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2 (10.00 am)
3 (Delay in proceedings)
4 (10.10 am)
5 THE CHAIRMAN: Ms Anyadike-Danes?
6 MS ANYADIKE-DANES: Good morning. Could I please call
7 Mr George Foster and Mr John Orr?
8 MR GEORGE FOSTER (called)
9 MR JOHN ORR (called)
10 Questions from MS ANYADIKE-DANES
11 THE CHAIRMAN: Thank you, gentlemen, please have a seat.
12 MS ANYADIKE-DANES: Thank you. Good morning. Can I check
13 that you both have your CVs there?
14 MR FOSTER: Yes.
15 MR ORR: Yes.
16 MS ANYADIKE-DANES: If I start with you, Mr Foster.
17 You have provided two reports to the inquiry. The first
18 is dated 2 April and the second, your supplemental
19 report after you received the witness statements, was
20 dated 21 January of this year.
21 MR FOSTER: Yes.
22 Q. The series for those is 223. Subject to anything that
23 you say now in your evidence, do you adopt that as your
24 evidence?
25 MR FOSTER: I wonder if you could speak up, please.

1 Chester Hospital.
2 MR FOSTER: I retired from that post in 2011. Currently
3 I work only at the Grosvenor Nuffield Hospital in
4 Chester.
5 Q. That's a private hospital, is it?
6 MR FOSTER: Yes.
7 Q. Thank you. So are you still engaging in clinical work?
8 MR FOSTER: I'm still engaged in clinical practice.
9 Q. Thank you. I think if we go to 002 of your CV, the
10 first page deals with your teaching and one can see
11 there what you did by way of anatomy. If we go to 002
12 and look at your surgical training, you became
13 a registrar at the Liverpool Royal Infirmary and also
14 at the Alder Hey Children's Hospital, surgical
15 registrar, and you had those posts from 1972 to 1974; is
16 that correct?
17 MR FOSTER: That's right. This is all part of a surgical
18 training rotation that took you through different
19 specialties.
20 Q. Yes. And then in 1974 to 1976, you became
21 a middle-grade, as you described it then, registrar at
22 the Chester Royal Infirmary.
23 MR FOSTER: That's right.
24 Q. We won't go through it now, but you can see immediately
25 under that section you describe the training as being

1 Q. Subject to anything that you say now in your evidence,
2 do you adopt those reports as your evidence?
3 MR FOSTER: I certainly do, thank you very much.
4 Q. Mr Orr, you have provided one report, which you were
5 asked to provide by the DLS; is that correct?
6 MR ORR: That's correct.
7 Q. That report is dated 30 January 2013.
8 MR ORR: Yes.
9 Q. The reference for that is witness statement 320/1. Once
10 again, subject to anything you say in your evidence
11 today, do you adopt that as your evidence?
12 MR ORR: I do.
13 Q. Thank you very much. I'm going to ask you both a little
14 about your background if I may.
15 Mr Foster's CV can be found at 317-007-001. Just so
16 that you have it at the same time, Mr Orr's CV is
17 towards the back of his report and that can be found at
18 witness statement 320/1, page 18. Going to your report,
19 Mr Foster, you qualified in 1968; is that correct?
20 MR FOSTER: Yes, that's correct.
21 Q. You became a fellow of the Royal College of Surgeons in
22 1974.
23 MR FOSTER: Yes.
24 Q. You are currently a consultant general surgeon in
25 colorectal and paediatric surgery at the Countess of

1 slightly different than than it is now.
2 MR FOSTER: Oh yes.
3 Q. More closely supervised and you benefited from more
4 one-to-one teaching.
5 MR FOSTER: It was very much an apprenticeship system and
6 you worked for one man and you did everything he did.
7 It's in some ways a pity that that system no longer
8 exists.
9 Q. Just after that, 1976 to 1983, that's when you became
10 a lecturer in surgery at the University of Nottingham.
11 MR FOSTER: That's right.
12 Q. Then in 1983 to 2011, that is your practice as a general
13 surgeon and as a consultant surgeon at that at the
14 Chester hospitals?
15 MR FOSTER: That's right.
16 Q. You took over from your teacher, Mr Hardy; is that
17 correct?
18 MR FOSTER: The man who taught me as a registrar, that's
19 right.
20 Q. Yes. If we go on to 006 of your CV, we see your
21 experience in paediatric surgery. And you say that you
22 did a monthly elective and paediatric surgical list
23 throughout your career with a specialist interest in
24 paediatric surgery. I wonder if I can pause there.
25 You have an interest in paediatric surgery. Would

1 I be right in saying though that you have extensive
2 interests as a general surgeon?
3 MR FOSTER: Yes. The paediatrics always came to Chester and
4 I took that on when I arrived. Over the years, it
5 changed as small babies were redirected, largely for
6 anaesthetic reasons, to Alder Hey. So it became a much
7 more generalist job in basic paediatric surgery. But
8 there was a list a month, we were doing around eight
9 cases a month.
10 Q. The reason I asked you that is because, in Altnagelvin,
11 they didn't have specialist paediatric surgeons; they
12 had general surgeons who were carrying out surgery on
13 paediatric cases, if I can put it that way. So as we go
14 through and you give your evidence on the issues
15 I raise, I think it'd be very helpful if you were to
16 tell me if you are now providing a view that is
17 something that is within the domain of a paediatric
18 surgeon and wouldn't be something really that a general
19 surgeon might appreciate. That would be useful. In the
20 main it would be quite helpful if you could keep to
21 what, from your experience, a general surgeon would have
22 been expected to recognise and undertake.
23 MR FOSTER: Yes.
24 Q. Then if we go on, we can see the administrative and
25 management positions that you have held at 007. And we

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1 MR FOSTER: And training, yes. There would be a college
2 tutor, there was a college tutor as well. Chester had
3 quite a strong interest -- always had a strong interest
4 in surgical training.
5 Q. And if there were critical incidents, is that the sort
6 of thing that you might have been alerted to and be
7 expected to address?
8 MR FOSTER: Yes. Any problems would come to the clinical
9 director because, in those days, the medical director
10 was a very new appointment and that role was acquiring
11 different responsibilities every year.
12 Q. Thank you. Then if we go over the page to 008, one sees
13 that between 2004 and 2010, you're chairman of the
14 Medical Staff Committee; can you briefly explain what
15 that involved?
16 MR FOSTER: That's a switch from management to being an
17 elected chairman of the whole consultant body. It
18 didn't have a -- I had no management role within the
19 Trust, so I was an independent member of the management
20 committee or management board, but I represented the
21 doctors' interests and concerns. And that would also
22 have an essential governance role within it.
23 Q. Yes. Is it in that capacity that you're a member of the
24 management board as we see in the line immediately under
25 that?

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1 see in particular, in 1990, you became clinical director
2 of surgery at the Countess of Chester Hospital. And at
3 the same time you were also a member of the management
4 board. Can you just explain a little bit what that
5 involved?
6 MR FOSTER: These were difficult times in 1990s, the Health
7 Service grew following the White Paper and I was the
8 first clinical director and, being the clinical
9 director, you would have a seat on the management board.
10 Q. That went with the position?
11 MR FOSTER: Yes.
12 Q. What was your responsibility as you sat on the
13 management board?
14 MR FOSTER: I represented the interests of the department of
15 surgery and that was the greater department, that was
16 orthopaedics, general surgery and all specialties,
17 plastics and so on, in this new era of the
18 purchaser-provider NHS.
19 Q. Not that we're going to deal with it to any great extent
20 today, but did that have a governance role?
21 MR FOSTER: Oh yes, I would be responsible for organising
22 the appointment of new doctors and the reasons for them
23 and we were responsible for the quality of services
24 provided by the hospital.
25 Q. And training?

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1 MR FOSTER: Yes.
2 Q. Thank you. You have also very kindly attached to that,
3 to this CV, a list of some of your publications. I take
4 it there isn't anything that particularly bears, from
5 a surgical point of view, on the aspects of this case?
6 MR FOSTER: There's a paper somewhere on appendicectomies,
7 1980, I think it was. It may be the next page. I lost
8 a lot of my publications with computer crashes and
9 things. But if we go to this next page, that would be
10 009, it might be there.
11 Q. Is it number 14?
12 MR FOSTER: Yes, that's the one.
13 Q. "Wound sepsis after appendicectomy"?
14 MR FOSTER: Yes, that was a large trial of the use of
15 prophylactic antibiotics or antiseptics on modifying
16 wound sepsis. That was a multi-centred trial. I was in
17 Nottingham then, across all the Nottingham hospitals, it
18 involved patients over 15 -- it was not children, but it
19 involved patients over 15. That was published in
20 The Lancet.
21 Q. I apologise, I see you have another paper at 19, which
22 is to do with suturing after appendicectomies. It's on
23 the next page, 010.
24 MR FOSTER: Oh yes, I'd forgotten about that one. That is
25 when I was in Chester.

8

1 Q. Thank you.
2 Mr Orr, I wonder if I might now turn to you? You
3 qualified in 1969; is that correct?
4 MR ORR: That's correct.
5 Q. And you became a fellow of the Royal College of Surgeons
6 in 1975.
7 MR ORR: Again, that's correct.
8 Q. And a consultant paediatric surgeon at the Royal
9 Hospital for Sick Children, Edinburgh, in 1984?
10 MR ORR: Correct.
11 Q. So in many respects the two of you are contemporaries.
12 MR ORR: Yes.
13 Q. I'm going to ask you the same question, or make the same
14 point to you. Did you have general surgery training as
15 opposed to paediatric surgery training?
16 MR ORR: Yes. Before I entered paediatric surgical
17 training, I completed my general surgical training, so
18 I am one of the few surgeons in the United Kingdom who
19 has double training in both general surgery and in
20 paediatric surgery. So as part of that training,
21 I carried out some of my training in remote and rural
22 hospitals and district general hospitals where we did
23 a whole range of general surgery, including the surgery
24 of childhood, so I'm well aware of some of the
25 challenges that are involved in delivering these

1 surgical services at the Western General Hospital.
2 Can you help us with roughly when that was?
3 MR ORR: That would be approximately 15 years ago. That's
4 a post I held for three years, managing a number of
5 services, including general surgery, colorectal surgery,
6 neurosurgery, and breast surgery. I then moved from
7 that post to the Royal Hospital for Sick Children since
8 there was a rationalisation of children's services in
9 Edinburgh, and I became the medical director at the
10 Royal Hospital for Sick Children in Edinburgh.
11 Q. And you also became the associate medical director of
12 the Lothian University Hospital Trust.
13 MR ORR: Yes, there was then another reorganisation of
14 Health Services and I then became an associate medical
15 director with a portfolio of -- mainly dealing with
16 performance issues, although I was obviously responsible
17 for a different group of services which had included
18 obstetrics, medical paediatrics, ENT, ophthalmology, and
19 I think that covered it. My portfolio mainly was
20 assisting the medical director with performance issues,
21 governance issues, things like that.
22 Q. And so for those three posts, do I take it that all
23 three posts took you into issues to do with governance
24 matters?
25 MR ORR: Yes.

1 services. I would also say at this point that I have
2 been involved later in a number of committees looking at
3 the delivery of children's services in Scotland and
4 in the UK.
5 Q. Thank you very much. So you're able to speak not just
6 as a specialist paediatric surgeon, but also from your
7 experience as a general surgeon and are able to assist
8 us in what might be expected of a general surgeon in
9 Altnagelvin, albeit handling some paediatric cases?
10 MR ORR: That is correct. I have approached my report from
11 the point of view of a general surgeon in a district
12 general hospital.
13 Q. Thank you very much. If we pull up your CV at witness
14 statement 320/1, page 18. We see that you started as
15 a consultant surgeon in the Royal Hospital for Sick
16 Children, Edinburgh, in 1984 and you continued on until
17 2009.
18 MR ORR: That's correct.
19 Q. And although you no longer practice from a clinician's
20 point of view, you are still involved in medical issues?
21 MR ORR: Yes, I retired from clinical work in 2009, but
22 I continue with a medicolegal practice.
23 Q. Thank you. Then if we look down at your organisations
24 and wider responsibilities, you also have been
25 a clinical director. You were a clinical director of

1 Q. Therefore, the issues that arise out of critical
2 incidents, would that be something you would have been
3 familiar with?
4 MR ORR: Yes, I was.
5 Q. Thank you. Thank you very much.
6 If I turn now to some of the issues that have arisen
7 in the course of the clinical aspects of Raychel's case.
8 The first I would like to ask both of you about really
9 is the administration of the IV Cyclimorph. You're
10 probably aware that there has been quite a bit of
11 evidence as to whether it should have been administered.
12 There has been quite some evidence, which has set up
13 a comparison between administering no analgesia and
14 administering that as the particular form of analgesia.
15 Am I right in saying that neither of you are advocating
16 not administering any analgesia at all to Raychel, the
17 issue is what form of analgesia is to be administered?
18 Would that be a fair way of putting it? Mr Orr?
19 MR ORR: Yes. You can administer analgesia, but I think the
20 important thing is that if you're going to administer
21 analgesia, the surgical staff who are going to be
22 managing the patient should see the patient before
23 analgesia is administered, for the reasons that I have
24 recorded in my report, that it may well mask symptoms
25 and make diagnosis and management difficult. I don't

1 know if you want me to comment about some of the other
2 evidence that's been introduced or whether that's
3 something we do later.

4 Q. Yes, I do, but not overly so, but yes because there are
5 some who have a slightly different view. If I can just
6 pull up the bit of your report which deals with this
7 just so that we have it there and perhaps that's
8 a useful starting place. It's witness statement 320/1,
9 page 4.

10 I think you can see it there under your comment,
11 1.3, the first paragraph:

12 "It was poor practice to prescribe an opioid
13 intravenous analgesic before the patient was reviewed by
14 the surgical team. This has the potential effect of
15 masking surgical signs and sedating the patient."

16 And one of the issues I wonder if you could help us
17 with is because Mr Foster has suggested you could
18 administer some pain relief. His view is that one
19 should not rush to administer something as significant
20 as IV Cyclimorph before having some sort of discussion
21 with either the surgical team or the surgical team
22 having had an opportunity to examine the child. So it's
23 not no pain relief, it's just the form of it. I wonder
24 if you can help us with your views on that.

25 MR ORR: Well, intravenous opioids are an extremely strong

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1 "The most common error here is to forget or delay
2 the administration of analgesia. Every patient in pain
3 must have that pain appropriately treated as soon as
4 possible. A patient does not have to 'earn' analgesia
5 and there is no situation in which analgesia should be
6 delayed to allow further examination or investigation.
7 Concern regarding masking of signs or symptoms, for
8 example in a patient with an acute abdomen, is not only
9 inhumane but incorrect."

10 So that's part of the rationale that Dr Kelly used
11 to administer the IV Cyclimorph to Raychel to relieve
12 her pain.

13 Mr Foster, I wonder if I can come to you. Your
14 view, as I understand it, is that the key term there is
15 to have that pain appropriately treated. So as I
16 understand your evidence, it's not that she shouldn't
17 have had any pain relief at all, the question is what
18 form and was the IV Cyclimorph the appropriate form?
19 I wonder if you can briefly help us with that.

20 MR FOSTER: I think it's got to be proportionate to the fact
21 that children get abdominal pain frequently and it's
22 been shown in the public domain that for children under
23 15, one in 3 will at some point or other have seen
24 a doctor with abdominal pain. And that doctor may not
25 necessarily be in Accident & Emergency, it would

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1 analgesic and, as I've said there, they are likely to
2 mask significant signs that the surgeon may wish to
3 elicit. We are talking about 2001 and I would suggest
4 that for the majority of surgeons in 2001, they would
5 not wish that type of analgesic to be administered
6 before they had an opportunity to take a history and
7 examine the patient. I'm aware that evidence has been
8 presented that that view may be changing, but it's
9 changing with time and it's recent experience that is
10 now indicating, as we run into 2013, that it may be
11 possible to give intravenous analgesic of this type, but
12 in 2001 for the majority of surgeons in the UK they
13 would wish to examine the patient before an opioid
14 analgesic had been given.

15 Q. Yes. The evidence that you might be referring to is
16 Dr Kelly, who was on duty at A&E. He referred in his
17 evidence to a text which was his reference work, if I
18 can put it that way, which is the Oxford Handbook of A&E
19 Medicine, and we see it at witness statement 254/1,
20 page 11, very briefly.

21 I wonder if we could enhance that a little bit? If
22 one sees on the left-hand side:

23 "Has the patient had appropriate treatment pending
24 inpatient team's arrival?"

25 And there you see it very clearly:

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1 probably be more likely to be the general practitioner.
2 And the use of intravenous opiates is not on the general
3 practitioner's radar and they would use, at the very
4 most, something simple like paracetamol. That's the
5 starting point.

6 For children with abdominal pain -- and again, it's
7 a well-known statistic -- 90 per cent have something
8 functional, it's not an organic condition; only 10
9 per cent have something like that. So when Raychel
10 arrived at the Accident & Emergency department with her
11 parents as an ambulant patient, she was in many ways
12 analogous to a child attending a GP. Dr Kelly was
13 a trainee GP, doing a period of time in A&E, and to
14 examine a little girl quite quickly, because Raychel was
15 triaged in at 20.05, and by 20.20 had had 2 milligrams
16 of intravenous opiate.

17 I believe examining children is not easy, they are
18 anxious and it is very easy for inexperienced junior
19 doctors to think of the first thing they think of
20 in relation to abdominal pain, and that is appendicitis,
21 but most abdominal pains aren't.

22 So I think to give an intravenous shot of a powerful
23 analgesic like that, which does have side effects,
24 without, as we know it, contacting -- or at least, if he
25 contacted Mr Makar, he's only spoken to him. To give

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1 that before Raychel was seen by somebody experienced,
2 and ideally by somebody who would be responsible for
3 subsequent surgical decisions was over the top.
4 THE CHAIRMAN: So you can act humanely without giving
5 Cyclimorph? Dr Kelly was relying on this to show
6 that -- it's the line about six or seven lines down:
7 "It is not only inhumane, but incorrect."
8 The text that Dr Kelly relied on refers to:
9 "It is not only inhumane, but incorrect."
10 And I think the point you're both making is that
11 giving Cyclimorph was incorrect, but it would be
12 perfectly humane and appropriate to have treated Raychel
13 at that point by giving a much milder or gentler
14 painkiller so that any examination of her which followed
15 a short time later may not have been disrupted; is that
16 fair?
17 MR FOSTER: Yes. I mean, this is basic medical fact. It's
18 standard treatment, standard practice. I believe to
19 give something simple like paracetamol syrup, 10cc
20 at the most, that's not going to affect any subsequent
21 anaesthetic implication. If you're going to do that,
22 then that is part of your clinical activity in assessing
23 the case globally to see the effect of that simple
24 analgesic on the patient's symptoms, which they have
25 attended the hospital with.

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1 use it for pain relief.
2 Q. If it had the effect of fairly speedily addressing the
3 pain -- we're going to go on to talk about something
4 else which you advocate, which is, "Let's have a period
5 of observation", if you like -- would that be part of
6 your view as to whether it was appropriate to move at
7 that stage towards surgery if the pain could be
8 adequately addressed by a reasonably mild analgesia?
9 MR ORR: I would not normally use response to paracetamol as
10 part of my diagnostic criteria in moving towards
11 surgery.
12 Q. Okay. I would like to move on now to the decision to
13 perform the appendicectomy at all and then, if you are
14 going to do it, or at least you think you might do it,
15 when you would be forming that view, if I can put it
16 that way.
17 If I start, Mr Foster, with you. You said that
18 there were a number of possible diagnoses, as
19 I understand you, in your report, your first report.
20 And in addition to an appendicectomy, there could have
21 been urinary tract infection, there might have been
22 that, and we'll come to that in a minute. There might
23 have been some sort of general non-specific abdominal
24 pain --
25 MR FOSTER: Yes.

