is not available, I will prefer
25 to speak with the consultant and let him know that.

1 Q. So if for some reason the registrar hadn't been there --
2 and is it the child's consultant that you would want to
3 talk to or just the consultant on duty?
4 A. First, consultant on duty is responsibility.
5 Q. That didn't happen. You weren't alerted to that. The
6 next interaction with a doctor that Raychel has is at
7 about 10 o'clock. The anti-emetic has not stopped the
8 vomiting, there is a pause, but it hasn't stopped it,
9 and a doctor, another JHO, is contacted to come and the
10 nurses' view was: administer a further anti-emetic. By
11 that time, there is a record of at least one incidence
12 of vomiting coffee grounds.
13 A. Yes.
14 Q. I presume -- perhaps I shouldn't presume -- would
15 you have been wanting to have been contacted at
16 10 o'clock to let you know that the vomiting is
17 continuing, there has been an incidence of vomiting of
18 coffee grounds?
19 A. Well, I think when I know that she is already serious,
20 then I will take myself care to her and I have to go
21 myself and see her on and off if -- if she has vomiting
22 like that, they have to inform me as well: look, she has
23 again vomited and this kind of situation is. Just
24 informing, yes.
25 Q. I see. I had put the question to you in a misleading



1 way. The first one that I had asked you was whether you
2 would have wanted to have been told about the 6 o'clock
3 and you said "yes" and that you'd have visited her.
4 A. Yes.
5 Q. And I think from you way you have answered that you have
6 indicated that you would have then, if you like, wanted
7 to keep an eye on her.
8 A. Yes.
9 Q. Assuming that they hadn't contacted you at 6 o'clock, so
10 you knew nothing about the anti-emetic at 6 o'clock, but
11 matters progress, she carries on vomiting, she has
12 a incidence of coffee grounds and the nurses want to
13 administer or have administered a further anti-emetic.
14 Would you have been wanting to be contacted at that
15 stage?
16 A. If this is first time -- of course, I like to know that
17 and if they will contact me that she is vomiting all the
18 way and she is now coffee-ground vomit is also there,
19 of course I will go to see her.
20 Q. And how serious would the incidence of coffee-ground
21 vomiting -- how seriously would you have taken that?
22 A. If she is already had many vomits, after that it's
23 going -- it is serious. She has continuous vomiting.
24 If it's not a coffee ground, if she has continued
25 vomiting without that, as well I would have gone and



1 seen her and --
2 Q. So you would have wanted to anyway, even if it wasn't
3 the coffee grounds?
4 A. Yes.
5 THE CHAIRMAN: We've had different views expressed on this.
6 In your eyes, how significant as an additional factor is
7 coffee-ground vomiting or is it significant at all?
8 A. It is a significant because it's going to be bile with
9 everything is going on and she has continuous vomiting
10 and struggling with that. I mean, it is significant.
11 MS ANYADIKE-DANES: What does it signify to you, the fact of
12 coffee-ground vomiting? What does it signify to you
13 about Raychel's condition?
14 A. I mean, it's a serious conditions. I will go that side.
15 My here is -- attention is that the vomits, right? It
16 is the vomits -- how much vomits, many times gone -- and
17 I will take that side, Mr Chairman, I'll look after that
18 side. Okay, she has vomited already many times and
19 she's going there and I have to do everything at that
20 stage for her what I can.
21 THE CHAIRMAN: We're asking you something slightly
22 different. Let's assume that Raychel has vomited six or
23 seven times. On what you have told us, that is already
24 significant and you will want to intervene to find out
25 what's going on and to do tests --



1 A. Yes.
2 THE CHAIRMAN: -- and to speak to your registrar. Does it
3 make it more serious if the last vomit or the last two
4 vomits are coffee-ground vomits or does not make any
5 difference?
6 A. It is getting more serious, she is vomiting and she is
7 vomiting coffee grounds, change that, I mean ... From
8 the stomach and [inaudible] intestines going out, that
9 is some things and she is not tolerating anything.
10 MS ANYADIKE-DANES: Would it have also added to your concern
11 to know that she was complaining of a headache? Is that
12 relevant to you?
13 A. If someone is already vomiting and this condition is --
14 and child always complains, "I have a headache as well",
15 most of child they do that. I will consider that side
16 and another indication of that, why she has headache as
17 well and vomiting as well. Most of child, they do
18 complain of headache.
19 Q. And you say that you would have gone to see her and
20 examine her?
21 A. Yes.
22 Q. And I think you had said that you'd have wanted to get
23 in contact with your senior.
24 A. Yes.
25 Q. Also. What would you have made of the possible role of

1 the fluids that she was receiving in her condition?
2 A. Here is again the question is low sodium and with vomit,
3 it's not an ideal situation this. This is -- the
4 literature says that if someone is -- vomiting
5 continues, then change the fluid from low sodium towards
6 normal saline, right? These are the things which I will
7 discuss with him. Look, she is vomiting, how many
8 vomits are there, and if we are giving her low sodium,
9 maybe there's something wrong going on that already.
10 Bloods are gone. I will wait for bloods. I will ask
11 express(?) blood site and results will be clear from the
12 bloods how much is sodium and how much is calcium and
13 potassium with her and I will discuss all that questions
14 with my senior or either if registrar -- I'm sure -- I
15 believe that if there is -- registrar is there he will
16 come and see her as well at the same time.
17 Q. Yes. When you said low sodium, big vomit, is not ideal,
18 and you said that --
19 A. No. Here, please, a bit confusing. Low sodium, big
20 vomit. There's vomits going on and the sodium is going
21 out, okay? And we are giving IV fluid with sodium, low
22 sodium. That I'm saying. That's my meaning.
23 Q. That's what I understood you to mean. It's not an ideal
24 combination: you're losing more sodium than you're
25 putting in.



1 A. Yes.
2 Q. So when you said if you had been contacted at 6 o'clock,
3 you would have wanted to carry out your review and have
4 electrolyte tests done, is that because, even at
5 6 o'clock, you might have been concerned about whether
6 or not her sodiums were low?
7 A. No, already she had enough vomits that there's
8 indications of sending the bloods, check the bloods,
9 because in the morning time we haven't done the bloods,
10 the reason was that, she was fairly stable, she was not
11 requiring at that time and the post-op immediately that
12 bloods. That's why I haven't asked that bloods. But at
13 that time, until evening, she has already clear
14 indications for that because she has vomiting.
15 Q. It's a follow on from something that the chairman asked
16 you, so that perhaps we're clear about it. The nurses
17 have said that sometimes it's difficult to reach
18 a member of the surgical team, certainly a more senior
19 member of the surgical team who might be in theatre or
20 might be otherwise engaged. So if for any reason the
21 nurses were not able to immediately get a response from
22 the JHOs in relation to Raychel's condition, what would
23 you have expected them to do? This is Raychel's
24 condition, so not in general terms, but given Raychel's
25 condition on Friday evening, what would you have



1 expected them to do?
2 A. If it's out of hours?
3 Q. We're talking any time from just before 6 o'clock, any
4 time at all that evening?
5 A. 5 o'clock, there's a lot of doctors are available.
6 I understand there's on-call doctors, which is a bleeped
7 already by their name and they have to call
8 specifically. But if in emergency cases, if doctor is
9 available in the ward or anyone, they can call to him
10 and come and see that patient. That is ethics of GMC,
11 they're saying that. A doctor is available in anywhere,
12 something going wrong with anyone on the road, if doctor
13 is available he has to go and see that patient, and the
14 same is here rules in the hospital during the normal
15 hour time. If something happened on the ward, any
16 doctor is available, he has to go and see that patient.
17 If it is out of hours -- before also there is on call --
18 "on call" mean bleeped doctors are available, they can
19 bleep. But out of hours definitely the on-call doctors
20 are available and they can call any one on-call person.
21 Q. Yes. Can I ask you this question about the
22 coffee-ground vomiting because the chairman is right,
23 we've heard slightly different views about its
24 significance. The inquiry has an expert surgeon who's
25 produced a report, Mr Foster. In his report,



1 223-002-016, he says:
2 "Coffee-ground vomiting is an indication of
3 significant or severe and prolonged vomiting and
4 retching. In a child, it should have attracted serious
5 attention as it is due to trauma to the gastric mucosa,
6 causing bleeding."
7 Do you have a view on that?
8 A. I agree, that's why coffee ground is named that because
9 it is mixed a little bit of blood with mucosa -- mucosa
10 that, that's why it named with that coffee ground.
11 That's why -- it is significant why it's coming out,
12 maybe some perforating, maybe something is going on,
13 some erosion has started already, which is starting
14 that, and after that next up will be maybe some sort of
15 eroding towards a small vessel and that can start more
16 blood coming out.
17 THE CHAIRMAN: So it's bad enough that a child --
18 A. It is significant.
19 THE CHAIRMAN: It's bad enough that a child is vomiting, but
20 it's worse if it's coffee-ground vomiting because that
21 raises more concerns and fears about what else is going
22 wrong or might go wrong?
23 A. Yes.
24 THE CHAIRMAN: Okay.
25 MS ANYADIKE-DANES: In any event, none of that happens and

1 you're not told about any of those events and the first
2 you hear is some time in the early hours of Saturday
3 morning, is that correct --
4 A. Yes.
5 Q. -- when Dr Curran bleeps you?
6 A. Yes, I think Saturday morning, early morning, yes.
7 Q. Do you remember him bleeping you?
8 A. I don't recall that. Only the moment that I was in A&E
9 with a serious, serious patient, which was not possible
10 to leave and go.
11 Q. Do you remember the fact that he bleeped you and you
12 weren't able to respond immediately; is that correct?
13 A. I don't remember that. I don't remember.
14 Q. Do you remember the bleep at all?
15 A. No, no, I'm telling that I remember that, bleep me,
16 I have responded to that bleep already. I don't
17 remember what was the -- I mean, the conversation.
18 Q. That was where I was going to ask you. When you
19 responded to the bleep, can you recall anything of what
20 Dr Curran told you?
21 A. I don't remember honestly speaking. It's a far long --
22 really, I don't remember that, what was conversation.
23 Q. But you know he bleeped you?
24 A. He bleeped me, yes.
25 Q. If you can't specifically remember, maybe you can help