19

1 MS ANYADIKE-DANES: Can I ask you both this finally?
2 Dr Scott-Jupp who is the consultant paediatrician who's
3 been retained by the inquiry was asked a similar
4 question, and in his evidence yesterday he thought that
5 the IV Cyclimorph was stronger than it needed to be in
6 terms of addressing Raychel's pain. He also made the
7 point that analgesia can be used as a diagnostic tool.
8 Is that what you meant, Mr Orr, by saying you give
9 something milder and see what happens?
10 MR ORR: Yes, I think so. You're giving it, if you wish to
11 give it, to allay anxiety and help symptoms; you're
12 giving it to see what will happen.
13 Q. Mr Foster, would you have a similar view, that you can
14 use it diagnostically, if I can put it that way?
15 MR FOSTER: That will be part of the reason for using it.
16 The reason for using it at all is if you thought her
17 pain, the little girl's pain, was significant. I don't
18 know how a junior Accident & Emergency doctor would
19 reach that conclusion. And I'm uncertain as to why, in
20 an Accident & Emergency department that takes all
21 comers, he didn't speak to a senior colleague before
22 organising that medication.
23 Q. Yes. Mr Orr, I wonder, would you like to comment on
24 that?
25 MR ORR: I wouldn't use paracetamol diagnostically. I would

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1 Q. -- and she might have been constipated. Those are the
2 contenders, are they, for her symptoms as she presented
3 at A&E?
4 MR FOSTER: They would be my main contenders. We perhaps
5 should put constipation into the package of functional
6 pain, perhaps the whole length of the gastrointestinal
7 tract. This little girl had walked in only three and
8 a bit hours after having her dinner and all the
9 observations done on her arrival were normal.
10 In addition, when she'd seen the surgeon, the blood
11 results would then have been available, indeed they
12 weren't available from my understanding when the
13 Cyclimorph was given. The blood tests were also all
14 normal. By this time, the Cyclimorph had been given and
15 Raychel was a lot better.
16 Q. So from your point of view, does that suggest that
17 waiting might have been appropriate?
18 MR FOSTER: Absolutely. There's, again, quite a lot of
19 information in the literature as to the timeline of
20 symptoms to pathology in appendicitis. The best
21 available would suggest something like a 30-hour, 24 to
22 30-hour delay to acute appendicitis, and something like
23 40 to 60 hours from the onset of symptoms until
24 a perforated appendicitis. This was only 3-and-a-bit
25 hours down the line with normal investigations, with

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1 normal observations. This was an acute district general
2 hospital with a paediatric ward and the facilities for
3 acute observation of Raychel, repeated examinations by
4 ideally the same clinician who made the original
5 diagnosis, a repeat of blood tests after a suitable time
6 and a repeat of urine tests as well. So the scenario
7 was a perfect one for admitting a little girl to
8 hospital for acute observation of her symptoms. That's
9 what hospitals are for and tests can be repeated as
10 necessary, even the next morning one could escalate
11 them, and in 2001 it was permissible to do an ultrasound
12 or something of that sort, particularly with the
13 possibility of a renal problem coming into play also.
14 These days, it's more common to do CT scans and things
15 like that, but they were not so much in the frame in
16 2001.

17 Q. Yes, thank you. We'll come back to some of the detail
18 of that. There was something that I think you had
19 pointed out, which I'm afraid I omitted to draw out and
20 it's just to draw out that issue of pain.

21 Mr Gilliland had produced a third statement for the
22 inquiry and, as part of that statement, he attached a
23 2005 paper titled "Early analgesia for children with
24 acute abdominal pain", and the starting point of it is
25 witness statement 044/3, page 9. You don't need to pull

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1 Accident & Emergency before the decision to give the
2 analgesic was made: they were examined by a paediatric
3 emergency physician. So it was at a different level,
4 but even a hospital operating at that level, which I'm
5 sure would have had access in 2005 to CTs and so on,
6 it's pointing out quite clearly that their current
7 practice needed modification maybe as a result of the
8 trial that they were going to perform.

9 Q. Yes. And that modification maybe is to be found in the
10 top three lines under "conclusions":

11 "Our data show that morphine effectively reduces the
12 intensity of pain amongst children with acute abdominal
13 pain and morphine does not seem to impede the diagnosis
14 of appendicitis."

15 But the point that you were making is that it took
16 trials like that to change what was the practice?

17 MR FOSTER: Yes, that was their purpose, and that's the sort
18 of publication that, quite rightly, should be coming out
19 of a hospital of that nature.

20 Q. Just as we leave it, it may just have been that Dr Kelly
21 was ahead of his time.

22 MR FOSTER: Well, I can scarcely see his academic
23 credentials to be so. He was a junior doctor in -- the
24 bolster(?) junior doctor in Accident & Emergency and
25 I think he was over the top rather than ahead of the

23

1 that part up, but if you will pull up page 10.

2 What I think you wanted to draw out is, if you see
3 that section called "Methods", then the penultimate
4 paragraph before that, just after halfway down:

5 "Current practice in paediatric emergency medicine
6 and paediatric surgery dictates that children should not
7 receive analgesics when presenting with acute abdominal
8 pain. This practice amongst children is a result of
9 traditional teaching and only recently [this being 2005]
10 has been challenged in a manner similar to that for
11 adults."

12 I think you wanted to identify that as a section in
13 a paper that Mr Gilliland had provided to us, which
14 seemed to suggest that the current practice, even in
15 2005, in relation to paediatrics, was not quite what
16 appears to have happened at Altnagelvin. But maybe you
17 can just comment briefly on that.

18 MR FOSTER: That's right. This paper's starting with
19 a standard introduction to justify the purpose of
20 writing the paper and that's in 2005, and they're making
21 it quite clear that, historically, the clinical practice
22 was of not administering analgesia until the patient,
23 child or adult -- in this case this paper came from
24 a paediatric hospital in Canada, a specialist hospital.
25 The children had not been examined by a junior doctor in

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1 team [sic].

2 Q. Mr Orr, if I turn to you. We don't need to pull it up,
3 but in your report you also advocate the benefits of
4 active -- I think you refer to active observation. So
5 purposeful observation, if I can put it that way.

6 MR ORR: Yes.

7 Q. Is that what you think would have been appropriate
8 practice in 2001 in relation to a child like Raychel?

9 MR ORR: Yes, I would. The principles of active observation
10 have been recognised since the mid-1970s. And most
11 surgeons dealing with children with abdominal pain would
12 pursue that type of policy. There is no urgency in
13 taking a patient to theatre unless there are very clear
14 criteria that this child has a major intra-abdominal
15 problem, and that was not the case here for all the
16 reasons that Mr Foster has just stated and I will
17 reiterate them.

18 I would suggest that for the great majority of
19 surgeons in the United Kingdom, they would pursue
20 a policy of actively observing a child like Raychel with
21 abdominal pain, initially overnight, and thereafter
22 a review in the morning with a decision whether further
23 investigation is required.

24 Q. The concern that Mr Makar had -- and he has been
25 supported in that concern by others, Mr Gilliland who is

24

1 the consultant, but also to some extent I think also
2 Dr Scott-Jupp, the paediatrician expert for the
3 inquiry -- was that if she did have appendicitis, which
4 is a difficult thing, as we have been led to believe, to
5 accurately diagnose amongst children, and if you waited
6 and that did continue to develop, the risks of
7 peritonitis were so great that outweighed, if I can put
8 it that way, the risks of carrying out possibly early an
9 appendicectomy or maybe even an appendicectomy which
10 ultimately will prove to be unnecessary. Can you help
11 us with that?

12 MR ORR: I would suggest that that is a rather historic
13 view. It was the view at the time that I commenced my
14 surgical training. The view was that you should act
15 urgently to prevent the scenario that you have just
16 outlined. But over the last 25 to 30 years, there has
17 been a change to keeping a very close eye on the
18 patient, doing the necessary investigations, and if you
19 do that, the risks of that patient suddenly perforating
20 their appendix and developing peritonitis are extremely
21 small. I would hesitate to say that it never happens,
22 but the risk is infinitesimally small that that scenario
23 would occur.

24 Q. Mr Orr, is that because it just takes time for that kind
25 of development to occur and there are signs as it's

25

1 those signs, then the consequences of that might be
2 quite serious for a child or are the signs sufficiently
3 clear that the chances of an experienced paediatric
4 nurse or nurse working on a paediatric ward missing
5 a series of signs like that are really quite low?

6 MR ORR: Active observation involves not just the nursing
7 staff, but the surgical staff. It is an intensive
8 process. It involves perhaps two to three-hour
9 observations by clinical staff. So that means that you
10 are observing that patient overnight. It's not a matter
11 of, at 11 o'clock, saying that's fine until the morning.
12 Depending on the patient's condition, you may well have
13 to re-examine that patient at 3 o'clock, 4 o'clock
14 in the morning. It is what it says: it is an active
15 process.

16 Q. Does that not make it rather resource intensive?

17 MR ORR: It is resource intensive, but that is what is
18 required.

19 Q. Apart from what happened with Raychel, are there risks
20 incidental to carrying out an appendicectomy which
21 proves to be unnecessary once you examine the appendix?

22 MR ORR: Sorry, are there risks?

23 Q. What are the risks? One might say why engage the
24 resources, why take any risks that any of these signs
25 are missed, why not simply, when you suspect an

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1 occurring, which is presumably what you're looking out
2 for? Is that why the risks are low and favour
3 observation?

4 MR ORR: Yes. If you're observing the patient, for example,
5 you'll see if there's a progression in the severity of
6 the appendicitis. It is likely that pulse rate will go
7 up, temperature will go up, the patient will develop
8 more severe pain in the appropriate area, repeat blood
9 investigations would show that the white cell count
10 starts to elevate. So there would be signs of
11 progression in the clinical condition.

12 Q. Thank you. In terms of timeline, I think Mr Foster's
13 view is: it's not like a balloon that you just burst,
14 these things don't just erupt in that way, there is
15 a period over which they gradually intensify, the
16 situation becomes worse and that is a time in which
17 those symptoms are developing and you're watching them,
18 but it's not something that, if you don't do it now
19 in the next couple of hours, it'll be a disaster?

20 MR ORR: That's correct. Some patients may progress more
21 rapidly than others, but if they're being properly
22 managed and observed, that will be identified by the
23 attending staff.

24 Q. And just so we have it, do you regard there as being
25 risks in managing and observing because, if you miss

26

1 appendicitis, simply remove the appendix?

2 MR ORR: Because you're then subjecting a patient to an
3 unnecessary operation and any operation will carry
4 a risk with it. For example, there is a risk of wound
5 infection, which could progress to a more severe form of
6 sepsis when you remove even a normal appendix. Now, it
7 shouldn't happen, but it can occur. So I would not
8 support an argument for returning to an era where you
9 remove the appendix because you thought that there might
10 be a risk of appendicitis.

11 Q. I understand. I'm just going to move on a little bit.
12 There has been a difference in views as to the signs
13 indicating appendicitis. Mainly that difference is
14 expressed between responses from Mr Gilliland to
15 Mr Foster's report. It's to do with the site of the
16 pain and whether there was appropriate tenderness,
17 guarding and rebound, whether the pain was noted to
18 increase in intensity, the significance of the fact that
19 the injection improved matters almost entirely within
20 a relatively short period of time, and also the dysuria
21 that was noted, the pain on urination. And maybe even
22 also the protein that was noted in the urine. All of
23 those things.

24 Mr Foster, I think, your view was you probably
25 should wait and observe this child anyway. But while

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1 you were doing that, you might be reflecting on some of
2 these things and trying to see if there was an
3 alternative or a differential diagnosis. Would that be
4 a fair way of characterising your view?
5 MR FOSTER: Yes, absolutely, and that's why the little girl
6 was going to be coming into hospital. It's not just to
7 do urgent surgery based on the diagnosis of -- however
8 experienced they might have been theoretically -- the
9 junior doctors at SHO level in the absence of positive
10 factors: blood tests, abnormal vital sign recording,
11 improvement in her pain, and then side issues such as
12 the proteinuria. Absolutely, as you say, that might
13 suggest an alternative diagnosis. You wait until the
14 light of day, reassess the patient, organise tests as
15 necessary, and the easiest thing in the world to
16 organise in a paediatric unit is to ask the
17 paediatricians to see the patient also and give you
18 their opinion.
19 Q. As you introduce the paediatricians there, the evidence
20 that we've had is that although this was a paediatric
21 ward, in large part the surgeons looked after their
22 patients and the paediatricians looked after the
23 non-surgical patients, if I can put it that way. But
24 when you say, "Ask the paediatricians", does that mean
25 that you would advocate perhaps a more collaborative

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1 come out of working parties over the last 15 years on
2 addressing the challenge of managing children's surgical
3 services in smaller district general hospitals. It has
4 been recommended that there should be close co-operation
5 between the surgical staff and the paediatric staff.
6 And as has been described in many units, it is the
7 paediatricians who in fact carry out the general
8 management, the general care of the child in the ward;
9 the surgeons would focus on the surgical aspects. So
10 these are issues which have been developed over the last
11 10 to 15 years and there will be variation across the
12 country as to how that has been implemented.
13 In 2001 it is still possible that there were units
14 where the surgeons managed their patients in the
15 paediatric ward, but they would have to be managed
16 appropriately.
17 Q. Yes. And when you say that there was perhaps, in
18 certain areas, a gradual realisation that perhaps in
19 those sorts of settings where you maybe don't have
20 specialist paediatric surgeons, that the paediatricians
21 perhaps should address the children, all the children,
22 is that a recognition of the fact that the surgeons are
23 not specialists in paediatric cases? Although they may
24 be perfectly specialist at that particular surgical
25 technique that they are carrying out, in terms of the

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1 working between the surgeons and the paediatricians?
2 MR FOSTER: I certainly do, and that has been my experience
3 ever since I worked in Nottingham, and throughout -- as
4 long as anyone can remember in Chester, the
5 paediatricians took the role of being in overall charge
6 of the children in the children's ward. One should
7 remember that the majority of them would be the
8 paediatric medical patients and there would only be one
9 or two surgical patients. I am well aware that on their
10 rounds -- and the paediatricians would do more than one
11 ward round a day, they would do two and sometimes
12 three -- they would stop at every bed. And if they saw
13 a surgical patient performing badly, a surgical patient
14 becoming ill, saw a surgical patient not behaving as
15 expected, they would take over control and do something
16 about it.
17 Q. That has been your experience?
18 MR FOSTER: Yes, definitely.
19 Q. I wonder if I can ask Mr Orr about that. You presumably
20 have also worked on, if I can call it this way, mixed
21 wards where there have been both general medical
22 paediatric and also surgical paediatric patients.
23 Do you have any experience of there being that kind of
24 collaborative working?
25 MR ORR: In fact, it's one of the recommendations that has

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1 patient, they may not be so aware of the patient as
2 a child than the paediatricians would be?
3 MR ORR: It's a recognition that the surgical team from the
4 houseman, now the foundation doctor, up to the
5 consultant, if they are general surgeons, will not have
6 the depth of experience of dealing with children and
7 dealing with issues such as fluid balance, pain relief,
8 drug dosages. So that is why the paediatricians in many
9 units have taken on the more general management of these
10 patients, obviously working with the surgeons, who have
11 to make the decisions about the surgical care of that
12 child.
13 Q. And if you're going to do that, I presume communication
14 then becomes very important.
15 MR ORR: Absolutely.
16 Q. Just to ask you, Mr Foster, to deal with some of the
17 particular things that Mr Gilliland raised. He said
18 in relation to the white cell count, for example, he
19 said it can be raised in case of appendicitis, but not
20 exclusively, and in fact it wasn't raised at that stage
21 in Raychel, but the fact that it wasn't raised doesn't
22 necessarily mean that she couldn't have appendicitis.
23 If we pause with that, would you accept that?
24 MR FOSTER: Yes. I'm not sure about that, to be honest. In
25 this modern age when we repeatedly examine patients and

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1 we can do blood tests as frequently as we wish, I think
2 it is quite uncommon for the white cell count to be
3 entirely normal in the absence of the signs of
4 appendicitis. If the white cell count is normal, then
5 you would probably find other abnormalities such as
6 a raised heart rate and increasing tenderness and so on.
7 I think too much can be made of the white cell count in
8 appendicitis; it almost always goes up in my experience
9 and goes up almost in proportion to the severity of the
10 disease.

11 Q. So your view is that you don't look at these things in
12 isolation?

13 MR FOSTER: No.

14 Q. I presume the point of doing the range of tests is you
15 look at the results of all of them and to see
16 collectively what that tells you in your experience
17 about the patient's likely condition.

18 So then, when you say "in the absence of other
19 abnormalities", Mr Gilliland goes on to say that
20 a normal temperature can be a common finding in children
21 with acute appendicitis. Is your point: well, yes, but
22 if you're stacking up all the tests that appear to be
23 normal then maybe you need to either wait or think again
24 about your diagnosis?

25 MR FOSTER: I think to say "a common finding" is not correct

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1 was quite in its infancy and there was a degree of
2 suspicion about the sensitivity and accuracy of that
3 form of stick testing. Back in 2001, 12 years ago,
4 we were still sending urine samples to the lab for
5 microscopy, and I accept to wait for cultures to come
6 back is probably not right, but to at least send them,
7 send them for microscopy, and at that time we certainly
8 still did that. All the proteinuria means to me is that
9 this is another tick in the box of something unusual and
10 it merited looking at Raychel a little more attentively.
11 And ideally, I think the next morning, amongst repeating
12 blood investigations, she should then have had her urine
13 tests dipsticked again and a referral made to the
14 paediatricians across the corridor about any comments
15 they would wish to make regarding the proteinuria in
16 a little girl. I would personally probably order an
17 ultrasound scan as well.

18 Q. Then if I ask you both, we know that the wait-and-see
19 approach is not one that was applied in relation to
20 Raychel. And what happened instead is that Mr Makar
21 went back to the ward to change over the fluid, the
22 IV fluid prescription he had made. He had originally
23 thought or at least wanted her to have Hartmann's and
24 was told that ward policy was Solution No. 18. So he
25 went back to the ward to do that. It doesn't seem that

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1 at all. You're looking at a score sheet here, which has
2 blood tests on it, it has vital sign recordings and it
3 has clinical observations, and if you like it also has
4 investigations such as ultrasound. And all those things
5 come together in a jigsaw to make the diagnosis of
6 appendicitis. As you very clearly say, you do not look
7 at one test on its own.

8 Q. Yes. And do you have a similar response to his comment
9 that a significant number of children with appendicitis
10 do have abnormalities on urinalysis and dysuria can
11 occur in children with appendicitis and the fact that
12 it's there doesn't necessarily mean that something else
13 is, if I can put it that way, going on?

14 MR FOSTER: Oh, I accept what he says, but nevertheless
15 along all the other things in the boxes, the proteinuria
16 was an abnormality. It is not normally seen in
17 children's urine, it's only around 10 per cent,
18 I understand. Amongst the recordings made from Raychel,
19 that included blood tests and examination findings and
20 blood tests, the only abnormality that came out of all
21 that lot were two urinalyses that showed protein that
22 needed at some point to be taken further. I accept that
23 in 2001 -- I would like to point out, rather, that in
24 2001 stick testing of urine for nitrite, which organisms
25 can make, or for esterase which neutrophils can make,

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1 he examined Raychel at that point. Her family's view
2 was that her pain had receded almost entirely and
3 there's reference to that in the charts at that stage.
4 And it seems that the next time that Mr Makar saw
5 Raychel was when he was bleeped to theatre. He deals
6 with it in his transcript of 6 February at page 125. He
7 says that she was already anaesthetised by the time he
8 saw her in the theatre.

9 He had accepted, when I was asking him questions,
10 that just because you have got a view that a child is
11 going to have an appendicectomy does not mean that if
12 the situation changes that you are not prepared to
13 respond to those changes and if it means you don't
14 pursue the surgery, well, then you don't, and he said he
15 had an open mind about that. And if he had been told
16 her symptoms had been relieved, he might have thought,
17 "Perhaps we'll wait and see what happens". So that was
18 the evidence he gave.

19 I wonder if you can comment, though, about how all
20 that could have worked if the next time he really has an
21 opportunity to see Raychel, she is already in theatre
22 and anaesthetised. Maybe, Mr Orr, you can help with us
23 that.

24 MR ORR: Well, if the next time he sees the patient she's
25 anaesthetised, ready to go to theatre, he's going to go

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1 to theatre. He had an opportunity to examine Raychel
2 again when he went back to the ward. And if the
3 symptoms had improved, if the signs had modified,
4 bearing in mind that she's already had morphine, he
5 might have been in a position to say, "Okay, we'll hold
6 off and we'll review the situation later on in the
7 morning". There was an opportunity.
8 Q. Do you think he should have examined her again then?
9 MR ORR: Yes.
10 Q. And do you think that the arrangements should have been
11 such that, absent that opportunity, that in fact she was
12 already anaesthetised by the time he got to theatre, or
13 would that be perfectly standard in your experience?
14 MR ORR: Well, as I understand it, the timing, potential
15 timing of surgery was moved forward. There was an
16 earlier decision perhaps to operate the next morning, as
17 I understand it, in some discussion with a more senior
18 colleague. But theatre became available and therefore
19 they made the decision to take Raychel to theatre and
20 carry out the appendicectomy late in the evening.
21 Q. So it's not so much that there was a procedure where
22 that would happen, in fact, just fortuitously or not, as
23 the case may be, he was in that position because a slot
24 became available?
25 MR ORR: That's what it would appear to indicate, yes.

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1 MR STITT: WS044/3. On my copy, it's essentially the second
2 page, so it may be 002 if we could check that. Yes. If
3 (iii) at the bottom could be magnified. And perhaps, if
4 to Mr Foster, the reference to the NICE guidelines --
5 I'll read the sentence:
6 "The NICE guidelines on urinary tract infection in
7 children state that, for children aged 3 years or older,
8 dipstick testing for leukocyte, esterase and nitrite is
9 diagnostically as useful as microscopy and culture and
10 can be safely used."
11 I wonder could that be put in conjunction with the
12 question to Mr Orr.
13 THE CHAIRMAN: Thank you.
14 MR FOSTER: I think the NICE guidelines were published in
15 2007.
16 THE CHAIRMAN: Yes.
17 MS ANYADIKE-DANES: These particular ones.
18 MR FOSTER: Yes.
19 Q. I think if we go to page 3, we can see that. It says:
20 "The NICE clinical guideline 54, August 2007,
21 page 13."
22 Right up at the top.
23 THE CHAIRMAN: Okay. That's one issue. You have a more
24 general issue which you'd like Mr Orr to be asked about,
25 about the extent of reliance on the dipstick test

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1 Q. I don't know if you can help with us this. Is it --
2 MR STITT: Sorry. I was looking for the right moment to
3 interject and this may be it. Three questions ago
4 Ms Anyadike-Danes asked about the urine, the
5 proteinuria, the plus plus, and she formulated
6 a question to Mr Foster, who answered it and part of his
7 answer was really new to this inquiry, namely that a
8 dipstick was in its infancy and he really didn't put
9 much reliance on it. I expected the same question to be
10 put or to seek a response from Mr Orr. The fact that it
11 wasn't is not a criticism, but it's why I didn't
12 interject at that time. And then Ms Anyadike-Danes
13 moved on to another point. May I, sir --
14 THE CHAIRMAN: Do you want us to go back to Mr Orr?
15 MR STITT: If I may. The relevant point I'd like to make,
16 if I may, is this: the relevant extract is page 34 and
17 35 [draft] and I would like not only to Mr Orr to have
18 the opportunity to comment on dipstick, but also I would
19 be grateful if a reference could be made to the
20 Gilliland number 3 statement, which has been elevated to
21 the status of a professional report, an expert report,
22 at the bottom of paragraph -- I don't have the
23 inquiry ... It's 044. If I may just ask this to be
24 called up, 044/3.
25 THE CHAIRMAN: It's a witness statement.

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1 results in 2001.
2 MR STITT: Yes, because we know the evidence of
3 Mr Scott-Jupp, consultant paediatrician, and the
4 Gilliland view, and of course we know that Mr Foster is
5 advocating redoing the dipstick the next morning and
6 then sending off for a test, but not holding anything up
7 should there be any intervention needed.
8 THE CHAIRMAN: Mr Orr, we've got your general point, which
9 is that there should be active observation, there should
10 have been active observation of Raychel. To the extent
11 that one of the triggers for moving forward was the
12 result of the dipstick testing, what would your view be
13 of the reliance which would be placed on that in 2001
14 when Raychel was admitted?
15 MR ORR: In 2001, if there was a dipstick showing
16 proteinuria, some protein in the urine, I would say
17 that's a marker that we have to explore. I wouldn't
18 immediately say this child has a urinary tract
19 infection. I would request that urine was sent off for
20 the lab for microscopy and thereafter culture and we
21 know that culture will take two or three days. So
22 that is something that's in progress. The urine
23 microscopy is looking for leukocytes, that's white
24 cells, in the urine, and again that would raise
25 a concern and it might point you to think about another

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1 diagnosis. But you would come back to an overall
2 assessment of the patient in terms of arriving at
3 a diagnosis of appendicitis. I think it's important to
4 emphasise that diagnosing appendicitis is not easy.
5 You have to look at a whole lot of factors in the
6 history, in the examination, in the various
7 investigations that you're going to carry out. So it's
8 not an easy diagnosis to make and you have to take all
9 these factors into account before you arrive at that
10 definitive diagnosis of acute appendicitis.

11 MS ANYADIKE-DANES: In fairness to you, Mr Orr, you do say
12 in your report at 320/1, page 4, that:

13 "The urinalysis revealed 1 plus of protein [that was
14 the one that you had seen in the records], which with
15 the history of urinary symptoms [and by that I think you
16 meant pain on urination] should have prompted a request
17 for an urgent urinalysis, ie microscopy and culture."

18 That was a view you expressed then in your report.

19 MR ORR: Yes.

20 Q. Irrespective of what the dipstick produced, you would
21 want to send a urine sample to the lab?

22 MR ORR: Yes.

23 MR STITT: A final very brief point on this. Could Mr Orr
24 be asked: is he aware of page 30 in the Altnagelvin
25 notes, which is the dipstick results, urine results,

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1 MR ORR: I think, as has been said, it is not normal to have
2 protein in the urine, so you would want to exclude the
3 possibility of a urinary tract infection.

4 Q. So even if you received this result, which showed
5 negative for nitrites and leukocytes, which might have
6 been suggesting towards a urinary tract infection, you
7 would still want to know, as I understand what you're
8 saying, why did she have protein in her urine?

9 MR ORR: Yes.

10 Q. Is it significant, or is this test not sufficiently
11 sensitive to distinguish, that it goes from 1 to 2?

12 MR ORR: I can't make a definite comment on that. It is
13 probably within the range, the accepted range 1 plus, 2
14 plus. It would require the individual or the group who
15 are doing this test to explain what their parameters
16 are.

17 Q. I understand. Mr Foster, do you have a view as to
18 whether you regarded that as significant?

19 MR FOSTER: I don't know enough about nephrology to make
20 a comment. But there are two consecutive tests which
21 are showing protein. A third would be even more
22 informative the following day, and that would then, I'm
23 quite sure, trigger the requirement for a 24-hour urine
24 sample to be taken. That would be normal practice to
25 look at the total protein and a referral to a medical

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1 received after 11 o'clock that evening? It's
2 020-015-030.

3 THE CHAIRMAN: This is the second test, we understand, isn't
4 it?

5 MS ANYADIKE-DANES: Yes.

6 Mr Orr, four up from the bottom, you can see
7 "protein, 2 plus".

8 MR ORR: I presume that's the time at 23.19.

9 Q. Yes.

10 MR ORR: What I didn't see on that was a date. But I see
11 that there's two plus of protein, so I assume that that
12 was a second test done later on that evening.

13 MR STITT: That's what we understand and I was referring to
14 the nitrite, the leukocytes at the bottom.

15 MR ORR: So these, yes, are negative, but again I would
16 still suggest that her urine should go for microscopy.
17 Again, this is something you would note, but I accept
18 that these are negative reports for the leukocyte --
19 I presume that is the LEU -- and the nitrite and the
20 blood.

21 MS ANYADIKE-DANES: Yes. From the evidence both of you have
22 given, you seem to have placed some emphasis on trying
23 to find out why she did have protein in her urine. Does
24 that mean you don't regard that as being an entirely
25 standard result?

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1 expert.

2 Q. Just as we leave this, my learned friend Mr Stitt was
3 correct that Dr Scott-Jupp expressed his view in
4 evidence that the proteinuria in isolation, that is
5 without the presence of leukocytes or nitrites, meant
6 that a urinary tract infection was very unlikely. In
7 fact, I think he regarded proteinuria as a very poor
8 test for urinary tract infection, but he wasn't able,
9 I think to, express a view as to why the protein was
10 there in the first place, if I can put it that way.

11 Just so that we have it, some of the other
12 clinicians that were involved in Raychel's care have
13 also regarded the absence of leukocytes and nitrites as
14 indicating that there may not have been a urinary tract
15 infection, one of whom is Mr Bhalla, who was the
16 registrar. We don't need to pull it up, but he says
17 that in his evidence on 14 March on page 40 at line 23.

18 Dr Scott-Jupp and some of the clinicians are also
19 not sure that the fact that she experienced pain on
20 urination necessarily points you towards a urinary tract
21 infection. We don't need to pull that up, but
22 Dr Scott-Jupp says it in his report at 222-004-003. And
23 Mr Gilliland says similar. So the urine issue, if I can
24 put it that way, Dr Kelly had noticed and it's also
25 in the observations that Raychel had experienced pain on

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1 urination. There are two results with protein in the
2 urine and there is an absence of nitrites and
3 leukocytes. So that's what the urine tells you, if you
4 like. Do I understand you to say that leaving aside all
5 the rest of it, that protein result requires some
6 further thought and study? Would that be a fair way of
7 categorising it?

8 MR ORR: I think that would be. We don't know whether she
9 had a urinary tract infection or not. All this is is
10 a marker for further investigation.

11 THE CHAIRMAN: But even if you don't know whether she's
12 got -- even if you're working on the assumption that she
13 doesn't have a urinary tract infection, it's still
14 premature to go for an appendicectomy?

15 MR ORR: I would say it's premature to go for an
16 appendicectomy given the findings that that decision was
17 based on.

18 THE CHAIRMAN: Yes, thank you.

19 MS ANYADIKE-DANES: I wonder if I can move you on to
20 a different issue entirely, which is to do with the
21 involvement of the consultant in the surgery or the
22 decision in relation to surgery? That stems out of the
23 NCEPOD report of 1989. That report, which one finds at
24 the back of one of your reports, Mr Foster -- the start
25 of it is 223-002-052, but the particular part I would

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1 children. So I would suggest that surgeons and
2 anaesthetists in the UK should have been well aware of
3 these recommendations.

4 Q. You mean because when it came out -- perhaps
5 "revolutionary" is not quite the right word, but it was
6 such a change from previous practice, that is something
7 you would have thought surgeons and anaesthetists would
8 have been alert to?

9 MR ORR: It received significant publicity and circulation
10 within the professions. It also triggered reviews of
11 services in order that units could try and comply with
12 these recommendations. And that's the challenge that
13 I referred to earlier, of delivering children's services
14 in smaller centres.

15 Q. Is that something that in your various positions in the
16 hospitals that you've been in, is that something you've
17 had direct experience of, the attempt to try and see how
18 these recommendations might be met?

19 MR ORR: Yes. And I think it's fair to say that people have
20 tried very hard to meet the recommendations, but it is
21 certainly not easy and you have to balance the ability
22 to deliver a local service to a community against the
23 potential of removing that service and parents and
24 children having to travel quite large distances to
25 receive the same service in a larger centre. So it's

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1 like to take you to is 223-002-054.

2 Before I ask you any questions about that: Mr Orr,
3 you weren't asked to address the 1989 NCEPOD report, but
4 are you aware of its findings and recommendations?

5 MR ORR: I am.

6 Q. Thank you. There are two recommendations in it that
7 have been the subject of some discussion. One is a more
8 governance question and it's something I think, Mr Orr,
9 that you have touched on, which is the third bullet:

10 "Surgeons and anaesthetists should not undertake
11 occasional paediatric practice. The outcome of surgery
12 and anaesthesia in children is related to the experience
13 of the clinicians involved."

14 And I think that goes to something you were saying
15 earlier. But the bullet that the witnesses spent some
16 time addressing is the final one:

17 "Consultant supervision of trainees needs to be kept
18 under scrutiny. No trainee should undertake any
19 anaesthetic or surgical operation on a child of any age
20 without consultation with their consultant."

21 And if I turn to you first, Mr Orr, I take it you
22 were aware of that recommendation?

23 MR ORR: I was and am. I mean, this report, that NCEPOD
24 report was a wake-up call to the surgical and
25 anaesthetic professions in regard to the management of

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1 complex.

2 Q. Are you speaking there primarily in relation to the
3 third bullet and the notion that one might perhaps
4 centralise -- more centralise specialist care?

5 MR ORR: Yes, and that is an argument, that's a debate that
6 has been addressed around the UK and Ireland.

7 Q. If we go to that bottom one, which takes you out of how
8 the region might organise its medical resources and
9 delivery of care, and look to within the hospital and
10 how the hospital within its various hierarchies of
11 grades of clinician organises the reporting and
12 supervisory structure, if I can put it that way, can you
13 help us with the extent to which that was appreciated,
14 being adhered to?

15 MR ORR: That is obviously best practice. What governs that
16 recommendation is the relationship between the junior
17 surgeon and the consultant. If the consultant has
18 confidence that the trainee or junior surgeon is going
19 to make good decisions in a range of cases, he may well
20 say, "You don't have to phone me up about every case",
21 and that may apply in some surgical teams. I'm not
22 defending it, but I'm saying that at a time of
23 transition, and this is 2001, so it's shortly after
24 these recommendations came out, there may well have been
25 agreements that --

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1 THE CHAIRMAN: Sorry, sorry. This is the 1989 report, so
2 it's 12 years later.
3 MR ORR: 12 years, yes, so there has been a considerable
4 period of transition, absolutely.
5 MS ANYADIKE-DANES: Pausing there before you go on, does
6 that change your view as to the extent to which systems
7 should already have been in place to comply with these
8 recommendations?
9 MR ORR: Yes, I think that one would have been working
10 towards implementing these recommendations, but you
11 could still have a situation where a consultant had
12 confidence in a junior surgeon's ability to assess,
13 manage, diagnose, operate on a certain range of cases,
14 including children with abdominal pain. But that would
15 be very much an individual relationship that had been
16 discussed between the consultant and his or her trainee.
17 Q. Well, Mr Orr, I understand what you mean about an
18 individual relationship, but if you had SHOs who, for
19 various reasons -- they may be coming from abroad --
20 they may be at SHO grade, although that may belie their
21 experience actually, and through a process of induction
22 or initial assessment, would it not be possible to
23 decide that a cadre of such people could carry out to
24 certain levels certain procedures without having to
25 contact the consultant? Could you not do it in that way

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1 MR FOSTER: Yes, indeed. NCEPOD was in the late -- as the
2 1980s went on, there became a very important and
3 respected part of the college's work in looking overall
4 at surgical standards. The look at paediatric surgery,
5 particularly occasional paediatric surgery, was one of
6 the first and most important things that had an impact.
7 And we were well aware of this; it began to slowly lead
8 to younger children in my hospital being referred
9 inwards to a specialist centre if they were very young
10 with particular conditions.
11 This business of being kept informed wasn't very
12 difficult. I just rang them up in the evening. If
13 there was an SHO and a team on that I didn't know, and
14 there might well be, that might well be a case in 2001,
15 the juniors were on rota systems that were restricting
16 their hours, therefore the team might not be your team.
17 And if I didn't know who they were, which you might not
18 necessarily, I would find out what was going on. I used
19 to ring them up about 9 o'clock in the evening and say,
20 "Have you got anything there that is of any concern to
21 you and what have you admitted through the evening?".
22 It wouldn't take someone long to tell me and, if there
23 was a child that someone was thinking of operating on,
24 I would be getting involved with that.
25 So it wasn't very onerous from my point of view, it

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1 as opposed to the closer relationship that you've
2 discussed between a given clinician and a consultant?
3 MR ORR: Yes, I would accept that, but the consultant would
4 have to work with the trainee to assess his or her
5 competencies.
6 THE CHAIRMAN: So this has to be a conscious decision taken
7 by the consultant in relation to each of the junior
8 surgeons --
9 MR ORR: Yes.
10 THE CHAIRMAN: -- rather than a more general, "Look, you
11 don't need to contact me, go on about your work"?
12 MR ORR: Yes, I'd be concerned about the latter. Obviously
13 I would prefer that there was a system where the junior
14 surgeon at least contacted the consultant and said,
15 "I've assessed this patient, here's the background,
16 I have made a decision that we need to take the patient
17 to theatre, are you happy with that; yes or no?", and
18 then proceed. And that is what is recommended.
19 THE CHAIRMAN: Thank you.
20 MS ANYADIKE-DANES: In other words, you don't have sort of
21 pre-clearance; you would need to know, for a given
22 procedure, that you were comfortable with that
23 particular surgeon's experience and expertise?
24 MR ORR: Yes.
25 Q. Mr Foster, could I ask you to comment on that?

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1 made life a little easier for me to know what was
2 happening. There's no doubt also that the level of
3 experience of junior doctors is extremely variable and,
4 as Mr Orr has said, you really have to know a doctor
5 quite well and have them work closely with you to know
6 the depth of their abilities and their decision-making
7 diagnostically and their ability to do an operation
8 before you can let them free. And there were some SHOs
9 that I wouldn't let do an appendix at all, even after
10 a year or more. They do undoubtedly vary, and you have
11 to keep on top of them. That's the role of
12 a consultant. We would only have a week on duty, which
13 we did a week at a time, as surgeon of the week, from
14 2000. There'd be two or three children during the week
15 that would need an appendicectomy, so it wasn't, from
16 the child surgery point of view, onerous to try to keep
17 on top of it.
18 Q. In fairness to Mr Gilliland, he comments on the
19 reception this report got or rather didn't get in
20 Northern Ireland. One sees it in his witness statement
21 at 044/3, page 3. If you look at (iv), he is responding
22 to your comment, Mr Foster, that surgery in children at
23 night should be carried out by a senior operator, citing
24 as evidence the NCEPOD report of 1989. He goes on:
25 "I disagree with Mr Foster's assertion that the

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1 recommendations of this report had become standard
2 surgical and anaesthetic practice in 2001. They were
3 not standard in Altnagelvin in 2001 and I suspect they
4 had not been implemented elsewhere within
5 Northern Ireland at this time."