1 us with what you would have thought appropriate to do,
2 if I can put it that way. Assuming that Dr Curran
3 bleeps you and the thing that had happened is that
4 Raychel had had a seizure. That's what had happened.
5 She had been attended to by the paediatric SHO, who
6 happens to have been there on the ward when it happened.
7 He had contacted, bleeped, Dr Curran and asked Dr Curran
8 to get a blood test done, and also to contact his
9 seniors. There's a bit of a difference between them as
10 to whether he was to contact you or he was to contact
11 the registrar, but in any event, contact his seniors.
12 Dr Curran's evidence is he bleeped you.
13 A. Right.
14 Q. And it would seem from what he said that what he would
15 have told you is that Raychel had had a seizure and
16 wanted you to come to the ward.
17 A. Yes.
18 Q. If you were dealing with a very sick person in A&E and
19 couldn't respond, then what do you think it would have
20 been appropriate to have done in those circumstances?
21 A. Well, I mean, definitely I respond that his bleep, and
22 something said to him, I don't remember that. Well, my
23 expectation is, if I am busy there, which is -- I mean,
24 I think he knows about that maybe or not. And he can
25 call, I mean, a registrar. He could call that. If I am



1 busy, he could call registrar. If patient is simple,
2 okay, I can leave and come, it was not a question, but
3 if patient was serious I think I can't leave that
4 patient at that stage. And simply he can call to the
5 next person who is on call.
6 Q. Well, he certainly seemed to have got the information
7 from you that you were tied up at that time, so you
8 couldn't come and that you would come as quickly as you
9 could, but there was no time for when that might be.
10 A. Yes.
11 Q. So are you saying that what you'd have expected him to
12 do in a serious situation where senior surgical input is
13 required is to bypass you, effectively, and contact the
14 registrar?
15 A. My understanding was at that time that really if I am
16 busy with some serious situation, it means that I'm busy
17 there and immediately he can call to my senior.
18 THE CHAIRMAN: Sorry, is there not another part of this,
19 Mr Zafar, which is this: he wasn't just calling you for
20 another opinion on a girl who'd vomited once or twice
21 more; he was calling you in the context of a girl who
22 was so ill that she'd had a seizure. Would I be right
23 in thinking that when a child gets to the stage of
24 having a seizure, that the position is very serious
25 indeed? Is that correct?



1 A. It is correct that she is serious then. My expectation
2 was at that time, Mr Chairman, that -- I mean, I am busy
3 there and he knows that who is on call, next person, and
4 he can definitely call himself, "He is busy and please
5 can you come and see that patient?"
6 THE CHAIRMAN: I don't want to be too harsh on an
7 inexperienced doctor like Dr Curran, but when the
8 condition that Raychel is in is so bad that she has had
9 a seizure, is it not possibly the case that he should
10 have bypassed you as an SHO and gone straight to
11 a registrar or to a consultant?
12 A. He can.
13 THE CHAIRMAN: That would be serious enough to do that,
14 wouldn't it?
15 A. No -- I mean, he can bypass me and he can call the
16 register or consultant, if that is the situation, that
17 if he feels it is very serious and better I call the
18 consultant, he can call a consultant.
19 THE CHAIRMAN: Is a seizure very serious?
20 A. Seizures are -- why seizures, after how many hours, she
21 is getting ... It was serious after appendicectomy.
22 MS ANYADIKE-DANES: He didn't do that, he bleeped you, and
23 I think he felt the thing to do was to contact the SHO.
24 I wanted to put the question in this way: the last
25 time you had anything to do with Raychel, she was well,

1 and you were expecting that she'd be well on her way to
2 being possibly discharged the next day. The next
3 contact you have is to tell you that she has suffered
4 a seizure and the JHO is wanting you to come as soon as
5 you can to attend to her. So it's not just a seizure,
6 it is a seizure in a child who you had previously seen
7 and thought was well and did not expect that outcome.
8 So if he has contacted you, he might be panicked,
9 I suppose, might be a fair way of putting it at that
10 stage. Instead of saying that he knows he could contact
11 the registrar, would you have not thought it appropriate
12 to tell him, "I don't know when I can get free from this
13 situation, contact the registrar immediately"? Would
14 that not have been an appropriate thing to have told
15 him?
16 A. Well, I agree that. It is possible. But my
17 understanding at that time was that he can contact
18 himself the registrar.
19 Q. He could do that, but in order to guide him, someone who
20 is a very junior and inexperienced, and the most
21 important thing is to ensure that Raychel has the
22 appropriate medical intervention, so instead of leaving
23 it to what he knew he could do, would it not have been
24 appropriate for you to have told him, "Contact the
25 registrar immediately, I don't know when I can get free



1 here"?
2 A. I don't remember that what I thought at that time --
3 what I thought I was expecting that that he can call
4 himself it minus me, but he knows that I'm busy in A&E
5 and he can call him and he can come. That was in my
6 mind at that time. I don't remember what was exact
7 situation or why I haven't said that, then I don't
8 remember that.
9 Q. In fact, ultimately, you do go to Ward 6.
10 A. Yes.
11 Q. Why do you do that?
12 A. Because I told him that I will come as soon as possible,
13 "Let me finish here and I'll come over there".
14 Q. Did you contact the registrar yourself?
15 A. No, no, not me, because I was busy with other patients.
16 Q. I appreciate that. But when you have got free, did you
17 contact the registrar?
18 A. Well, I mean, everybody was there when I came.
19 Q. This is before you got there. Did you contact the
20 registrar?
21 A. Because I didn't get a time. I immediately finished
22 there and I came into the ward.
23 Q. I understand.
24 A. Yes. When I came in the ward, everybody was there.
25 Q. It's a bit over an hour between when Dr Curran bleeps