6 We'll leave the other bullet, this is focusing on
7 the involvement of the consultant. The NCEPOD report
8 comes out in 1989 and we're talking about 2001. If
9 that is correct, that it wasn't standard practice and
10 not being implemented elsewhere in Northern Ireland --
11 and I put this to both of you -- would that have
12 surprised you, given your experience with this in other
13 hospitals in the rest of the UK?

14 MR ORR: It would have surprised me. There's 11 years to
15 implement a report which, as I say, made a major impact
16 on the profession.

17 THE CHAIRMAN: Would it worry you?

18 MR ORR: Yes, it would.

19 MS ANYADIKE-DANES: And would it worry you because it might
20 have betrayed something about how the guidance and
21 learning in these reports is disseminated, is that the
22 respect in which it might have worried you?

23 MR ORR: I think the respect in which it would worry me
24 is that in Scotland -- and I can only speak immediately
25 for Scotland -- when this report came out there was

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1 tutor. I presume this hospital had a college tutor.
2 I'm not certain as to why this was not picked up and
3 made the subject of a fairly early meeting and
4 discussion. Particularly as this is a hospital some
5 distance from the centre where the major children's
6 hospital is. This should have been more relevant to
7 Altnagelvin than most hospitals, even those like mine in
8 Mersey, which is only 25 miles from Alder Hey.

9 Q. You may not know the answer to this, in which case
10 I apologise for putting it, but I think both of you have
11 said -- and perhaps more from Mr Orr -- that this was
12 really quite a change when this came in. Am I right to
13 assume that a report like this doesn't come without
14 having had some considerable research and work to
15 generate these guidelines or recommendations, which
16 themselves may be the subject of discussion before the
17 report is actually finally issued and presented? So
18 there is information already out there that leads to
19 these recommendations; would that be a fair way of
20 characterising the process?

21 MR FOSTER: Very much so. NCEPOD, when they recommended
22 anything, base it on informed information from NCEPOD
23 reporters. My understanding re the NCEPOD reports
24 is that they do have data fed to them from a number of
25 hospitals in Northern Ireland. I can't now recall

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1 a huge amount of discussion as to how we can implement
2 its findings and I'm quite sure the same happened in
3 many areas in England. And as I say, I'm surprised if
4 it hadn't happened in Northern Ireland.

5 THE CHAIRMAN: Just for the record, there are extensive
6 links through the colleges and otherwise between
7 surgeons throughout the UK; is that right?

8 MR ORR: There are, yes.

9 THE CHAIRMAN: Through the colleges, through conferences and
10 through personal contacts?

11 MR ORR: Yes, that's correct.

12 MS ANYADIKE-DANES: If we follow up what the chairman said,
13 both of you are members of the Royal College of
14 Surgeons; is this the sort of thing that would have been
15 discussed and generated debate within the college?

16 MR ORR: Yes.

17 Q. Mr Foster, can I ask you whether, if that was the case
18 in Northern Ireland -- the same point that I've put to
19 Mr Orr -- whether that would have surprised you and
20 concerned you?

21 MR FOSTER: It would certainly have surprised me and
22 it would have surprised NCEPOD, who I think did their
23 very best to disseminate their recommendations and they
24 were clearly written and sent on to college
25 representatives. After all, each hospital has a college

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1 reading the names of them, I don't think they
2 necessarily stated, but it was incumbent on hospitals to
3 feed in data to the centre regarding surgical practice.
4 So I don't know what happened to an NCEPOD request to
5 this hospital, if it happened, for some information
6 about the volume and type of children's surgery
7 performed.

8 THE CHAIRMAN: Thank you.

9 MR STITT: I appreciate we're dealing with the general and
10 that is one of the recommendations of the NCEPOD report.
11 But there's also a particular side to this because
12 Mr Foster in his answer said there's a great variance
13 between the capabilities of junior doctors and those who
14 are not consultants. And he said there are some, for
15 instance -- I'm paraphrasing -- who he wouldn't let
16 operate and so on. I've got two questions that I'd like
17 maybe to have put to him.

18 The first is: is he aware of Mr Makar's experience
19 in June 2001? And secondly: does he agree that the one
20 thing that everyone agrees about in this sad episode,
21 sad sequence of events, is that the actual surgical
22 treatment given to Raychel has not been criticised by
23 anybody in the manner in which it was carried out?

24 THE CHAIRMAN: Yes. The issue here, Mr Stitt, isn't that
25 the surgery wasn't well conducted, in fact all that

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1 we've been talking about so far this morning is
2 effectively a preliminary issue in the context of the
3 hyponatraemia inquiry because what went wrong with
4 Raychel wasn't -- well, it could only I suppose
5 indirectly be attributed to the operation. What went
6 wrong afterwards really is an indirect and perhaps
7 avoidable consequence of successful surgery. But
8 I think the point that you want to ask about how much
9 the experts know about Mr Makar and his experience -- my
10 concern about that is that the case being advanced by
11 what was the Altnagelvin Trust isn't Mr Gilliland
12 saying, "I was confident that Mr Makar was sufficiently
13 experienced and qualified to do this surgery without
14 referral to me". His line is, "Look, that NCEPOD
15 recommendation wasn't standard practice in
16 Northern Ireland". That's an entirely separate point.
17 If he had said, "Look, I knew about NCEPOD, there
18 were difficulties in implementing it, but I was
19 satisfied that, of the four junior surgeons on my team,
20 two or three of them were capable of conducting this
21 operation", then that's one line for him to take. But
22 the line that he has taken and the line that he has
23 specifically volunteered in this additional statement
24 that we have on the screen in front of us is that the
25 NCEPOD recommendations from 1989 were not standard

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1 MR STITT: It's that aspect of it.
2 MS ANYADIKE-DANES: Mr Chairman, I wanted just to ask one
3 short question in this area before moving on to a larger
4 area to do with fluid management and I wondered if
5 it would be appropriate to ask the short question and
6 then we might perhaps take a break then for the
7 stenographer and then move on to the fluid management
8 issues.
9 THE CHAIRMAN: We have to take a break for the stenographer,
10 who's working hardest here, so he needs a break every
11 couple of hours or so.
12 So let's deal, Ms Anyadike-Danes, with that short
13 point.
14 MS ANYADIKE-DANES: I'm very grateful, Mr Chairman.
15 The short question -- well, I hope it's going to be
16 a short question -- well, it is a short question,
17 whether it'll be a short answer ... It is to do with
18 major surgery and that is whether an appendicectomy, so
19 far as either of you are concerned, constitutes major
20 surgery. I wonder if I could invite you, perhaps
21 Mr Foster first, because I think you've actually
22 commented on this.
23 MR FOSTER: Definitely. Anything that enters the abdomen is
24 a major operation because you're doing it for a surgical
25 reason, hopefully with some diagnostic criteria to

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1 practice in Altnagelvin, nor elsewhere in
2 Northern Ireland, and that's what's causing the experts
3 their concern.
4 MR STITT: I appreciate that, and I follow the point.
5 That's why I prefaced my question by saying I was coming
6 from the general to the particular. I appreciate the
7 general point that's being made and that can be dealt
8 with in due course under another heading in this inquiry
9 and we will see just what shortcomings, if any, there
10 were in relation to the Altnagelvin Trust and the NCEPOD
11 report of 1989.
12 But the point really was this: whenever Mr Gilliland
13 was giving his evidence -- and it is a different point,
14 but nonetheless it's linked to Mr Foster's evidence --
15 there's no -- not that I'm aware of -- serious challenge
16 to the, on paper, capabilities of Mr Makar to perform
17 the appendicectomy on the patient.
18 THE CHAIRMAN: That's right. This point in essence refers
19 back to the earlier one, which is -- it more ties in not
20 with how the operation was eventually conducted, but it
21 ties in more with whether the operation should have been
22 performed in the first place.
23 MR STITT: Yes, it does.
24 THE CHAIRMAN: That's more the point, isn't it?
25 MR FOSTER: Yes.

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1 embark upon it. But once you enter an abdomen, you may
2 find anything that might require a major procedure such
3 as a bowel resection, it might require something more
4 simple like an appendicectomy, but that still is
5 removing part of the intestinal tract. So any operation
6 that enters the abdomen is major.
7 Q. Yes. I think in her evidence on 7 February, I think
8 it's page 60, Dr Jamison's evidence was that anything
9 that breached the cavity, as you're talking about there,
10 in her view -- she's an anaesthetist -- is the
11 definition of major surgery.
12 I wonder, Mr Orr, if I could ask you to comment on
13 that: does an appendicectomy constitute major surgery?
14 MR ORR: I would say that an appendicectomy always has the
15 potential for major surgery. There are some definitions
16 of surgical difficulty -- minor, intermediate, major,
17 major plus -- these are terminologies that are used in
18 the private sector when it comes to operations. So you
19 could categorise a straightforward appendicectomy as an
20 intermediate operation. But as has been said, there is
21 always the potential for an appendix operation to become
22 a major procedure with a removal of bowel.
23 Q. So since you don't know what you're going to find,
24 do you start off treating it as major surgery, even
25 though it may turn out to be relatively straightforward

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1 and minor in that particular respect?
2 MR ORR: If you're going to carry out an appendicectomy, you
3 either have to be competent in managing any progressive
4 difficulties that emerge or have the ability to call on
5 a senior colleague to help you with that.
6 MS ANYADIKE-DANES: Thank you very much.
7 THE CHAIRMAN: Okay, we'll break for 10 minutes.
8 (11.50 am)
9 (A short break)
10 (12.00 pm)
11 (Delay in proceedings)
12 (12.12 pm)
13 MS ANYADIKE-DANES: I'd like to turn now to the issue of
14 intravenous fluid management and to look at it both from
15 the perspective of preoperative and post-operative and
16 to take in the issues of hyponatraemia and SIADH. So
17 it's a rather large area, but it all comes within this
18 topic of IV fluid management.
19 Mr Foster, in your report -- and we don't need to
20 pull it up -- at 223-002-039 -- what you say is:
21 "I don't think Mr Makar had any choice in the use of
22 his preoperative fluid regime. The use of
23 Solution No. 18 was standard practice on the paediatric
24 ward. This was the default fluid for use with
25 paediatric medical patients who were under the care of

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1 particular fluid that he thinks is appropriate for
2 a child in those circumstances, that that is changed
3 because of a ward practice?
4 MR FOSTER: Yes, indeed. I've never heard of a practice
5 like that before. This was new to me completely. I am
6 always used, on a personal basis, for post-operative
7 fluids to be written up by anaesthesia and for that
8 prescription to be adhered to. My understanding is that
9 in the hospitals where I've worked, as far as people can
10 think back, right into the 1990s, that is exactly what
11 has happened. I can't understand a change to a default
12 fluid that is basically water, although I do know that
13 fifth-normal saline is something that has been used for
14 many years by paediatricians for good, theoretical
15 medical reasons.
16 Q. If I interrupt you there -- and I apologise for doing
17 so -- the fluid regime -- and I want to run through it
18 in chronological order -- starts off with Raychel
19 preoperatively.
20 Mr Makar forms a view as to what fluid he wants her
21 to have. He takes a view she needs some fluid and he
22 forms a view as to what that fluid should be. We'll
23 come on to the rate he wants secondarily. Then there's
24 the period of time during her surgery, which is when her
25 fluids are being managed by the anaesthetists and they

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1 paediatricians and surgical children were under the care
2 of surgical junior doctors who would have had little
3 experience with the use of this fluid."
4 Just so that we're clear, you mean little experience
5 with the use of Solution No. 18; is that what you meant?
6 MR FOSTER: The junior doctors you mean?
7 Q. Yes.
8 MR FOSTER: I don't think, until they walked through the
9 door of the paediatric ward, a junior doctor would have
10 heard of fifth-normal saline.
11 Q. Yes, but if we move away from the JHOs and address
12 Mr Makar, who's not in that category. So far as we can
13 understand it from his CV and from his evidence, he's
14 actually an experienced SHO, and his experience from his
15 evidence was to do with Hartmann's. So he wasn't very
16 familiar with Solution No. 18, not because he was
17 a junior doctor, but because in the hospitals that he
18 had practised in he used and recommended Hartmann's.
19 MR FOSTER: Yes.
20 Q. This is the question I want to ask and it's about
21 clinical practice really. It's quite clear that, absent
22 the ward practice or protocol on Ward 6, Mr Makar would
23 have prescribed Hartmann's, and that's what would have
24 been administered to Raychel. How significant is it, do
25 you think, that when a clinician forms a view that the

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1 form a view of what they think is the appropriate fluid.
2 And you are quite right, in the immediate post-operative
3 phase, the anaesthetist did actually think that part of
4 his role was to prescribe that fluid and he did so. As
5 it turned out, that was not the position that happened
6 in Altnagelvin on Ward 6.
7 Then there is a period of time after that, perhaps
8 leading up to the ward round, and at the ward round
9 itself, when there is a further opportunity in relation
10 to what the fluids should be. So there are a number of
11 phases when Raychel's fluid management could come under
12 the scrutiny of a clinician, but I was at the very
13 start.
14 This is Mr Makar, pre-surgery, deciding that for
15 clinical reasons he wanted Raychel to be administered
16 Hartmann's. And he is then told by Staff Nurse Noble
17 that Hartmann's is not the solution that is used on
18 Ward 6 and he goes up to Ward 6 and changes it and the
19 prescription is written up for Solution No. 18, which is
20 the ward protocol.
21 So my question to you was: if a clinician has taken
22 the view that a particular fluid is appropriate for his
23 patient, can you pass comment on that being changed to
24 satisfy or fit in with the ward practice?
25 MR FOSTER: Well, obviously on Ward 6 there was a protocol

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1 that was set in stone that the only fluid that goes into
2 a patient is Solution No. 18, fifth-normal saline. One
3 has to put oneself in the position of a junior doctor,
4 even an SHO of Mr Makar's experience, and he was
5 probably ahead of the pack in terms of his clinical
6 background, in a hospital he's not worked in for a great
7 deal of time, being in a position to do what he is told.
8 And he's told: this is the protocol for this ward and
9 this is laid down by the consultant staff and it's what
10 all the children have, would you change it please? And
11 I don't think he would have had a great deal of choice
12 at his level of seniority, but to comply with what Staff
13 Nurse Noble asked him to do.

14 He would assume that at that stage all Raychel
15 required was replacement fluid to cover a period of
16 starvation whilst he was unsure of the diagnosis and
17 wished to starve her pending a clinical decision on
18 surgery or not. And it probably didn't matter at that
19 stage what the fluid was. It could have been dextrose
20 by itself. That's water as well. Personally, what
21 I would have done is, when the time came to realise --
22 hopefully realise this operation can be postponed until
23 tomorrow, I would probably have let her drink. But then
24 that didn't happen, so she went on to theatre.

25 But I think at that point in time when all he was

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1 So that was an established protocol. And protocols are
2 there for good reasons because it means that everyone
3 gets used to using them, it doesn't mean to say that
4 they are set in tablets of stone, they can be changed.
5 But I think it would be difficult for a registrar who
6 may not have had a huge experience on that ward to say,
7 "I insist that we change the fluid", because, as has
8 been said, he's envisaging a straightforward
9 appendicectomy, probably coming off the intravenous
10 fluids later that day with the introduction of oral
11 fluids, so would probably not be too concerned that
12 he had to comply with a request to use Solution No. 18.

13 MS ANYADIKE-DANES: Do I take it from the way that you've
14 answered that that you're not concerned with there
15 being -- it may not entirely have been a protocol, it
16 may be more accurately described as a practice? You are
17 not too concerned about there being a practice like
18 that? Would you be concerned about a practice that was
19 inflexible so that it couldn't be changed to suit
20 a given circumstance?

21 MR ORR: Yes, I would be. There should be flexibility in
22 any guideline, protocol, so that it can be adapted to
23 the clinical situation. But the clinical situation
24 envisaged here was, as I say, a progressive and rapid
25 recovery from the operation when giving this solution

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1 wishing to cover was her tentatively preoperative period
2 of fluid starvation, it was perfectly in order to use
3 Solution No. 18, but I don't think Mr Makar had any
4 choice, as a doctor of his seniority, in complying with
5 the request.

6 Q. I think what you have said there reflects some of his
7 evidence, which is that did he change it, but given the
8 length of time he thought that Raychel was likely to be
9 under that regime, he didn't think in the scheme of
10 things it was a particularly significant change.

11 MR FOSTER: Yes.

12 Q. But if it had been, if it had been post-operatively, for
13 example, would it have been of concern to you that
14 a junior doctor might feel they had to fit in --
15 THE CHAIRMAN: Sorry, let's leave the post-op. Let's stick
16 with the phases.

17 MS ANYADIKE-DANES: Yes. I'll put that to Mr Orr then.

18 THE CHAIRMAN: Do you take a different view on what
19 Mr Foster's said about the preoperative fluid?

20 MR ORR: There was clearly an established protocol on the
21 ward, and as I understand it, in many other units across
22 Northern Ireland in paediatric units, and in fact,
23 looking at the literature, in the 1960s/1970s, many
24 paediatric units used fifth normal, 0.18 normal saline
25 and dextrose as the standard fluid therapy on the wards.

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1 would not have caused -- or should not have caused --
2 any difficulties in the short-term.

3 Q. Yes. It's probably correct to say that, in view of some
4 of the doctors and nurses, I think their evidence
5 amounted to: if a given clinician felt very strongly for
6 clinical reasons that some other fluid ought to be
7 prescribed, then that probably would have happened, and
8 I think at least one said it had happened. But this was
9 now the routine, it may be that the degree of
10 flexibility was perceived in differing ways by different
11 clinicians, and that may be something that has to be
12 addressed later on in another stage of the inquiry. But
13 if I summarise what your position is and, Mr Foster,
14 maybe comment if you disagree with it, that a default or
15 a practice that was the generally held view as to what
16 should happen with children's IV fluids was common and
17 possibly there is no difficulty with it so long as it
18 can be adapted to suit a given need in a certain
19 situation. Would that be a fair summary of your
20 position?

21 MR FOSTER: Yes. Surgery doesn't work like that. People
22 have things wrong with them, they may vomit, they may
23 have diarrhoea, they may have particular problems, they
24 may be different ages, there may be electrolyte results
25 that point at something. You have to have a flexible

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1 approach to putting fluid into people's veins.
2 THE CHAIRMAN: Mr Orr, you started your answer to that issue
3 by saying that there was clearly an established protocol
4 on the ward and in many other units across
5 Northern Ireland in relation to Solution No. 18.
6 Am I reading too much into that to get an indication
7 from you that you would be a bit unhappy about that as
8 an established Northern Ireland practice?
9 MR ORR: We're talking about -- it was established ...
10 Well, I don't know when it was established in
11 Northern Ireland, but it appeared to have been practice
12 on medical paediatric units in the UK during the 1960s,
13 70s, 80s, running on up into the 90s. So if this was an
14 agreement by clinicians that this was the basic fluid
15 that they would use, allowing for any adaptation that
16 was indicated clinically, I would have been comfortable
17 with that.
18 THE CHAIRMAN: Okay.
19 MS ANYADIKE-DANES: And in 2001?
20 MR ORR: I'm not advocating it for surgical patients. This,
21 as I understand it from reading the material a couple of
22 months ago now, was the established guideline for usage
23 in the medical paediatric wards.
24 Q. If they had applied that to post-surgical paediatric
25 patients and included them in their established

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1 because the view was that it wasn't going to be very
2 long, I don't think anybody has expressed -- but tell me
3 now if you have -- particular concern about the fluid
4 being set at 80 ml an hour pre-surgery. You're not
5 particularly concerned about that?
6 MR FOSTER: Preoperatively, again expecting a normal
7 clinical course from an appendicectomy if it was
8 required, he's covering a starvation period where
9 there's no oral intake, and it probably didn't matter,
10 for the few hours that they envisaged, what rate the
11 fluid was. But if you go back to basic principles to
12 calculate intravenous requirements of a child of
13 25 kilograms, then the rate is too high.
14 Q. It's too high, but if it wasn't going to persist for
15 very long, it wouldn't be overly troubling to you; would
16 that be fair?
17 MR FOSTER: If it was over a short time -- and we're talking
18 here about 65 to 80, we're only talking about 15cc
19 an hour difference -- of course it wouldn't matter. But
20 in the very long-term, the effect of a higher rate would
21 multiply.
22 Q. Mr Orr, would you be of similar view?
23 MR ORR: Yes, I would agree.
24 Q. Thank you. That's pre-surgery. During surgery, she
25 goes on to Hartmann's and it's not clear what the rate

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1 practice, if I can put it that way, in 2001, would that
2 have concerned you?
3 MR ORR: Not if the patients were being monitored actively
4 and we'll no doubt come on to this. If you had
5 a patient on a longer term intravenous fluids, you would
6 be checking their urea and electrolytes and you would be
7 adapting the intravenous fluids accordingly. It clearly
8 wouldn't be my practice and it would be for others to
9 say what the practice was amongst the surgeons carrying
10 out children's surgery in this hospital.
11 Q. So if I understand you, it wouldn't be what you would
12 do, but if that was happening in relation to
13 post-surgical paediatric patients, then you wouldn't be
14 very uncomfortable with it so long as they were being
15 appropriately monitored?
16 MR ORR: Yes.
17 Q. Thank you. We'll come on to what "appropriate
18 monitoring" might mean, but that's a fair statement of
19 your view?
20 MR ORR: It is.
21 Q. Mr Foster, would you disagree with that?
22 MR FOSTER: I completely agree with Mr Orr.
23 Q. The other part of what Mr Makar prescribed is the rate.
24 There have been varying views as to whether the 80 ml
25 an hour was an appropriate rate, but I think ultimately

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1 was that she was on. It also wasn't clear until
2 a retrospective note was made exactly how much
3 Hartmann's she received. The anaesthetic note, all it
4 says is "1 litre of Hartmann's". The retrospective note
5 indicates that it was 200 ml. There is a bit of an
6 issue between Dr Gund and Dr Jamison as to whether it
7 was 200 or 300. I think most people have formed the
8 view that that doesn't really matter very much in the
9 general scheme of things. What we come on to next is
10 the post-operative period. Dr Gund is the anaesthetist.
11 He was of the view that what he would have liked her to
12 have, if I can put it that way, is Hartmann's, and he
13 would have liked to have continued that Hartmann's on,
14 but in fact he went so far as to write a prescription
15 for it, which you may have seen, and that was struck
16 through because he was disabused of that and told that
17 the immediate post-operative fluids would be addressed
18 on the ward. He took it no further than that except,
19 I think his evidence indicates that he did think that
20 a clinician would actually turn their mind to it and
21 write up a prescription and I think he's joined in that
22 by Dr Jamison, the other anaesthetist, who also thought
23 a prescription would be written up for those fluids.
24 Can I ask a similar question that I asked for the
25 pre-surgical position? Here you have another clinician,

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1 of a different discipline this time, who wishes the
2 child to have a particular fluid, Hartmann's, after
3 surgery. Presumably he does that for clinical reasons,
4 but he's dissuaded from doing that. Do you have a view
5 as to whether he, as the anaesthetist, should have been
6 able to establish what her immediate post-surgical fluid
7 regime was?

8 MR FOSTER: I think if he had been one grade up, SPR or even
9 higher, of course. Dr Gund was a fairly new
10 anaesthetist to working in this country, although he had
11 worked in India in quite a busy capacity for a long
12 time. But one has to put oneself in the position of
13 a young doctor, finding his feet in a new country, in
14 a hospital he's new to working in, and he would, I'm
15 sure, have been disconcerted to be asked to change his
16 prescription, which is a perfectly normal post-operative
17 prescription for a child, a balanced electrolyte
18 solution post-operatively.

19 But he would have taken this as a request. For all
20 he knew it may have been backed up by senior clinicians
21 somewhere as part of a policy. In fact, it probably --
22 that's probably what it meant. So he did what he was
23 requested. He, I am sure, had problems with that.
24 A senior person would have said, "I'm sorry, I'm not
25 prepared to prescribe this, I would sooner prescribe

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1 MR FOSTER: What I'm saying really is that I have never
2 heard of a policy where the fluids to be given to
3 a child pre or post-operatively were dictated by
4 a protocol generated from the ward. That virtually
5 takes the whole anaesthetic profession out of the frame
6 and out of the ability to prescribe fluids for children
7 that they had anaesthetised. That seems bizarre and
8 non-professional, but it would have taken a more senior
9 anaesthetist than Dr Gund to go up there and say so.

10 MS ANYADIKE-DANES: Yes, but if we just follow on that you
11 didn't know of such a practice, I take it from that that
12 your position is he should have been allowed to control
13 that aspect of her immediate post-surgical fluid regime.

14 MR FOSTER: Absolutely.

15 Q. I think you were saying to the chairman it is your
16 experience that the anaesthetists do that very thing,
17 that the immediate post-operative period is one where
18 the anaesthetists do prescribe the fluids because -- I'm
19 assuming -- they have been in control of the fluid
20 regime during surgery, they know what's happened, and
21 they know what they're trying to address.

22 MR FOSTER: That would be the policy in their hospital and
23 they would prescribe the fluids for the patient
24 post-operatively. I always thought, on a national
25 basis, the fluid prescribed post-operatively for a child

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1 Hartmann's please. That is my prescription, please
2 apply it", but I think if one puts oneself in the
3 position of a young man who feels in a vulnerable
4 situation, he's going to go along with it, bearing in
5 mind, in the long-term, he's going to think, "Oh well,
6 okay, she's had a normal appendix removed or at the
7 very, very most a slightly-inflamed one removed, let's
8 go along with it because there won't be a problem
9 particularly and she'll be on oral fluids tomorrow".

10 Q. I understand that, but my question to you was slightly
11 different. It was: should he, as the anaesthetist, have
12 been allowed to manage those immediate post-operative
13 fluids? I understand your answer.

14 THE CHAIRMAN: I think there's a bit of confusion earlier
15 on. You had asked Mr Foster a question about pre-op and
16 he answered it in terms of post-op. I'm just looking
17 back at the answer you gave a few minutes ago,
18 Mr Foster. You said you had never heard of a practice
19 like this before:

20 "This was new to me completely. I am always used,
21 on a personal basis, for post-operative fluids to be
22 written up by the anaesthetist and for that prescription
23 to be adhered to."

24 Do I take it that that's your position on what
25 happened --

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1 is prescribed by anaesthesia. That is their role and
2 they should be given it freely.

3 Q. Yes. Can you see any benefit in the immediate
4 post-operative fluids being managed and prescribed, not
5 by the anaesthetist, but by a practice that has
6 presumably been developed by the paediatricians on the
7 ward? Can you see any benefit of that?

8 MR FOSTER: No benefit at all. What I see is a little
9 recipe here for problems in the future.

10 Q. I wonder, Mr Orr, if I could ask you to comment on --
11 I don't want to put the self-same questions, you have
12 heard the questions so you know what the issue is.
13 I wonder if I could ask you to comment.

14 MR ORR: It would appear that the practice was that when
15 a patient goes back from theatre to the ward, then the
16 prescription was taken over by the ward staff -- and I'm
17 using that in the broadest terms. It would be my
18 experience that, normally, it is the anaesthetists who
19 prescribe in the post-operative period. That period
20 varies, but it's normally until the patient gets back to
21 the ward and perhaps the next six hours, but it will
22 vary. Usually, the initial prescription is by the
23 anaesthetist. I'm not aware what the arrangements were
24 in the hospital here for that kind of process. You
25 would have expected that, again, there would have been

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1 a standard way of managing that transition from theatre
2 to the ward.
3 Q. And can you see any benefit in it being other than the
4 standard practice you've just described, which is that
5 the anaesthetist does it for the immediate
6 post-operative period?
7 MR ORR: Only that there was an established methodology and
8 established protocol so that would avoid any confusion,
9 but the downside is that it does not allow the
10 anaesthetist to control what he sees as the required
11 fluids in the immediate post-operative period. And
12 I think we could come up with scenarios where the
13 anaesthetist would have to insist that the patient has
14 fluids other than Solution No. 18.
15 Q. And then if we move on --
16 THE CHAIRMAN: Sorry, that would be, for instance, if there
17 were significant losses during surgery?
18 MR ORR: Exactly.
19 THE CHAIRMAN: Yes.
20 MS ANYADIKE-DANES: I suppose one could say if there were
21 that sort of thing, he could enter a note on to charts
22 and whoever is going to prescribe that on the ward could
23 take that into consideration. That's one way of
24 addressing it, to which you might wonder if he was going
25 to do that, why doesn't he simply prescribe out of his

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1 would happen in my practice or in other hospitals that
2 I've worked in.
3 MS ANYADIKE-DANES: Mr Makar said that actually he didn't
4 appreciate that that's what happened in Altnagelvin.
5 His firm view in his evidence was that, had he known
6 that, he would have said something about that, because
7 his evidence was: look, I prescribe a particular fluid,
8 in this case he didn't have much choice as to what the
9 fluid was, but I certainly prescribe a particular rate
10 in the light of the condition of the child and that may
11 not be the condition of the child after her surgery. So
12 his view was not only would he have wanted to make his
13 views known, he foresaw there might be some dangers in
14 such a practice because you might have a child who was
15 on a wholly inappropriate rate for that child because it
16 didn't take into consideration what had happened during
17 surgery. Do you have a view on that?
18 MR ORR: My view is that normally the anaesthetists make
19 a decision on post-operative fluid management and it
20 wouldn't be a fallback to whatever the fluid was
21 preoperatively.
22 Q. If there was such a practice, would you be surprised?
23 MR ORR: Well, if there was an established practice, yes,
24 I would be surprised because it would go against what
25 the anaesthetic community certainly would think about

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1 knowledge and experience of what happened in theatre?
2 MR ORR: Yes.
3 Q. I wonder if I could ask you this. Things happened
4 slightly differently, as you probably know, in Raychel's
5 case, which is that in addition to Solution No. 18 being
6 the practice as to what the IV fluids should be on
7 Ward 6, it seems that there was a practice -- it's not
8 entirely clear, but it seems that there may have been
9 a practice -- which is that if there was no other
10 prescription, when the child, post surgery, arrived back
11 on the ward, they simply reactivated any preoperative
12 prescription for fluids there might have been and simply
13 just carried on with that. Mr Orr, do you have any
14 knowledge of that as a practice?
15 MR ORR: In this instance, if they'd done that, from both
16 the surgical point of view and from the anaesthetic
17 point of view, Raychel would have received Hartmann's
18 solution.
19 THE CHAIRMAN: No, sorry, this is reactivating the
20 preoperative fluid prescription, not the perioperative.
21 MR ORR: Right, okay.
22 THE CHAIRMAN: So the question was: have you any experience
23 of the preoperative fluid prescription becoming the
24 post-operative fluid prescription?
25 MR ORR: It would not be my experience that that is what

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1 post-operative fluid management.
2 Q. And would you be concerned?
3 MR ORR: Yes.
4 Q. Mr Foster, you have heard the question. It's the same
5 thing. Can you comment on that?
6 MR FOSTER: I agree with Mr Orr. Post-operatively,
7 intravenous fluids should start off with a clean sheet,
8 depending on what has happened during the operation, and
9 it would be anaesthesia who would ordinarily do this or
10 it would be anaesthesia and the surgeon in consultation
11 who would write up the fluids to succeed theatre. If
12 I had been in the situation of Mr Makar, I can see his
13 problem, he would just assume that what would happen
14 would be the practice that he has accepted and seen
15 regularly in the past. I would not expect a rather
16 bizarre protocol to be followed when fluids had been
17 used before at the same rate. It doesn't make
18 anaesthetic or surgical sense.
19 Q. That leads into another issue that both of you address,
20 which is the recognition that the body's response to
21 stress and trauma is to release antidiuretic hormone.
22 Very frequently, in surgical circumstances, that's what
23 the body does, the effect of which is to retain water.
24 And I think both of you have expressed the view that it
25 was common to, in recognition of that, actually reduce

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1 the rate of any IV fluids post surgery to ensure that
2 the patient didn't receive too much fluid, bearing in
3 mind that the body's response is retaining fluids for
4 some period of time.

5 I wonder if you could help us with -- maybe if I ask
6 you first, Mr Orr -- how well-established, if I can put
7 it that way, that tendency was in your experience to
8 reduce the rate of post-operative fluids?

9 MR ORR: It is or was an area for debate and there was
10 variation. There is a great deal of published
11 information about this, which can be viewed contrary.
12 There is an argument to reduce fluids by about a third
13 of what you would normally prescribe post-operatively,
14 but not all units follow that protocol. So I wouldn't
15 say that giving the normally estimated post-operative
16 volume was something which was wrong or abnormal. I'm
17 not expressing that very well.

18 What I'm saying is that there is an argument for
19 reducing the fluids post-operatively, there is also an
20 argument you should carry on giving patients fluid
21 because there are circumstances where this inappropriate
22 reaction can be seen as a response to a lack of fluids.
23 So it can be a response to hypovolaemia as opposed to
24 too much fluid.

25 THE CHAIRMAN: In Raychel's case, there are really three

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1 day entirely?

2 MR ORR: Yes, that's correct.

3 THE CHAIRMAN: Okay. Had that happened, then the fact that
4 she had been getting 80 ml, say, between, for the sake
5 of argument, from post-operatively until around midday,
6 and then reduced to, say, 50 or 40 ml, then we wouldn't
7 be where we are today, we wouldn't be sitting here?

8 MR ORR: Yes. Sorry, chairman, clearly we all know it's
9 more complex than that because it's not just about the
10 rate; it's about the type of fluid that she was
11 receiving.

12 THE CHAIRMAN: And the vomiting?

13 MR ORR: Yes.

14 THE CHAIRMAN: We'll develop those.

15 MS ANYADIKE-DANES: Just before, Mr Foster, I ask you to
16 comment on that, for the sake of clarity if we pull up
17 your report, Mr Orr, where you deal with this very
18 point. It's at 320/1, page 7. You say:

19 "It is usual on the first post-operative day to
20 reduce the volume of maintenance fluid because of the
21 inappropriate secretion of antidiuretic hormone, leading
22 to a potential increase in water retention."

23 I should have said that's 3.3. It's the last
24 sentence in that paragraph.

25 That's the bit that I really wanted to ask you, what

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1 figures: 80 ml is the rate which was prescribed
2 preoperatively; 65 is the rate which you think would
3 have been appropriate, but neither of you has any
4 particular difficulty with 80 because it was envisaged
5 as being a short-term prescription; and then there's an
6 argument about whether the post-operative rate should
7 have been reduced to somewhere around 52 or 50.

8 So if I understand your answer, Mr Orr, you're
9 saying there's an argument for reducing the 65 to around
10 52 or maybe by a little bit more, but that wouldn't be
11 uniform. So that in itself would not be a strong
12 criticism. But before we turn to Mr Foster, maintaining
13 a rate of 80, is that significantly more questionable?

14 MR ORR: Yes. Maintaining a rate of 80, you would have to
15 look at, because clearly the longer that fluid rate goes
16 on, the greater the differential between what would be
17 the normally prescribed level of 65, so let's say
18 12 hours on you've then got a significant extra fluid
19 load, so I'd be uncomfortable with 80 ml being carried
20 on for a long period. But it would appear that it was
21 envisaged that that rate was going to be cut back as
22 Raychel became established on oral fluids.

23 THE CHAIRMAN: And the broad picture is, by around lunchtime
24 on the Friday, that rate would have started to be
25 reduced and might have been discontinued later on that

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1 you meant by "usual" in those circumstances.

2 MR ORR: "Usual" in my practice, the practice in my
3 hospital, but not necessarily a standard practice across
4 the UK.

5 Q. Thank you. And even if it wasn't being followed as
6 a standard practice, was the issue of fluid reduction
7 and whether in any given patient it should happen,
8 is that something that you would expect surgeons to be
9 aware of?

10 MR ORR: It would be something that I would expect surgeons
11 to have a view about and have discussed with their
12 anaesthetic colleagues and therefore there to be some
13 kind of consensus on a surgical unit because if you
14 don't have that consensus, you will have confusion if
15 there's a number of different surgeons and anaesthetists
16 working to different policies.

17 Q. Yes. Mr Foster, I wonder if you could comment on that
18 issue as to the extent to which it was a recognised
19 matter that, post-surgically, you reduced fluids by
20 whatever margin in recognition of the effects of
21 antidiuretic hormone?

22 MR FOSTER: It's something that's been in my mind ever since
23 I was taught it in 1973. I can remember -- it's one of
24 those few things I have a picture of the
25 professor speaking as to the importance of this, not

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1 necessarily in children, it was said I'm sure
2 in relation to adults and the elderly who could easily
3 be driven into overloading of fluids in cardiac and
4 pulmonary problems. But the theory still applies to
5 anyone who's had an operation. And it's a practice
6 we have always adhered to.

7 I used to do a lot of major bowel surgery in adults,
8 of which a number were elderly, and it was always
9 thought to be extremely important to do this because
10 there are great fluid shifts around the body after two
11 or three hours of having a major operation, and the
12 anaesthetists always liked to see fluids reduced
13 post-operatively until they saw a level playing field,
14 as it were, after a few hours, and they did some
15 bloods -- that's electrolytes, full blood counts and so
16 on -- and they saw where they were with the patient and
17 then they would normalise them.

18 Q. But the very example you've given there may be a reason
19 why you perhaps wouldn't have a blanket policy because
20 you accommodate some sort of surgery where the bodily
21 cavities are exposed for some considerable period of
22 time, where you might expect there are more losses,
23 greater shock or trauma to the system, and other
24 procedures which are short and perhaps less invasive
25 than that, which might not produce the same reaction.

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1 other parameters coming in, affecting fluid requirements
2 and the ability of the body to cope with them. And
3 I would always defer to expert anaesthetic colleagues
4 from this point of view.

5 Q. Yes. It's right to also mention a paper that
6 Mr Gilliland relied on to show that fluid reduction --
7 both of you had it in your reports. It perhaps wasn't
8 as standard or as commonplace as was suggested. The
9 paper is called:

10 "Perioperative fluid therapy in children: a survey
11 of current prescribing practice."

12 The advance publication date was 2006, it's
13 published in the British Journal of Anaesthesia. The
14 reference for it, which I can give, is 317-029-001, and
15 what I would like to pull up is page 003.