1 you and you hear that the child has a seizure and you're
2 able to get free and get to the ward.
3 A. Yes.
4 Q. In the context of a post-surgical child who's had
5 a seizure nearly 24 hours after surgery, is an hour
6 a significant period?
7 A. It is significant period, but here the question is: how
8 I can leave A&E? That was the only question of mine.
9 I understand that it is significant, but at the same
10 time when other doctors are available there, the
11 registrar is available, he's supposed to call the
12 registrar and he is supposed to come and see that. I am
13 doing with another patient, serious patient. It was
14 serious patient. Just imagine, thinking that it was
15 serious patient, I don't know what I was doing, I was
16 not a simple -- clerking the patient, even. It was not
17 that situation.
18 Q. I understand that you were bleeped at 3.19 and
19 you weren't able to get to the ward until 5 o'clock. So
20 that's very nearly one-and-three-quarter hours?
21 A. I don't remember time. I don't remember time.
22 I remember that only when I free from A&E I came
23 immediately to the ward.
24 Q. Yes. And all that time you had no way of knowing
25 whether any more senior surgical intervention had been



1 provided to Raychel.
2 A. I was busy in A&E and I do not know anything about that.
3 Q. When you arrived, you say there were others there. Was
4 Mr Bhalla there, who's the registrar?
5 A. Honestly, I don't remember anybody, but there was all --
6 I only remember that I think there was all there.
7 Q. And can you recall what was actually happening with
8 Raychel when you arrived?
9 A. I think they were resuscitating her.
10 MR STITT: May I interject for one moment on a point of
11 fact? I've just spent the last few seconds checking
12 a time. I think Ms Anyadike-Danes put to the witness
13 that he was bleeped at 3.19. I think it's Dr Curran
14 who's bleeped at 3.19 and it's 3.44 when this witness is
15 bleeped. If I'm wrong, I apologise.
16 MS ANYADIKE-DANES: No, I think you're right about that. In
17 fact, it is Dr Curran who's bleeped at 3.19 because we
18 looked at his bleep register. It's not entirely clear
19 precisely when Mr Zafar is bleeped, you're correct about
20 that.
21 MR STITT: Dr Curran says, in his statement, he's definite
22 about it. Whether he's right about it is a different
23 issue of course. He says 3.44 just for the record.
24 MS ANYADIKE-DANES: Thank you very much indeed.
25 Sorry, you say that she was being resuscitated --

1 A. She was.
2 Q. -- when you got there. So from the surgical team,
3 there's the JHO, who's Dr Curran. He's there. There's
4 yourself as the SHO. And there's the registrar.
5 A. I think. I don't remember that. I think, yes.
6 Q. Were you aware of whether anybody had informed either
7 the on-call surgical consultant or Raychel's consultant,
8 who you knew as Mr Gilliland?
9 A. No, I don't know that someone informed or not. I don't
10 remember that, that someone informed or spoken with
11 consultant or not.
12 Q. Well, given what you saw happening, would you have
13 thought it appropriate that either the on-call surgical
14 consultant or Raychel's consultant be informed?
15 A. Well, my question is at that time that all consultants,
16 anaesthetists consultants, I think paediatricians
17 consultants, and registrars, all the senior to me all
18 were there. And my input at that time was I was feeling
19 that I -- I mean, what shall I do here? I cannot --
20 I mean, all right and go and do something. I haven't
21 done anything at that time because I was at a very
22 junior level.
23 THE CHAIRMAN: We understand how, when you arrived, since
24 your registrar was there and there was a consultant
25 paediatrician and a consultant anaesthetist, you might



1 well have thought there's not much more that I can do.
2 But I think Ms Anyadike-Danes' question to you was
3 a slightly different one. There's a consultant
4 paediatrician there, there's a consultant anaesthetist
5 there. Did it strike you whether there should have been
6 a consultant surgeon there because Raychel was
7 a surgical patient?
8 A. When I arrived there, surgical team is there, registrar,
9 SHO and JHO. If there are three there, if JHO is there
10 and has spoken with me and the registrar is there, it's
11 all going towards response. At that time to inform to
12 the consultant or speak with the consultant I think more
13 likely is going towards the registrar's duty and
14 registrar has to direct me and the JHO, not I will
15 direct registrar go and speak with the consultant or
16 not.
17 MS ANYADIKE-DANES: I understand that. I put it to you in
18 a slightly different way as to what your expectations
19 might be.
20 A. No, my expectation, I understand that, what you are --
21 looking at that, I agree with that. Surgical consultant
22 might be -- I mean, could be called immediately before
23 anybody else.
24 Q. Actually, the person with responsibility, if I can put
25 it that way, for Raychel's care is actually her own



1 consultant, which is Mr Gilliland.
2 A. Yes.
3 Q. And that's why I was putting it to you, not that it
4 should be you who should go and direct that, but would
5 it have been your expectation that he would have been
6 notified that this is what has happened to his patient?
7 A. Well, that's my expectations. But the question is the
8 directions coming towards from -- the senior is there
9 and their directions I have to follow, not my directions
10 or expectations to be followed.
11 Q. I understand that. See if you can help me with
12 this: given that she was a surgical patient, who did you
13 think should have the responsibility for talking to her
14 parents?
15 A. Surgical patients, surgeons have the responsibility to
16 speak with the parents.
17 Q. And given the three that were there, which is Dr Curran,
18 the JHO, yourself, the SHO, and Mr Bhalla, the
19 registrar, who did you think should be speaking to the
20 parents at that stage?
21 A. At that stage, it depends on the -- I mean, who are
22 there. First I've told that surgical responsibility --
23 because she was surgical patient. I'm just saying that.
24 That's the reason. Otherwise, if ... Already from
25 intensive care consultant is there as well from



1 paediatric consultant is there. They can also speak
2 with the relatives, not necessarily that they have to
3 wait the surgeons will come and then speak.
4 Q. Of course.
5 A. Surgeons will speak with the relatives, but they can
6 give at that time information to the parents what's
7 going on with the child.
8 Q. Yes. Okay. Would it have been your expectation then
9 that a senior member of the surgical team would have
10 spoken to the parents?
11 A. If he is not available, if consultant is not available
12 at that time, either registrar can speak or if registrar
13 is thinking no, consultant will come and he will speak
14 with the parents. That is right. But already spoken
15 someone from them. At that stage, someone has spoken
16 with the parents and delivered the statement and after
17 that they are expecting from the surgeons as well, they
18 can deliver that statement, okay, surgeons will come and
19 they will speak as well.
20 Q. I understand. You're saying that it's not exclusively
21 the surgeons who could speak to the parents.
22 A. Yes.
23 Q. I had taken that on board. I was simply asking whether
24 you thought in addition to that, that given she was
25 a surgical patient, whether you thought a senior member

1 of the surgical team should be speaking to the parents.
2 Leaving aside what any of the actual treating physicians
3 at that stage, the paediatricians and perhaps the
4 anaesthetists, might have said, would you have expected
5 somebody from the surgical team?
6 A. Yes.
7 Q. Is that a yes?
8 A. Yes.
9 Q. How long do you actually stay there with Raychel?
10 A. I do not remember. In the morning time, you're saying?
11 Q. No, no, no, no -- sorry, if you mean the early morning
12 time ... I mean at this point in time.
13 A. I don't remember how long. I was there -- I think she
14 was after that gone for CT scan and, et cetera, et
15 cetera. I don't remember how long I was there.
16 Q. Do you think that you left if not before then, but when
17 she went for her CT scan?
18 A. I don't remember that.
19 Q. You didn't go with her to intensive care.
20 A. Because other doctors and other --
21 Q. It's not a criticism. I'm just trying to benchmark --
22 A. I don't remember that I have gone with her or not.
23 Q. Then were you aware of the fact that she was going to be
24 transferred to the Children's Hospital?
25 A. I was aware about that, that she was going to be



1 transferred after that, because at that time they were
2 talking with the Children's Hospital when I was there --
3 I mean I don't need to be. And I don't know what
4 time -- who is going with her, I don't remember.
5 Q. I wasn't going to ask you that. If you were aware of
6 that, were you aware of why she was being transferred to
7 the Children's Hospital?
8 A. First of all -- I mean, in Altnagelvin there was not
9 specifically -- specific unit, intensive care unit in
10 Altnagelvin for childrens. That is one reason. That's
11 why they have transfer to Altnagelvin -- Children's
12 Hospital, Belfast. The reason is they have a specific
13 facilities for the childrens for intensive care as well
14 as the other treatment is better than the
15 Altnagelvin's ...
16 Q. I think you said that you were aware that they were
17 discussing with the surgeons at the Children's Hospital;
18 did you say that?
19 A. I said that. They were talking at that time that needs
20 to be transferred to Belfast.
21 Q. Yes. Did you know what the surgical issue was likely to
22 be that they were transferring her for?
23 A. No, I don't remember at that talk any time because
24 already that talk was not on my level, it was level of
25 consultants.



1 Q. Yes. Even if you didn't know what the surgical issue
2 was, was it your impression that she --
3 THE CHAIRMAN: Sorry, I'm not sure he did say the surgical
4 issue on the transcript. I think you've picked him up
5 as saying that. I think he said they were talking to
6 the Children's Hospital.
7 MS ANYADIKE-DANES: I said:
8 "Did you know what the surgical issue was likely to
9 be that they were transferring her for?"
10 And he said:
11 "No, I don't remember at that time --
12 THE CHAIRMAN: No, go up to line 20 [draft]. I think you
13 said:
14 "Were you aware they were discussing with the
15 surgeons?"
16 But I'm not sure where you got that question from.
17 MS ANYADIKE-DANES: I think he said earlier that he was
18 aware of that when I asked him if he knew whether
19 Raychel was going to be transferred to the Children's
20 Hospital.
21 THE CHAIRMAN: That's your question at line 2 [draft]:
22 "Were you aware of the fact she was going to be
23 transferred to the Children's Hospital?"
24 The answer at line 4 [draft]:
25 "I was aware she was going to be transferred because