16 This paper followed on from a survey of
17 anaesthetists', current at that time, fluid-prescribing
18 practice during the perioperative period and looking at
19 departmental fluid protocols and the awareness of
20 concerns of the Royal College of Paediatrics and Child
21 Health about Solution No. 18, actually. And if one
22 looks at post-operative fluids, which is why I pulled up
23 this page, you can see that the most commonly prescribed
24 fluid for post-operative maintenance was 4 per cent
25 dextrose/0.18 per cent saline or 2.5 or 5 per cent

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1 MR FOSTER: Yes, I accept that, but I think, again, back to
2 anaesthesia, my colleagues who I would trust to get it
3 right would be aware of the length of time an operation
4 took and would be aware of in-theatre losses by
5 evaporation and so on and would factor that into the
6 post-operative fluid requirements. But as a general
7 rule, if there wasn't an excess loss of fluid by direct
8 blood loss, intestinal contact loss, evaporation due to
9 time, then you would calculate an amount of fluid based
10 on the body's requirement and reduce it by a small
11 amount. It's just something I've said for so many years
12 I don't see a -- I have never seen an alternative
13 process.

14 Q. So all of that really is pointing to, because of the
15 very circumstances you have just discussed, the
16 anaesthetist, perhaps in combination with the surgeon,
17 being the people who are most knowledgeable about what
18 happened, prescribing the appropriate type and rate of
19 fluid?

20 MR FOSTER: In a big operation, you would be discussing with
21 anaesthesia, and you would come up with a consensus as
22 to the rate of fluids. But as a surgeon doing the job,
23 you wouldn't be aware of what had gone on -- I'm talking
24 adults now -- gone on from a cardiac point of view and
25 so on and you would have to -- there's all sorts of

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1 dextrose with 0.45 per cent saline. And then one sees:
2 "Isotonic fluids were not commonly prescribed."
3 If we go to the next column, just above
4 "Discussion", you see:

5 "194 respondents provided information on how they
6 calculated post-operative maintenance fluid."

7 "It's not a very large sample size, I recognise
8 that, but nonetheless you may be surprised at the
9 results:

10 "The majority based the calculation on
11 Holliday-Segar."

12 That's 81.8 per cent.

13 "Nineteen, the equivalent of 9.3 per cent, quoted an
14 approximate, but incorrect formula."

15 But if you move on:

16 "Only 5.9 per cent [of that survey] would restrict
17 the fluids. 72.4 per cent would prescribe 100 per cent
18 of predicted maintenance fluid and 2 per cent would give
19 volumes in excess of the amount calculated."

20 So in terms of fluid restriction, it's actually
21 quite a small percentage of an admittedly small sample
22 size. So by 2006 anyway, post-operative fluid reduction
23 didn't seem to be something, on the basis of this
24 paper's sample, that was commonly followed, if I can put
25 it that way. Are you in a position to offer a --

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1 MR ORR: Clearly this is paper that's 2006 and certainly
2 I hadn't read that paper before I made my comment. But
3 my comment was in relation to what I realised, that
4 certainly there were units that would prescribe at
5 100 per cent. I couldn't have given you figures.
6 Q. Yes.
7 THE CHAIRMAN: But again, the problem isn't so much that
8 Raychel goes back on 100 per cent or that she's getting
9 80 ml an hour, the problem is what then happens as
10 Friday progresses.
11 MS ANYADIKE-DANES: Yes. I wonder if I could ask you this
12 question to do with the inappropriate antidiuretic
13 hormone, or rather moving on from the antidiuretic
14 hormone response. That can develop or at least in some
15 children that can be expressed as an inappropriate
16 response. I wonder if you can help with -- it may be
17 that you don't know -- why some children develop an
18 inappropriate response. Mr Foster, maybe?
19 MR FOSTER: I don't really know and I don't think anybody
20 does. But there is one thing that bothers me here and
21 this is to go back to the protein in the urine again.
22 Because it is signifying something not right happening
23 in the kidneys' filtration mechanism or tubular
24 mechanism to allow protein to be lost. I'm not
25 a nephrologist, but I have always been slightly

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1 they did not develop in the way that Raychel did. There
2 may be some other factors that distinguished Raychel,
3 but this is why I asked you that question.
4 I don't know, Mr Orr, if you can help, whether you
5 are aware of why some children develop -- and Raychel
6 seems to have been one of them -- from that normal
7 hormone response into SIADH.
8 MR ORR: Again, I think it's important to emphasise that I'm
9 not an expert on inappropriate ADH secretion, nor indeed
10 in the nephrological aspects of this case. But what
11 I think I can say is that we are not always sure why
12 patients develop this potentially catastrophic response.
13 There are cases in the literature where children undergo
14 very minor surgery with minimal fluid replacement and
15 still go on to develop the signs of inappropriate ADH
16 with fluid retention, cerebral oedema, the fitting, and
17 that has been recorded in minor cases, and it's
18 difficult to explain why it occurs in these cases.
19 THE CHAIRMAN: But you know that there's a risk that it can
20 occur and this all feeds back into observations on the
21 Friday, does it, and on monitoring Raychel's progress
22 and acting in a timely way?
23 MR ORR: Yes, but there are cases where patients appear to
24 have made an initial uneventful recovery and then some
25 hours later go on to develop this syndrome, which

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1 bothered, I think, about the situation here: was there
2 something in the kidneys that predisposed Raychel to an
3 inappropriate response of the kidneys to hormonal
4 feedback and the ADH problem and led to an
5 over-retention of fluid? It bothered me and I have to
6 vocalise it here. I can't give you an answer because
7 I'm nothing like academic or specialist enough in
8 nephrology.
9 Q. The significance of it, following on from the way the
10 chairman was posing the question, is things move on,
11 that combination of that inappropriate retention or too
12 much retention of fluid, coupled with the loss of the
13 sodium-rich gastric juices through prolonged and severe
14 vomiting, added to receiving, over a significant period
15 of time, over-maintenance levels of low-sodium fluid.
16 That combination of those three factors, it seems the
17 experts have suggested -- and indeed the coroner
18 found -- have led Raychel to the development of her
19 cerebral oedema, which ultimately led to the herniation
20 and coning. So that's why I was asking you about why
21 Raychel, if you could help us, developed the SIADH. The
22 evidence from the clinicians is that Raychel was treated
23 not particularly any different to any number of children
24 of her age, who would have come in to have an
25 appendicectomy or other surgery of a similar nature and

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1 clearly is worrying. That's why I'm saying it's
2 difficult to say exactly why Raychel developed this
3 progression downwards.
4 MR STITT: If I may, just on this point, clearly the SIADH
5 is one of the central issues in your inquiry, sir. And
6 it's something which was addressed by Mr Scott-Jupp
7 yesterday. And you will recall -- and I have made
8 a note of the page -- at page 113 of his evidence, he
9 said that he had never seen this degree of hyponatraemia
10 causing a cerebral oedema on this type of fluid. And he
11 concluded that there was a very excessive degree of ADH.
12 Maybe that's not disputed.
13 But may I ask, before we pass on this subject -- and
14 it's no more than a hypothesis and Mr Foster is
15 reasonable enough to say that it's not evidence-based --
16 but if there is in the evidence some paper or something
17 which he, not being a nephrologist, believes would
18 sustain the contention that the plus or plus plus
19 proteinuria was somehow a factor, I would ask that that
20 be articulated at this point. But if it's merely
21 a feeling, it's one which we respect, but I would like
22 to know the weight and the degree of confidence which
23 Mr Foster has in his theory.
24 MR FOSTER: It's merely that the -- we have an abnormality
25 in this case preoperatively, which was proteinuria, and

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1 we know it is seen in a number of children normally if
2 there is such a word as "normally". It is the only
3 thing that was detected preoperatively as something that
4 didn't fit in the box of "normal", and post-operatively,
5 there was a problem with renal excretion of excess
6 water. I'm probably just posing the question from
7 common sense and being a basic doctor that -- is there
8 a link here? And that's where we need a nephrologist
9 maybe. So it's a possibility that has occurred to me.

10 All this illustrates, as far as I can see, is the
11 importance of making measurements in the perioperative
12 and post-operative situation that identify problems,
13 that identify where a patient of any sort is not fitting
14 into the profile of what should be expected, and that is
15 why fluid balance charts have to be accurate, otherwise
16 there's no point in keeping any of them. That's why
17 records of fluid loss should be accurate, otherwise
18 there's no point in keeping any of them. And as long as
19 these protocols are adhered to with great care, that is
20 the only way you can identify the very rare patient who
21 fits into this category.

22 MR STITT: For clarity, on behalf of the Trust, I will not
23 be disputing the importance of record keeping and that's
24 what the charts are for, I think that's self-evident.
25 But I'm just trying to get some clarity as to where

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1 can't accurately predict, you can, I think as Mr Foster
2 was saying and the chairman was indicating, start to
3 chart whether it is developing, would be I right in
4 saying that, by monitoring, to start with, whether there
5 is urine output? That might be a way to start seeing
6 whether the child is behaving abnormally; can I put it
7 that way?

8 MR ORR: It's the basis of post-operative management of all
9 patients that you have a clear idea of their fluid
10 balance. That's critical, not just in thinking about
11 inappropriate ADH. But it is critical that you have
12 accurate fluid balance charts and you respond to these
13 appropriately in terms of your fluid prescription.

14 Q. Dr Scott-Jupp said yesterday, yes, you do want to have
15 some appreciation of the volume of vomit, the incidence
16 and volume of it, but he regarded it almost as equally
17 important to have an appreciation of output: when did
18 she pass water, how often did she do it. If you've got
19 any sense of what sort of volume it is, that might be
20 easier to do in some children than others, but anyway
21 that's another important measurement so far as
22 Dr Scott-Jupp was concerned; would you accept that?

23 MR ORR: Yes, I'd agree.

24 MR FOSTER: Yes.

25 THE CHAIRMAN: Let's come on to post-operative management

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1 we are in relation to this proteinuria point again
2 because we've dealt with the dipstick point and we know
3 that a full analysis, laboratory analysis, would take
4 two or three days, which is obviously further down the
5 line. But I think that the witness has answered as best
6 he can.

7 THE CHAIRMAN: Thank you.

8 MS ANYADIKE-DANES: I wonder if I can just follow up from
9 something which both the chairman and you, Mr Foster,
10 mentioned, and put this to you, Mr Orr, which is: even
11 though you may not be able to predict in advance why any
12 given child develops SIADH, is it something nonetheless
13 that was recognised as a possibility? That's one part
14 of what I would like to ask you. In 2001, was the
15 possibility of an inappropriate response recognised so
16 far as you're aware?

17 MR FOSTER: Yes. Yes, and I recall going to meetings and
18 hearing discussions of this as a reinforcement of the
19 reason for accurate record keeping because you couldn't
20 in any other way predict these cases or spot them.

21 Q. If I ask Mr Orr the same question.

22 MR ORR: In 2001, there should have been a knowledge in the
23 surgical community of the condition of inappropriate
24 ADH.

25 Q. Yes. And then, as I say, if it's something that you

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1 after lunch. We'll start again at 2 o'clock.

2 (1.10 pm)

3 (The Short Adjournment)

4 (2.00 pm)

5 MS ANYADIKE-DANES: Good afternoon. If I could follow on
6 from the discussions before lunch about urine and its
7 measurement, I think both of you have expressed the view
8 that it was --

9 MR STITT: I'm sorry for cutting across, I thought --

10 MS ANYADIKE-DANES: I am going to deal with that.

11 Both of you agreed with Dr Scott-Jupp that it was
12 important to measure the urine output insofar as you
13 could because the volume of it or the incidence of it
14 might tell you something about the child's condition, in
15 particular whether the child was developing this
16 inappropriate response, if I summarise it in that way.

17 Does it follow from that that you're of the view
18 that the nurses or the junior doctors during the day
19 should have been noting whether she was producing urine?

20 MR ORR: Yes. You should be observing the fluid balance
21 chart, both the nursing staff and the doctors, when
22 they're looking at the patient.

23 Q. Yes. So it's one thing to be accurately recording the
24 output, but it's also something to note, to take note of
25 the incidence of passing urine, whether it's happening

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1 at all and if it is happening, how often it's happening;
2 would that be fair?
3 MR ORR: Yes.
4 Q. In this case, the record, if they'd looked at it -- in
5 fact I think there's one record of it on the fluid
6 balance sheet that she passed urine at 10. If they had
7 asked Raychel's mother or she realised that was
8 important, she could have told the nurses that she also
9 went to the toilet at about noon or thereabouts and
10 there's a query over whether she went to the toilet and
11 passed urine on one other occasion after that. But if
12 that's all you had, is that something that, in
13 combination with the vomiting, you think the nurses
14 should have been cognizant of and been drawing to the
15 attention of the junior doctors?
16 MR ORR: Yes.
17 Q. And if the junior doctors had been aware of it, is it
18 something that should have resonated with them and, if
19 they didn't know what the implications of it were
20 exactly, but drawing it to the attention of their SHOs?
21 MR ORR: Yes.
22 Q. Thank you. Sorry, I didn't specifically ask you,
23 Mr Foster, but I saw you nodding there. Does that mean
24 that you agree with that?
25 MR FOSTER: I agree to all three yeses.

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1 MR ORR: I can do that.
2 Q. Thank you very much indeed.
3 It may be that there are some in the article that
4 Mr Gilliland kindly furnished to us. If you could give
5 us an indication if this is the sort of thing you had in
6 mind, it's reference 317-029-006. If one goes to the
7 second column, just a little above halfway down, it
8 starts:
9 "The syndrome of inappropriate ADH (SIADH) was
10 described in 1957; the production of inappropriately
11 concentrated urine in the presence of hyponatraemia and
12 low plasma osmolality in the absence of hypovolaemia and
13 with normal renal and adrenal function. Experts have
14 emphasised the dangers of administration of hypotonic
15 saline solution in the presence of elevated ADH
16 concentrations in a child who is acutely unwell, either
17 advocating only isotonic solutions with dextrose in the
18 post-operative patient or avoiding hypotonic solutions
19 if the plasma sodium decreases below 138 mmol/litre."
20 And it goes on. There are, within that block that
21 I've been reading out, references to the footnotes of
22 authorities. That particular one is 31, which, without
23 going to it now, the page, I can say it is a paper
24 titled:
25 "A syndrome of renal sodium loss and hyponatraemia,

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1 Q. Thank you. There was a point that I wanted to pick up
2 with you, Mr Orr, something that you said before lunch.
3 It's on page 90 [draft]. You were talking about the
4 extent to which children have gone on to develop SIADH,
5 associated with low sodium. Are you able to help us --
6 and you said that that was known. Are you able to help
7 us with whether that's known because it's in the
8 literature or it's known because just generally
9 clinicians have experienced it? What is your reference
10 for that?
11 MR ORR: I have references for cases that have occurred.
12 When they have occurred -- I'm in danger of repeating
13 myself. They have occurred in patients who have
14 undergone minimal surgery and then, at a later stage,
15 have developed the inappropriate ADH syndrome with
16 cerebral oedema, et cetera, et cetera. But it's not
17 clear why these specific patients had developed
18 inappropriate ADH secretion.
19 Q. When you say "cases", do you mean case studies that are
20 in the literature, if I can put it that way?
21 MR ORR: Case reports in the literature.
22 Q. I'm not going to ask you to do it off the top of your
23 head now, but if you do have those, I wonder if you
24 could furnish them to the inquiry so that we can make
25 those available?

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1 probably resulting from inappropriate secretion of
2 antidiuretic hormone."
3 And that paper was dated 1957. Incidentally, in the
4 references, one sees the first case in the inquiry at
5 reference 3, which is a paper by Armour:
6 "Dilutional hyponatraemia: a cause of massive fatal
7 inappropriate cerebral oedema in a child undergoing
8 renal transplantation."
9 Which is a paper that was published in 1997 in the
10 Journal of Clinical Pathology.
11 In any event, are you saying that in these sorts of
12 articles there are papers that deal with the question of
13 SIADH and how one should address it and how it might
14 arise?
15 MR ORR: What I am saying is that clearly the syndrome is
16 well recognised in the literature and has been since
17 1957, that there are a small number of cases where
18 children who have not had major surgical operations have
19 gone on to develop inappropriate ADH syndrome, and it's
20 unclear why these children have developed that syndrome.
21 Q. Yes. I'm not going to put this up, but for those who
22 can access this paper, if you look at page 008, there is
23 a list of references, some of which are dealing with the
24 very issue that you're talking about as well as other
25 related matters to do with fluid management.

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1 But if you have your own case study papers, if you
2 could furnish those, that would be very helpful.

3 If we can now move on to the question of the ward
4 round and consultant involvement at that stage.
5 You have assisted us by commenting on the immediate
6 post-operative phase and who you think ought really to
7 have been prescribing and in control of Raychel's fluids
8 and why you've said that. We come now to a time when
9 her night-time, if I can put it that way, seems to be
10 entirely uneventful: nothing really happens, she doesn't
11 vomit, she's asleep, and we get to the ward round, which
12 is some time about 8/8.30. It's not entirely clear
13 because it's not dated in the notes, but it would seem
14 to be around that time.

15 That ward round is carried out by Mr Zafar, who's
16 an SHO. He has conceded that he had very limited
17 paediatric experience. I wonder if you could help me
18 with that as a first stage, which is in your view, on
19 a post-take ward round involving paediatric patients and
20 what level or grade of clinician do you think should
21 have been conducting that ward round? Maybe starting
22 with you, Mr Orr.

23 MR ORR: It would be good practice for either a consultant
24 or a senior trainee to take a post-take ward round.

25 Q. And by "senior trainee", do you mean a registrar?

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1 the incoming team, the consultant's team, as I have read
2 it, of the patients who had come in.

3 It's also important that there's continuity
4 maintained for the patient's benefit and that a doctor
5 who had seen the patients the day or night before would
6 be a familiar face to them on the post-take ward round
7 with a consultant that they had not met. So it is
8 an important part of the day. It is an opportunity to
9 teach the medical students about emergency presentations
10 and should be taken extremely seriously.

11 Q. The way you have characterised that ward round is a team
12 of clinicians, really, going round to see the patients.
13 You haven't said so, but I assume you'd expect a nurse
14 to be present at that time?

15 MR FOSTER: Oh yes. There would be a different nurse on
16 each ward, but the team remains a team and it can have
17 a central starting point which, if a child had come in
18 my hospital -- it doesn't have to be -- it was
19 convenient to start on the paediatric ward because there
20 would only be one or two children, it wouldn't take
21 a long time, and then you'd go on to the others. But
22 the team goes around. Occasionally we would let someone
23 go if they had to go off somewhere, but I would expect
24 the specialist registrar, two SHOs, PRHOs and some
25 students.

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1 MR ORR: Yes. In 2001, it would still be a registrar, yes.

2 An experienced registrar or a senior registrar if there
3 was a senior registrar in the hospital.

4 Q. And why do you say that?

5 MR ORR: Because I don't think that an SHO with limited
6 experience has the required experience and indeed
7 competencies to take a post-op ward round -- a post-take
8 ward round.

9 Q. I wonder, Mr Foster, if I can ask for your comments on
10 that issue.

11 MR FOSTER: Well, a post-take round is one of the most
12 important events in a surgical unit. If a consultant is
13 on call, say once or twice a week, we are talking about
14 one or two occasions to go round and see the patients
15 who have come in under your care and to progress some
16 treatment plans for them for the next few days.
17 Undoubtedly such a round should be taken by a senior
18 person, consultant preferably, very much so, or an SPR
19 at the very least, just about so.