1 at that time they were talking with the Children's
2 Hospital."
3 MS ANYADIKE-DANES: I thought he said the surgeons.
4 THE CHAIRMAN: No, that's why I --
5 A. Not surgeons; Children's Hospital there she's going to
6 be transferred.
7 MS ANYADIKE-DANES: Okay, sorry. I don't know how I
8 misheard that. Were you aware of who they were talking
9 to at the Children's Hospital?
10 A. I don't.
11 Q. I don't mean the individual, but whether it was
12 surgeons, whether it was anaesthetists. Were you aware
13 of who they were talking to?
14 A. I don't remember that, who was speaking with them.
15 I mean, I don't remember that.
16 Q. I misheard you, I apologise for that.
17 When do you hear that Raychel has died?
18 A. I don't remember. I only know that they have gathered
19 some meeting and et cetera.
20 Q. Well, that meeting that you say -- did you attend
21 a meeting in relation to her death?
22 A. I don't know which kind of meeting are you asking me.
23 Q. I'm just asking you if you attended a meeting.
24 A. One meeting I remember well there was initial -- that's
25 all the staff and et cetera, the plan to go Raychel's

1 house. I know that only and not any other meeting.
2 Q. Let's go with the one that you remember. How were you
3 told about that?
4 A. That was -- I just -- I don't remember how they told me,
5 but I remember that they gathered surgeons and the
6 paediatric ward and the anaesthetists together and just
7 to plan to go and ...
8 THE CHAIRMAN: To the family?
9 A. Yes, yes.
10 THE CHAIRMAN: We're talking at cross-purposes. I think
11 Mr Zafar is talking about was there a visit to the
12 Fergusons' home; no? No, there wasn't?
13 A. Something, I don't know, then they decided the senior
14 nurse will go, only one person or something. I don't
15 know that. That was one meeting I remember.
16 MS ANYADIKE-DANES: Let me put something to you and you can
17 see whether this helps your memory. This is a statement
18 that Dr Fulton made. He made it to the PSNI and
19 Dr Fulton at the time was the medical director of
20 Altnagelvin. Okay?
21 A. Right.
22 Q. If we pull up 095-011-049. If we go right to the top,
23 this is Dr Fulton:
24 "On 12 June, I set up a critical incident enquiry
25 involving all relevant clinical staff to establish the



1 clinical facts. The critical incident enquiry started
2 at 4 pm on Tuesday on 12 June in Trust headquarters."
3 Then he lists the people who were there. If you
4 follow down your list, you can see, "Mr Zafar, SHO,
5 surgery" --
6 A. Yes.
7 Q. -- and a number of other people who were there.
8 A. Yes.
9 Q. Do you remember a meeting like that?
10 A. I don't remember, honestly speaking.
11 THE CHAIRMAN: Do you know what a critical incident enquiry
12 or a critical incident review is?
13 A. I don't remember about that anything.
14 THE CHAIRMAN: It's a different question, Mr Zafar.
15 A critical incident review involves gathering round
16 doctors and nurses who were involved in treating
17 a patient, as many of them as possible, and they sit
18 down, in effect, and discuss what happened and what
19 lessons might be learned from it. Okay?
20 That is the meeting which is being described by
21 Dr Fulton. Do you remember, whatever the meeting was
22 called or whenever it was held, sitting down with the
23 nurses and the other surgeons and the paediatricians and
24 the anaesthetists and discussing what happened in
25 Raychel's case?



1 A. One meeting I remember where all three, four --
2 surgeons, paediatricians, anaesthetists, intensive
3 careists, nurses, all that together. One meeting
4 I remember. Not more than that. Maybe this is that
5 meeting or not, I don't know that.
6 THE CHAIRMAN: Can you tell us what you remember about that
7 meeting?
8 A. Well, that was only they discussed on that, this is what
9 we -- what happened is not good. Just how we can
10 improve ourselves and et cetera. And then we have to --
11 I mean, one or two senior nurses have to go to Raychel's
12 house. Nothing more than that I remember.
13 MS ANYADIKE-DANES: Let's just pause there a minute.
14 A. I don't remember any more.
15 Q. Just a moment. When you said that there was a view that
16 what had happened wasn't good and there was a discussion
17 as to what we could do to improve --
18 A. That's only -- yes.
19 Q. So in terms of what had happened wasn't good, that part
20 of it, can you remember what it was that people thought
21 had gone wrong?
22 A. I don't remember about that, all discussions, no.
23 Q. Well, did you form a view as to what you thought had
24 gone wrong?
25 A. I only remember that I have attended only one meeting.



1 Q. I'm just asking you about --
2 A. No, they didn't ask me any about, but I have present
3 there.
4 Q. I'm asking you about that meeting, I'm asking you
5 whether you had formed a view as to what had gone wrong.
6 A. My own personal?
7 Q. Yes.
8 A. It's very difficult me to memorise at that time what
9 I was thinking. I don't know that now. I cannot
10 comment on that really. I am not say --
11 THE CHAIRMAN: I'm sorry, Mr Zafar, I don't really quite
12 understand why it is difficult. For instance, if you
13 were at that meeting, which was almost certainly within
14 a few days of Raychel's death, and if you had learned at
15 that meeting that Raychel, after your ward round, had
16 continued to vomit, that the vomit had gone on well into
17 Friday night, that the volume of fluids which you had
18 got had not been reduced, that the type of fluid which
19 she had got had not been changed, and that two JHOs had
20 been called out and had given her anti-emetics, would
21 you not have formed the view at that time, as you have
22 described today, that you should have been called back
23 in much earlier and that there should have been
24 a reassessment of her condition and that her bloods
25 should have been tested? Would you not have formed that

1 view at that time in the same way as you've described it
2 to me this afternoon?
3 A. No, this -- Mr Chairman, I understand that. I can say
4 about that. The question is here -- I mean, at that
5 time the senior consultants are sitting, they have
6 formed a view and we have said, yes, that is the right
7 thing that we have to look after further how can we
8 improve ourselves and how we can improve our teamwork,
9 how we can improve our coordination. [inaudible] and
10 what's going on [inaudible] and reach immediately and
11 sort out the problems.
12 MS ANYADIKE-DANES: Yes. Well, if that's what you're trying
13 to do "to see how we can improve", as the chairman's
14 just put it to you, you have something to contribute to
15 that because, on your way of assessing, an important
16 thing that's gone wrong is that this child has
17 deteriorated from a stage when you thought she was very
18 well and you have not been informed about it. In fact,
19 you didn't know about her deterioration until she
20 suffered a seizure.
21 A. Yes.
22 Q. Is that not something that you would have wanted to
23 communicate and say, "We need to see how we address
24 this"?
25 A. My views, what they have asked, I have told them.



1 "Look, I saw her in the morning time and she was fine.
2 There was no other problem at that time". Nothing more
3 than that, that was my input in that.
4 THE CHAIRMAN: I'm sorry, Mr Zafar, I have to say, with the
5 greatest possible respect, that doesn't make sense. If
6 you're at a meeting on how to improve things for the
7 future, then surely you have a contribution to make, and
8 your contribution is, "Look, next time something is
9 going wrong with a patient who I've seen, instead of
10 calling back an inexperienced JHO, come to me or come to
11 another senior house officer or the registrar". Is that
12 not a lesson to be learned?
13 A. It is, yes.
14 THE CHAIRMAN: And haven't you told me this afternoon that
15 that is something which should have happened at the
16 time, on 8 June 2001; is that right?
17 A. Yes.
18 THE CHAIRMAN: So if that's the view which you hold, which
19 seems to me a perfectly rational, reasonable view, why
20 would you not express that view at the meeting with the
21 other consultants and junior doctors?
22 A. My only question, if that is the meeting, I don't
23 remember that meeting is at that meeting. We have
24 gathered, I understand that, Mr Chairman. The question
25 is here, I don't remember that meeting is where I have



1 established my views on the meeting. I don't remember
2 that.
3 THE CHAIRMAN: I think there's a limit to what we can do
4 with this.
5 MS ANYADIKE-DANES: Yes.
6 THE CHAIRMAN: Sorry, there is a point, I think you have
7 a point about the nurses. Would you ask Mr Zafar about
8 the nurses' view?
9 MS ANYADIKE-DANES: Yes. The nurses, at least Sister Millar
10 and Staff Nurse Noble, do remember some of what took
11 place at that meeting. What they say is -- let's start
12 with one of the things. One of the things that they
13 said is that there was a recognition that Raychel had
14 received too much fluid. Do you remember that?
15 A. Such conversation?
16 Q. Yes.
17 A. I don't remember.
18 Q. There was a recognition she received too much fluid?
19 A. I don't remember there was a conversation of such.
20 Q. Even if you don't remember it, if the details had been
21 described as you were saying, I was saying what I did,
22 if everybody else was saying what they did and the
23 medical notes and records of Raychel were there in the
24 room, which we understand they were so everybody could
25 see what her fluids were, the rate and how long they'd



1 been given, if that information had been there would you
2 have disagreed with that view that Raychel had received
3 too much fluid?
4 A. Again, here, she had received a bit more fluid, I will
5 say that way, because the question is that now here you
6 are asking me total 20 hours, that fluid, from 8 o'clock
7 until morning 4 o'clock.
8 Q. Yes.
9 A. That is the question to me, I understand that.
10 Q. Yes, that's the question. Would you have agreed with
11 the view that Raychel had over that period of time
12 received simply too much -- and let me add to it -- too
13 much of the wrong fluid, too much Solution No. 18?
14 A. This is true. Because she was vomiting, her sodium was
15 going out and she was given a low sodium. I agree with
16 that, it's wrong fluid given, not too much, the wrong
17 fluid given.
18 Q. So you would have agreed with that?
19 A. I agree with that, yes.
20 Q. Would you also have agreed, which is something else that
21 the nurses say come out of that, that Raychel had
22 suffered severe and prolonged vomiting, that people
23 recognised that?
24 A. That's why she has -- I mean, low sodium that she has
25 lost to the vomits and given a low sodium.