20 It should also contain a representative of the team
21 who were on call overnight and the day before ideally.
22 Doctors are on strict rotas these days, way back in 2001
23 too, and it is likely that the SHO who was on overnight
24 and the previous day would be going off before too long
25 and should have accompanied that ward round to appraise

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1 Q. Well, what happened in this case, as you probably know
2 from the evidence, is that there may have been a team
3 like that. It's not entirely clear who comprised it,
4 but it seems that there was a registrar there. The
5 identity of that registrar we don't know. But in terms
6 of Raychel within that ward round, Mr Zafar was sent to
7 deal with her -- I think the expression used is an
8 outlier -- because she was the only post-take surgical
9 child in Ward 6 and may in fact have been the only
10 surgical child in Ward 6, so he was sent off to go and
11 do that ward round by himself, as it were, and it may be
12 that the team then carried on and saw other patients.
13 Before I come to you, Mr Orr: Mr Foster, what comment
14 do you have on that as a practice?

15 MR FOSTER: Extraordinary. It's almost as if Raychel was
16 treated as an afterthought, "Oh, there's a paediatric
17 patient in the children's ward, somebody's got to go and
18 see her". It's serious business when somebody has come
19 under the care of the unit and had an operation just
20 a little over 12 hours before, if that -- let me get my
21 arithmetic right, not even that, 8 hours and a bit
22 before. She requires assessing, ideally by the person
23 who had done the operation or, just about acceptably, by
24 somebody else of experience who had spoken to the
25 surgeon who had done the operation, but not by somebody

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1 who, by his own admission, has had very limited
2 experience of children and has a long experience of
3 specialist cardiothoracic training, which is very
4 different to general surgery and to be sent off there on
5 his own with no particular plan or being told by your
6 senior what he's going for and what he's supposed to do
7 is extraordinary.

8 Q. Would it make any difference to your view to know that
9 it may be that it was considered appropriate or
10 acceptable to ask Mr Zafar to carry that out because, in
11 fact, it had been an uneventful surgery and she appears
12 to be in a completely unproblematic and un concerning
13 state, if I can put it that way?

14 MR FOSTER: At that point, I don't think so because it would
15 only be an uneventful operation if somebody of seniority
16 had checked young Raychel post-operatively and deemed it
17 so.

18 THE CHAIRMAN: So is part of your concern is that this is
19 a continuation of Raychel not being seen by somebody in
20 a senior position?

21 MR FOSTER: Yes. This is a post-operative check. She's
22 only been in the ward under the nursing care and vital
23 sign recordings, so this is the first time for a doctor
24 to see her and compare her to her appearance and
25 condition preoperatively. That's why in my view

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1 THE CHAIRMAN: I think it's also right to throw into this
2 rather complicated mix that there had been concerns
3 expressed by the nursing staff on Ward 6, the paediatric
4 ward, that it was taking some considerable time into the
5 day for the surgeons to reach them because they were
6 starting on the adult wards and working their way along
7 and there may be an interpretation of the evidence which
8 is that, in order to ensure that surgical children were
9 seen reasonably promptly early in the morning, that
10 somebody would be sent from the normal surgical ward
11 round to the children's ward to check up on the children
12 patients. Okay?

13 MR FOSTER: If they wanted to adopt that practice, then the
14 senior person on the ward round should have gone. But
15 it may well be that the senior person on the ward round
16 was Mr Zafar.

17 THE CHAIRMAN: Yes.

18 MR STITT: The point I'm making is, with respect, it's
19 unfair to say that the hospital was treating Raychel as
20 an "afterthought". The nurses had responsibility for
21 her, two doctors had seen her, and the consultant
22 apparently had been advised as to her condition. If she
23 was not well --

24 THE CHAIRMAN: Sorry, Mr Stitt, you're commenting on the
25 evidence. What you're saying is that you disagree with

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1 Mr Makar should have been doing this little part of the
2 job.

3 MR STITT: Mr Chairman --

4 THE CHAIRMAN: I was just going to mention Mr Makar.

5 It's fair to say that as Mr Zafar, just after he had
6 seen Raychel and as he was leaving with the ward sister
7 who accompanied him, they passed Mr Makar, who was
8 coming in to see Raychel post-operatively. They don't
9 appear to have had any discussion of substance and then
10 Mr Zafar went on his way and Mr Makar went on in and saw
11 Raychel in what Mr Makar described as his check to make
12 sure that things were progressing as he had expected.

13 MR STITT: That was the point I was going to make. I was
14 also going to say that the evidence would show that both
15 Mr Makar and Mr Zafar addressed their minds to Raychel's
16 condition. We know -- and this can be put to the
17 witness -- that there is no witness saying that
18 Raychel's condition gave any cause for concern.
19 I appreciate that's slightly off the point, but
20 nonetheless ... And thirdly, Mr Gilliland, who was the
21 named consultant, believes that he was on the ward round
22 in one of the other wards and believes that he would
23 have been informed as to Raychel's condition by, he
24 thinks, Mr Zafar, although the evidence on that is not
25 absolutely clear.

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1 their evidence. A comment on the evidence is
2 inappropriate.

3 MR STITT: Of course it is.

4 THE CHAIRMAN: Mr Foster said "almost as an afterthought",
5 but his basic point, which is absolutely clear, is that
6 this is one of the most important events in a surgical
7 unit and his surprise is clearly that Raychel was seen
8 on that ward round not by a consultant and not even by
9 a registrar. That's his point.

10 MR STITT: That's his point. But that having been said, if
11 the judgment of those who had looked at and seen Raychel
12 was faulty, then there might have been some more weight
13 to the point.

14 THE CHAIRMAN: I'm sorry, that's a second comment on the
15 evidence, Mr Stitt, and I won't accept it. We are going
16 to get through the evidence this afternoon without
17 people standing up and commenting on the evidence.
18 Okay?

19 MS ANYADIKE-DANES: Mr Orr, if I can ask you now for your
20 view. You've heard the line of discussion in relation
21 to this question about the ward round. If we can start
22 with your view as to whether you agree with Mr Foster
23 that the kind of ward round that he was anticipating
24 might happen is where the team, if you like, moves
25 through and sees the patients. Is that a ward round in

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1 a paediatric ward that you would be familiar with?
2 MR ORR: Yes. I think a team approach is entirely
3 appropriate and it is very common in many units. That's
4 what you'd expect. You would also expect that team to
5 go to the paediatric ward. We've heard the reasons why
6 somebody might be detached and report back, but it is
7 still important that a senior person, a consultant or
8 specialist registrar, actually sees the patient.
9 Q. I think the way Mr Foster put it was really twofold.
10 One, it's important because the patient warrants
11 somebody of that seniority to assess their condition and
12 plan their care for that day; and the other, it provides
13 a very good teaching opportunity for trainees and more
14 junior clinicians so you can use the patients and how
15 you're regarding their condition as a way of teaching
16 your more junior clinicians. Would you accept it has
17 a dual function in that way?
18 MR ORR: I would accept it has a dual function, but the most
19 important thing is that the consultant, the named
20 consultant in charge of that patient, has actually seen
21 the patient, or his delegated representative, and that
22 can only be in a children's ward -- in this situation,
23 where that is not the main part of their practice, it
24 has to be a senior registrar or specialist registrar.
25 Q. And how significant or important do you think that is,

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1 didn't envisage her being on IV fluids for very long at
2 all. So in his mind, that fluid regime was going to
3 come to an end, so from that point of view, it really
4 didn't matter to him particularly -- I hope I'm not
5 undermining his evidence -- but it didn't really matter
6 to him that she was on Solution No. 18 at 80 ml an hour
7 because she wasn't, in his view, going to be on any
8 IV fluids for very long.
9 If I start with you, Mr Orr, if you had formed that
10 view that here is a child who had come through very
11 successfully a rather short and entirely straightforward
12 appendicectomy, if you'd formed that view and that you
13 didn't really think that she was likely to need much
14 further IV fluids, can you comment on how acceptable it
15 was not to look at her current IV fluid regime?
16 MR ORR: Well, I don't think it is acceptable. It's
17 standard practice: as you do a ward round, you look at
18 the charts, and these charts are pretty standard across
19 the UK and Ireland. You have a fluid balance chart,
20 you have a temperature/pulse/respiration chart, pretty
21 standard. You look at these as part of the process, you
22 look at the patient, you make an assessment. So you
23 should not omit looking at charts on a ward round.
24 Q. Even if the child looks to all intents and purposes
25 perfectly well to you, the parent who's with her seems

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1 that that is a practice that should have existed?
2 MR ORR: I think it's very important. I would be very
3 uncomfortable not to have seen patients that have come
4 into my ward.
5 THE CHAIRMAN: So we can debate and discuss what the
6 consequences are for Raychel of what happened on that
7 ward round and it may be that on this particular
8 occasion the consequences were not very serious, but the
9 concern I'm receiving from both of you is that this
10 practice was below standard?
11 MR ORR: Yes.
12 THE CHAIRMAN: Mr Foster, yes?
13 MR FOSTER: Yes.
14 THE CHAIRMAN: Thank you.
15 MS ANYADIKE-DANES: Thank you. When Mr Zafar does go, it's
16 not entirely clear the charts that he looks at. He says
17 that he didn't appreciate that Raychel had vomited at
18 8 o'clock, although he recognises that that is recorded
19 on her fluid balance chart. Sister Millar, who was
20 there, says she told him that, but in any event he said
21 he didn't appreciate that. He also didn't, on his own
22 evidence, pay very much attention to the fluid regime
23 that she was on and how long she had been on it and so
24 on and the details of it. And his explanation for
25 that is because she looked so well to him that he really

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1 to be happy with her condition and the sister is not
2 reporting any concerns? Even in those circumstances?
3 MR ORR: I would still look at the chart.
4 Q. Mr Foster?
5 MR FOSTER: Completely agree. It's not just looking at the
6 patient, it's looking at the pieces of paper that have
7 been kept over the night on her condition and
8 observations. One observation was of a vomit. That,
9 I believe, should have prompted --
10 THE CHAIRMAN: Although the vomit is entered in the record
11 at 8 am, it is not clear on the evidence that Raychel
12 had vomited before the ward round. That entry may have
13 been made at some time before 9 o'clock after the ward
14 round.
15 MR FOSTER: I think so, but I can't recall offhand, if
16 someone could prompt me.
17 THE CHAIRMAN: I think that is the position. It's unclear
18 whether that vomit had been recorded.
19 MR FOSTER: The vomit was at 8 --
20 THE CHAIRMAN: Sorry, if you look at the record, it appears
21 that it was at about 8, but in fact the records which
22 were made during that day tend to have vomit recorded at
23 8 or 11 or midday, but you shouldn't take that to be
24 precisely that time. That might mean 11.30 or 11.45 or
25 something. Okay? So it's not clear that there was

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1 a vomit to have taken into consideration at the time the
2 ward round was conducted.
3 MR CAMPBELL: Sir, Sister Millar's evidence was clearly to
4 the effect that she had informed Mr Zafar of that vomit.
5 THE CHAIRMAN: And he had either no recollection or denied
6 it. I can't remember which.
7 MR CAMPBELL: I accept that, but the point is that she was
8 clear in her recollection that she had imparted that
9 information and she had entered in the treatment book
10 "oral fluids later". The later --
11 THE CHAIRMAN: Because of the vomit?
12 MR CAMPBELL: -- became significant because he had said,
13 "Delay those because of the vomit".
14 THE CHAIRMAN: Sorry, thank you very much. That's quite
15 right. In that event, let's go back to the question.
16 It might be that I have picked up the wrong sequence.
17 If sister's right, if Raychel's vomit took place
18 before the ward round and if this was drawn to
19 Mr Zafar's attention, does that emphasise the fact that
20 that's another thing for him to take into consideration?
21 MR FOSTER: Yes, I understand, sir. That should have
22 prompted him, at the very least, to have said -- well,
23 accepting that he expected her to follow the expected
24 recovery profile, I think he should have realised that
25 having noticed that and being aware of the very junior

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1 MR FOSTER: Yes. I think as I said, that should have
2 prompted Mr Zafar to issue some command, instructions,
3 to sister, as he was the only person who wasn't a junior
4 house officer covering the ward, and that should have
5 been to please let me know if this happens again and
6 I will come and see her. I'm not saying he should
7 necessarily have ordered some blood tests at that point,
8 but it should have prompted him to act as a doctor, as
9 a surgeon, and say to the sister, "I will come back if
10 this happens further".
11 Q. If I can ask you, Mr Orr, you have said in your view,
12 irrespective of how well Raychel looked, he should
13 really have looked at the charts, fluid balance chart,
14 temperature, respiration, pulse, and so on. If he had
15 done that, what is it that you believe he should have
16 taken from that? What effect should that have had?
17 MR ORR: It may be that there was nothing of note on the
18 fluid balance chart or on the observation chart, but if
19 there was a record of vomiting, then that would have
20 prompted a response, a request, to be informed if there
21 was a further episode of vomiting.
22 Q. There were two actual fluid balance charts. One started
23 at 8 o'clock for that day and there was a fluid balance
24 chart from the previous day. If he'd looked at those,
25 he would have seen that she had been on Solution No. 18

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1 nature of the cover below him of the doctors who were
2 responsible for the ward, I think that should prompt
3 merely a comment to Sister Millar, "Please let me know
4 again if anything like this happens later in the day and
5 I will come and see her".
6 MS ANYADIKE-DANES: Mr Chairman, just for reference
7 purposes, I think it's Sister Millar's evidence on
8 28 February, page 87, lines 1 to 4.
9 THE CHAIRMAN: Is it in accordance with what Mr Campbell
10 said?
11 MS ANYADIKE-DANES: I believe so. In fact, my recollection
12 is that she had said, in her inquiry witness statements,
13 two things: one that she had told him that and,
14 secondly, that it was in the fluid balance chart.
15 There we are:
16 "I said to Mr Zafar that Raychel was progressing
17 well. Her observations were normal. There was nothing
18 of major concern except I pointed out or said to him she
19 had had a vomit at 8 o'clock."
20 So that repeats what she said in her inquiry witness
21 statement.
22 So in your view, that should have prompted some
23 consideration?
24 MR FOSTER: The vomit?
25 Q. Yes.

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1 at 80 ml an hour throughout, apart from the period when
2 she was in theatre. If he had seen that, is that
3 anything that should have prompted any further
4 consideration by him, whether or not in combination with
5 the vomit?
6 MR ORR: At this stage, no. I think we've already discussed
7 the fact that he is proposing to reduce the intravenous
8 fluids, to increase the oral fluids, so, no, I don't
9 think it should have prompted any other action at this
10 stage.
11 Q. And Mr Foster?
12 MR FOSTER: I think that's perfectly reasonable. He was
13 expecting a normal situation to be developing as the day
14 went on and that would have allowed the fluids to be
15 reduced. The only blip was the vomit and he should,
16 I believe, have -- it would only have taken him
17 5 seconds to ask that he be informed if it happened
18 again.
19 Q. What it seems he wanted to happen was Raychel to be
20 gradually introduced to fluids orally, so she was to
21 start with sips and so forth, and then in due course for
22 her to come off the IV fluids completely. That's not
23 recorded in the note that he made of the ward round, but
24 in that territory is something that the sister
25 understood. They may have slight differences of exactly

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1 the detail of it, but the sense of that she understood.
2 There was an issue as to whether Mr Zafar meant she
3 should stop fluids completely, but leaving that kind of
4 question aside, do you think that it would have been
5 appropriate for him to have included a little more
6 detail in his ward round note about what he was
7 anticipating or what he would have wanted to happen?
8 Mr Orr, if I ask you that.
9 MR ORR: That would have been good practice, but it could
10 well be that the standard practice on the ward was that
11 if you're dealing with this kind of information, such as
12 the introduction of oral fluids, that that was dealt
13 with verbally between the medical and the nursing staff.
14 And if that was the accepted practice, I wouldn't
15 criticise that.
16 Q. Yes. Mr Foster?
17 MR FOSTER: I think as long as -- let me just see where
18 we are here. I think a good sister should be well
19 capable of receiving an instruction to introduce oral
20 fluids, reduce the IV, and start oral fluids. And
21 a sister of many years' experience would, I believe,
22 have known how to do that, by starting sips and
23 increasing them, and when she thought that Raychel was
24 stabilising on oral fluids -- and I think that should
25 include the recording of some urine output to match the

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1 discussion as to how you thought she presented and your
2 plan for her?
3 MR ORR: As I understand it, this is a senior ward sister
4 that we're talking about, who is comfortable taking oral
5 orders on the ward round.
6 Q. Yes.
7 MR ORR: In my experience, senior ward staff have no
8 hesitation in coming back to the doctors, saying,
9 "I have a concern about this patient. We're not able to
10 progress the patient to oral fluids because she is
11 continuing to vomit". So I'd expect feedback when the
12 expected progress is not being made.
13 Q. Yes. And some of that will depend, from the way you've
14 framed that, on the quality of the communication. If
15 Mr Zafar has made clear how he sees matters developing,
16 then you would expect that the senior ward sister would
17 pick up on that and, if matters are not progressing like
18 that, to let somebody in the surgical team now?
19 MR ORR: Yes. So this is the difficulty. We're now talking
20 about oral communication, which is not recorded. So
21 clearly, it has to be very clear between both parties
22 just what is expected.
23 Q. Yes.
24 THE CHAIRMAN: Sorry, that also sort of leads sideways into
25 an issue we're going to inevitably spend a little time

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1 oral fluids, then it's perfectly reasonable for a good
2 ward sister to then discontinue the IV. In my
3 experience, that's what the sisters do.
4 Q. In fairness to Mr Zafar, I think he has acknowledged
5 that it probably would have been better if he had added
6 a line or two to the entry he made in the chart just to
7 make matters clear in ease of anybody coming after him,
8 they would be clear as to what he had wanted.
9 Can I put it in this way: following on from what
10 Mr Foster said, Mr Orr, if he's communicated what his
11 plan for Raychel is, in fact how he envisages she will
12 continue to progress, would you agree or not with
13 Mr Foster when he's indicating that should something
14 happen that isn't quite in accordance with that, that he
15 would want to be told? Mr Foster's example was if she
16 were to vomit again. Do you have a view on that?
17 MR ORR: Yes. You're making an assumption that if you have
18 a plan for the introduction of oral fluids, withdrawal
19 of IV fluids, and for whatever reason that cannot
20 progress, you would expect, later on in the day, to be
21 informed that that wasn't happening. So there should
22 have been an alert, let us say, a few hours after that.
23 Q. And do you think that's something that you would have
24 needed to tell the sister or do you think that's
25 something the sister should have understood from your

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1 on this afternoon which is: if Raychel does vomit again,
2 is it Mr Zafar she goes back to because he knows
3 something about Raychel because he saw her on the ward
4 round, or is it sufficient to contact a JHO?
5 MR ORR: In my experience, if a doctor raises a management
6 point with a nurse, the nurse will try and get back to
7 the doctor that initiated the order in the first
8 instance.
9 MS ANYADIKE-DANES: Mr Foster, do you have a view on that
10 also?
11 MR FOSTER: My view is absolutely the same as my
12 colleague's. The surgeon is the person to be
13 communicated to and not an extremely junior
14 pre-registration house officer.
15 Q. Yes. There might have been a point that I missed with
16 you, Mr Orr, and I apologise if I did or if I'm
17 repeating myself. Mr Foster had said that one of the
18 things he thought should happen in the ward round
19 is that Mr Makar should be involved and then we went
20 into that discussion about how Mr Makar and Mr Zafar
21 met. What I wanted to ask you is whether you think that
22 Mr Makar should have been involved in the ward round so
23 that there could effectively be a handover as well as
24 a ward round. Do you have a view on that?
25 MR ORR: Ideally, there should have been some form of

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1 handover, but that has to be placed in the context of
2 whatever shift or on-call arrangements took place that
3 morning. I am hearing now that there perhaps was
4 a discussion between Mr Makar and Mr Zafar and that
5 would be entirely appropriate. I wouldn't say that
6 Mr Makar would have to go on the ward round provided
7 he'd communicated the previous night's findings, his
8 operation, and what his plan was post-operatively with
9 Mr Zafar.