1 Q. I appreciate that. But the actual vomiting that is
2 recorded for her, the nurses say, or those two nurses
3 that I've mentioned to you, say it was recognised that
4 that was severe and prolonged vomiting.
5 A. Right.
6 Q. Would you have agreed with that?
7 A. Yes, I agree that it's written there, yes.
8 Q. There was also a view that she should have had her
9 electrolytes tested.
10 A. Yes.
11 Q. Would you have agreed with that?
12 A. Yes.
13 Q. I mean before she did, which was some time in the early
14 hours of Saturday --
15 A. Morning time, no. Not 8 o'clock, morning. Not
16 8 o'clock, morning electrolytes. If it is already after
17 that she had a vomit, two or three vomits, that was
18 enough, they have to do the electrolytes.
19 Q. So some time during the day, after --
20 A. During that day, yes.
21 Q. -- she'd had about two or three vomits, if that's what
22 was being said you would have agreed with that?
23 A. It was indicated that they send the bloods, yes.
24 Q. There was also a concern from the nurses that the
25 surgeons, because of their other commitments, were not



1 very good or not really able to monitor their paediatric
2 patients who were on IV fluids. Would you have accepted
3 that that was a concern?
4 A. Well, that was not ... I mean here is a debate again,
5 debatable that -- because if patients are in a
6 paediatrics ward and the surgeons are not available as
7 well, I understand the patient is a surgical patient and
8 the surgeon has to monitor that, surgeon has to look
9 after that, no doubt. But if paediatric ward is there
10 and patient is there, they can look after that as well
11 fluid. I mean, I understand that, that should be
12 monitored.
13 Q. They should be monitored?
14 A. IV fluids, if someone is on IV fluids, should be
15 monitored.
16 Q. Just finally, you left Altnagelvin in July 2001?
17 A. I think so, yes. I think. I don't remember now.
18 Q. Were you there to see any of the changes in practice
19 that resulted from Raychel's death?
20 A. Where, in Altnagelvin?
21 Q. Yes.
22 A. I was only very short while. I can't see anything or
23 comment on anything ...
24 Q. Actually, something happened immediately, which is that
25 on 12 June a notice went up in relation to the surgical



1 patients. 095-011-059j. That notice says:
2 "From now onwards, 12 June 2001 ..."
3 So that's the very day that took place and that's
4 the change that's to happen:
5 "... all surgical patients are to have IV Hartmann's
6 solution. All post-operative children on IV Hartmann's
7 solution are to have daily electrolytes and six hourly
8 [measurements]."
9 Were you aware of that?
10 A. I was wrongly understanding your question. I was
11 thinking that you were asking me anything else.
12 I understand that they developed the guidelines that
13 after that we have to check things.
14 Q. Did you see that?
15 A. It is there, yes.
16 Q. I know it's there, but were you aware of it?
17 A. They have that, yes, I am aware of that.
18 THE CHAIRMAN: Can I say, Ms Anyadike-Danes, I'm not sure of
19 the handwritten date of 12 June on that note because,
20 according to Dr Fulton's statement to the police, it was
21 an action point on 12 June to consider whether Solution
22 No. 18 should continue to be used. And Dr Fulton says
23 that Dr Nesbitt made urgent enquiries elsewhere and that
24 point was then activated on 14 June. I wouldn't bank on
25 12 June being accurate if Dr Fulton's statement is



1 right. It's more likely that the practice changed on
2 14 June rather than 12 June. Maybe a day or two doesn't
3 matter because it was urgently followed up and the
4 change was made. So the only point I'm making is that
5 it didn't come directly on 12 June if Dr Fulton's
6 statement is right.
7 MS ANYADIKE-DANES: Yes. It's one of those things we're
8 going to deal with with Dr Fulton because there may
9 actually have been two notices. We are going to deal
10 with that.
11 THE CHAIRMAN: It was changed and it was changed very
12 quickly.
13 MS ANYADIKE-DANES: Yes.
14 And what you're saying is that you're aware there
15 was a change?
16 A. Yes. I was in June there and it was there, yes.
17 MS ANYADIKE-DANES: Yes. Mr Chairman, I don't have any
18 further questions.
19 THE CHAIRMAN: Mr Quinn has nothing for the family.
20 Mr Stitt, unless you have any?
21 MR STITT: No, sir.
22 THE CHAIRMAN: Mr Zafar, that brings an end to your evidence
23 to the inquiry unless there's anything more that you
24 want to add that you haven't had a chance to say.
25 A. Thank you very much. I did myself -- I did cooperate

1 how much I could and how much I remember and all my
2 memories. I most welcome myself -- if you need any
3 further input from my side, I'm more than happy to come
4 and help the inquiry.
5 THE CHAIRMAN: Thank you very much indeed.
6 We're finished earlier than expected, which I have
7 no complaints about at all. Tomorrow we've got the
8 return of Mr Makar and Dr McCord. Do we know what the
9 order is?
10 MS ANYADIKE-DANES: I think it's Dr McCord first and
11 Mr Makar after him.
12 THE CHAIRMAN: It'll be the same tomorrow. Since Mr Makar
13 is coming back tomorrow, we will have to finish his
14 evidence tomorrow afternoon, but I think that's
15 feasible. Then we have Mr Bhalla and Mr Gilliland on
16 Thursday. So it's 10 o'clock tomorrow, but let me
17 remind you, the video link with Mr Bhalla is for 9.30 on
18 Thursday morning.
19 (3.35 pm)
20 (The hearing adjourned until 10.00 am the following day)
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1 I N D E X

2 DR BERNIE TRAINOR (called) ...........................1
3 Questions from MS ANYADIKE-DANES .................1
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