10 Q. Does that mean that, in your view, Mr Makar actually
11 ought to have had a post-operative plan, which he could
12 then discuss with Mr Zafar, who's going to be having the
13 conduct of Raychel's care during the day?

14 MR ORR: I would hope that all surgeons have
15 a post-operative plan in their mind that they discuss
16 with their colleagues when they're handing over.

17 Q. Yes. Mr Zawislak, who was the registrar to whom
18 Mr Makar says he spoke before he carried out the
19 surgery, when he was asked in his evidence about ward
20 rounds and handovers in Altnagelvin, his view was that
21 they happened simultaneously, that you had a handover
22 within the ward round as it were. Is that something
23 that you'd be familiar with?

24 MR ORR: I'm familiar with a joint ward round between the
25 outgoing staff and the ingoing staff, but I think what

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1 be a proper handover. Without a discussion, there isn't
2 a handover or there wasn't a handover.

3 Q. Thank you. Mr Zafar's view in his evidence was that he
4 thought that Raychel would be, if she wasn't going to be
5 off her IV fluids by noon, would be off them fairly soon
6 after that. And as a result of that, his view was that
7 if a paediatrician or any clinician was being asked to
8 put up another bag of IV fluid, he would have rather
9 wanted to know about that. Mr Foster, do you think
10 that's something that ought to have been communicated to
11 Mr Zafar?

12 MR FOSTER: I think the timeline of expecting Raychel to
13 have started fluids by lunchtime is about the norm, yes.
14 To just put up another bag is committing IV fluids for
15 a litre's worth of 80cc an hour necessarily over
16 10 hours, more IV fluids.

17 Q. Sorry, if I just interject at that stage. Does it have
18 to? If you put up another litre of Solution No. 18,
19 does that have to commit to you 10 hours or can you not
20 just say, "We'll just use two hours' worth of this bag",
21 if I can put it that way?

22 MR FOSTER: Oh yes, I quite agree. Not at all does it
23 commit you as long as someone is actively in control of
24 the administration of it and not just leaving it on some
25 sort of autopilot.

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1 you're describing is something different.

2 THE CHAIRMAN: That could encompass it, couldn't it? When
3 the overnight team arrives or a member of the overnight
4 team arrives at Raychel's bedside with a member of the
5 day team, you can do the ward round and have any
6 handover simultaneously.

7 MR ORR: You could do that, yes.

8 MS ANYADIKE-DANES: I think that's what Mr Zawislak had in
9 mind.

10 Mr Foster, Mr Orr has said what he thought would
11 happen in an exchange, whatever place it happened, but
12 in an exchange between Mr Makar and Mr Zafar, Mr Makar,
13 who would have had in his mind a post-operative plan for
14 Raychel, would be discussing that with Mr Zafar, who's
15 now going to come on and take over the management of her
16 care during the day. Do you agree with that or
17 do you have some other view as to what would be involved
18 in that kind of discussion?

19 MR FOSTER: I very much agree. Mr Makar had done an
20 operation that finished after midnight the night before.
21 He, I personally believe, should have gone himself to
22 see Raychel and see her dad at the same time, check that
23 he was happy about her -- he was the operating
24 surgeon -- and then he should have handed over to
25 Mr Zafar with any instructions that he had. That would

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1 If the bag had been put up, then that has to
2 correlate with some form of close control over Raychel's
3 oral intake over the next few hours. And I agree that's
4 something Mr Zafar should have been asked about.

5 Q. And Mr Orr?

6 MR ORR: I agree.

7 Q. When you were discussing the fluid regime earlier and
8 you were saying that Solution No. 18 at the rate of
9 80 ml an hour, that might be something that could be
10 done in certain units, and you wouldn't be perhaps
11 overly concerned about that depending on how long it
12 went on so long as there was appropriate observation and
13 monitoring, that would be the key because that would
14 alert you to that particular regime causing any
15 difficulties, if I can summarise it in that way, what
16 did you mean by that? What kind of observations are you
17 talking about? Who is to direct them and when?

18 MR ORR: I'm talking about fluid management, which involves
19 observation of urine output and vomiting. So if you
20 reach a situation with a patient, let us say round about
21 1 o'clock in the afternoon, where there has been
22 vomiting and there are concerns about the urine output,
23 I would be reassessing the fluid regime and I would
24 probably be considering taking bloods for urea and
25 electrolytes.

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1 Q. In the way that you have put that, because it wouldn't
2 be you personally making those observations, although if
3 you were in the position of a surgical team you might be
4 in receipt of the information about them and any
5 concerns they gave rise to, it would be the nurses
6 really doing that. On a paediatric ward like Ward 6,
7 would you be expecting those nurses to be monitoring
8 that in that way, alive to the potential significance of
9 it, without any direction from the doctors?

10 MR ORR: The nursing staff should have been briefed on the
11 ward round as to what was expected. If there was
12 a variance from that expectation, then the nursing staff
13 should be contacting the medical staff appropriately.

14 Q. So they take their lead from the plan, if you like,
15 that's discussed at the ward round?

16 MR ORR: From the plan and from their experience of managing
17 post-operative patients.

18 Q. Thank you. And Mr Foster, in terms of the observations,
19 is that something that, as Mr Orr has said, you would
20 expect experienced nurses to do once they appreciated
21 the plan that the clinician had or do they require
22 further direction in relation to that?

23 MR FOSTER: Well, as I said earlier, I think Mr Zafar should
24 have put in the caveat that if vomiting repeated, he
25 would like to know. What should also have happened is

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1 continue. I'm sure any good paediatric SHO -- and I do
2 believe that Dr Butler is entirely conscientious in
3 this -- had picked up any vibration that all was not
4 well, she would have gone to see Raychel on her own
5 initiative and have taken things further.

6 Q. Should she have asked? If I can put it in this
7 way: I asked a similar sort of question to Dr Johnston,
8 who was also a paediatric SHO, and his view is that he
9 would have been quite reluctant and a bit uncomfortable
10 to go in and do even that for a surgical patient because
11 it's not his patient and he doesn't know the context in
12 which he is doing it. So he would have wanted to know
13 a little bit more about Raychel before he did even
14 something that appears as straightforward as erecting
15 a new bag of IV fluid.

16 THE CHAIRMAN: Be careful because he went a bit further than
17 that. He said: but on the other hand, you have to weigh
18 up the fact that you're working with these nurses every
19 day as the paediatrician on the ward, and if you appear
20 to be overly cautious or a bit unhelpful, it might not
21 go very well for you.

22 MR FOSTER: I think that was a very careful comment from
23 Dr Johnston. He's advising caution in just going
24 blindly prescribing because, once you do that, you're
25 putting yourself in a slot of being one of the patient's

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1 the second thing, the nurses should have been seeing
2 round about lunchtime, round about 12 o'clock, that
3 Raychel was beginning to depart slightly from the
4 expected clinical profile of recovery and, yes, they
5 themselves should have expressed their concern to either
6 Mr Zafar himself or to Dr Butler, who was asked to
7 prescribe the next bag.

8 Q. And now that you've mentioned Dr Butler, do you see any
9 role for Dr Butler in here in relation to Raychel's
10 fluid management? Perhaps I could ask you that, since
11 you have mentioned her, Mr Foster.

12 MR FOSTER: I think the accepted practice on the ward was
13 obviously that the paediatric SHOs -- and she was
14 a paediatric SHO -- were, from time to time, asked to
15 provide continuity prescriptions. There should probably
16 have been some guidelines when that sort of process was
17 adopted so that, after all, a doctor who was beginning
18 to be paediatrically trained would be given some
19 information as to what they were actually writing up and
20 why it was and why it was required at this point after
21 an appendicectomy. It's very easy for a busy young
22 doctor to just say, "Oh, you want another bag, fine,
23 I'll write it up then", and not, unless any anxiety or
24 concern is expressed to them, appreciate that this
25 wasn't just a mechanistic act to allow a drip to

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1 caring doctors. He put this as well as anybody could.
2 It is a pity that paediatric SHO missed the opportunity
3 to get a little more acquainted with the case, but
4 I wouldn't necessarily say that that was bad practice.
5 I think she just thought she was being helpful to the
6 nursing staff and having had no concerns expressed to
7 her, did what she was asked. I suspect having heard of
8 later events, she regretted that.

9 MS ANYADIKE-DANES: Which is the sort of thing that might
10 get picked up when you do critical incident reviews
11 after the event to look at those sorts of practices and
12 the extent to which they expose both doctors and
13 patients.

14 MR FOSTER: Oh yes.

15 Q. I wonder if I can now turn that to you, Mr Orr. The
16 same issue, really, which is what role you think
17 Dr Butler ought to have had, if any, in Raychel's fluid
18 management.

19 MR ORR: It would appear that there was a practice on the
20 ward for the duty medical paediatric SHO to prescribe,
21 whether that's fluids or medication, and one can see why
22 that occurs on a paediatric ward. The difficulty
23 I would have with it is that you then take the surgical
24 staff out of that potential line of information. If one
25 of the surgical HOs had been involved, he might have

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1 then questioned, "Right, we're prescribing intravenous
2 fluids for how long? How is this patient going to be
3 monitored? Is this a patient that I've actually seen?".
4 So I do have a concern about that particular practice.
5 I can see why Dr Butler acted as she did and I think it
6 was appropriate that she did that prescription.
7 Q. Yes. And when you say that it could have the effect of
8 taking the surgical team out of the loop a little bit
9 and therefore a slight loss of continuity of care or
10 information in relation to care, might that be addressed
11 from the perspective of communication? So if she'd done
12 that, but either written something more up in the notes
13 or in fact just contacted her surgical colleague and
14 said, "Look, I've just been asked to do this, just to
15 let you know, I have put up another bag, that's
16 something for you to be aware of".
17 MR ORR: I think the latter would be more appropriate, but
18 I do appreciate that these are busy wards with busy
19 junior staff and there may well have been some
20 interruption where she didn't have the time to do that.
21 But ideally, there should have been some communication
22 between the medical SHO and the surgical junior staff.
23 Q. And if she didn't do it, could the nurse who's actually
24 asked her to do it -- and they provide the absolute
25 continuity of care -- not have notified a member of the

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1 trainees and the junior staff need to know what that
2 arrangement is.
3 Q. Mr Foster?
4 MR FOSTER: I agree with Mr Orr. If there's proper
5 collaboration and communication between the teams and,
6 as you say, as Mr Orr says, at consultant level the
7 teams would feel free to talk to each other frankly and
8 properly at any time.
9 THE CHAIRMAN: How normal would such an agreement have been
10 in 2001 in a district general hospital between surgeons
11 and paediatricians?
12 MR FOSTER: It was very normal. It was certainly the
13 protocol in the hospital I worked in and where I worked
14 previously in Nottingham. The paediatricians took
15 overarching control of all children, surgical and
16 medical, and would visit and see each patient every day,
17 and this made sure it was clear who was in charge. The
18 surgeons were also there for surgical matters, but that
19 immediately eliminated any equivocation about who was in
20 charge and controlling the case. So I think that was
21 a protocol followed by a significant number of
22 hospitals, but I can't say how many, sir.
23 THE CHAIRMAN: Dr Scott-Jupp finished yesterday afternoon by
24 saying an arrangement which he described as
25 paediatricians increasingly taking the lead

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1 surgical team to say, "Just to let you know, this is
2 where we stand with Raychel: I've asked for another bag
3 to go up because the first one's finished and I think
4 we're not at the stage where we can cease IV fluids";
5 would that have been appropriate?
6 MR ORR: It would have been possible. Whether it's
7 appropriate really depends on what the arrangements were
8 in the paediatric ward for management between the
9 medical paediatricians and the surgical junior staff of
10 surgical patients.
11 Q. Yes. When you were discussing earlier about what
12 happens on mixed wards, if I can put it that way, and
13 you had characterised the sort of multi-team approach
14 perhaps and communication in that would be very
15 important, is that the sort of thing that would be
16 helpful to have some sort of guidance or practice about?
17 Because essentially, one discipline is coming in to
18 provide care to another discipline's patient, if I can
19 put it that way, albeit for the very good reasons that
20 you have mentioned. In terms of making sure there's no
21 misunderstandings, nobody slips between the two
22 disciplines, is that something that in your experience
23 one might have a guidance or practice note about?
24 MR ORR: Yes. There needs to be clarity and that clarity
25 has to be agreed at consultant level and all the

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1 responsibility on a ward such as Ward 6 in Altnagelvin
2 was becoming increasingly common in recent years, though
3 he thought it was probably not yet a standard
4 arrangement. Would that be an assessment you would
5 agree with?
6 MR FOSTER: Oh, very much so.
7 THE CHAIRMAN: Sorry, I should say I think he was, in terms
8 of a timescale, dating it in more recent years rather
9 than 2001.
10 MR FOSTER: People I've spoken to -- it goes so far back
11 they can't remember when this was followed. It
12 pre-dates people who have retired in the last few years.
13 I think that is common, the paediatricians feel
14 responsible for children because they're paediatricians,
15 and that is the ward which they go round and live on and
16 they go round at frequent intervals and are in
17 a position to see the children rapidly if necessary.
18 MS ANYADIKE-DANES: Yes. Mr Orr, there are two issues
19 there. One is whether there is a developing practice
20 whether in a paediatric ward the paediatricians
21 essentially have the effective management of those
22 children with other disciplines coming in and dealing
23 with issues specific to their disciplines, for example
24 the surgeons or whomsoever, orthopaedic perhaps,
25 whomsoever. The other one is where you haven't got to

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1 that stage, so essentially the medical and surgical
2 disciplines have their own patients, but in recognition
3 of the point that Mr Foster's made that the
4 paediatricians are there more frequently on the ward,
5 that there is a collaboration between them, so that the
6 paediatricians do involve themselves in the care of
7 surgical patients when a surgeon is simply not
8 available. Do you see those two different things and
9 have you seen those two different things in operation?
10 MR ORR: Both these models can be applied -- and where you
11 say "a developing model", I would also say "developing
12 and developed". I was a surgical houseman a long time
13 ago in a district general hospital with a medical
14 paediatric unit with paediatric surgical patients in it.
15 There was a range of surgical specialties and the
16 paediatricians there managed the medical needs,
17 including the fluid balance, in consultation with the
18 surgeons. So that is almost 40 years ago. So these
19 models are not new. I'm not saying they were
20 universally applied -- clearly they were not -- so there
21 have been examples of that type of co-operation over
22 many years and a looser approach of discussion between
23 surgeons and paediatricians as to how they're going to
24 cooperate on managing patients in the ward.
25 Q. Thank you. We are in the area of the system of care and

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1 should be an arrangement where junior surgical staff can
2 obtain advice, support and direct intervention from the
3 paediatric medical staff."
4 And then, thirdly, in relation to the nurses:
5 "The nursing staff should be aware of their
6 responsibilities when communicating with junior doctors
7 who are caring for children, recognising that they may
8 need support and encouragement."
9 Presumably particularly if they are very junior and
10 inexperienced in paediatrics.
11 I'm wondering if the comment that you make there
12 comes out of your experience. Do you have experience of
13 how systems either work or don't work when they rely on
14 the very junior members?
15 MR ORR: The simple answer is that they don't work if you're
16 relying only on junior medical staff because junior
17 medical staff are not experienced, particularly in
18 medical paediatrics. It's very unusual -- well, I think
19 nowadays it would be very unusual for a foundation
20 doctor, an F1, to be exposed to paediatric patients. It
21 did occur around about this time that you would have
22 pre-registration house officers carrying out duties on
23 a medical paediatric ward, but they would be very
24 closely supervised.
25 Q. Yes. Well, firstly, you've answered one part of the

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1 the responsibilities for post-operative care and how
2 that worked on Ward 6. That's really the natural place
3 where we are. If I can move to you, Mr Orr, because in
4 your report -- and I think it would be helpful to pull
5 this up. This is witness statement 320/1, page 15.
6 It's your answer to (x). This has moved on to
7 a different issue. What you have so far been helping us
8 with is the situation where one discipline is assisting
9 in the care, from time to time, of the patients of
10 another discipline. This issue is to do with
11 effectively -- or some of it is to do with -- who's
12 in the front line of the surgical team, who are those
13 who are most likely to be exercising their immediate
14 judgment about whether anything needs to be done,
15 whether a more senior surgeon needs to be contacted, and
16 maybe even a paediatrician brought in.
17 So at least the comment that you make in answer to
18 the question of the adequacy of the system that
19 Altnagelvin had in place for the provision of medical
20 care for post-operative children is:
21 "The system in 2001 appeared loose."
22 You talk about that if the junior house officers are
23 expected to care for children:
24 "... they have to be closely supervised and have
25 immediate access to senior advice and support and there

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1 question that I wanted to follow up with you, which is
2 that it did actually occur, so in 2001 this practice was
3 known.
4 MR ORR: Yes.
5 Q. Is it something that met with any comment that junior
6 house officers were in this position so far as you're
7 aware?
8 MR ORR: Well, I think it has always been recognised that
9 it is very challenging for a newly-registered doctor
10 doing their preregistration post to be working in
11 a paediatric environment. It is a post that usually
12 attracts highly motivated, very good junior doctors.
13 Q. Is it a practice that developed by default because they
14 just happened to be more readily available or is it
15 a conscious practice so far as you're aware to have
16 junior doctors as the first port of call before you
17 bring in more senior members of the team who may be busy
18 doing other more serious things? Not serious, sorry,
19 but things that require greater experience.
20 MR ORR: I would hope that it hasn't developed by default
21 because these are training posts, so these are posts
22 which should have been assessed by the deanery as having
23 educational value and the supervision and support would
24 have to have been in place before these posts were
25 recognised.

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1 Here, I'm talking about pre-registration house
2 officers, and as I understand it, the situation here
3 is that there are medical paediatric SHOs and
4 pre-registration house officers, one of whom seemed to
5 have duties in both the medical ward and then on
6 rotation covering the surgical wards at night.
7 Q. Yes.
8 MR ORR: So I'd assume that that post had been educationally
9 approved and was well supervised.
10 Q. What he said was he had done his first six months in
11 surgery and he was now doing his second six months on
12 the medical ward and that he had been asked -- and we're
13 talking about Dr Curran here -- to come back and cover
14 the evening as a surgical pre-reg because the person who
15 would otherwise be doing that simply wasn't available.
16 He did say that that was the first time that he'd been
17 asked to do that so he can't say that that was
18 a practice. But the practice I was referring to was the
19 pre-reg, the JHOs, being the first port of call at all,
20 which seems to have been the system for the surgical
21 patients. They didn't have JHOs in paediatrics, so the
22 first port of call for them would have been an SHO, if I
23 can put it that way.
24 Do you have any comment about the JHOs being the
25 first port of call, effectively, for the nurses and

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1 Can you comment on that as a JHO's, in 2001, role?
2 MR ORR: I'd say there'd have to be a real clarity about how
3 he was supported if, as you say, he felt he should not
4 be prescribing, yet here he was prescribing and he was
5 prescribing very effectively or a very effective
6 anti-emetic.
7 Q. In fairness to Dr Devlin, there's a distinction between
8 he and Dr Curran. Both of them administered
9 anti-emetics. Dr Devlin who came at 6 o'clock
10 effectively carried out a prescription that Dr Gund had
11 written up, if necessary, if you like, and the nurses,
12 by that time, had decided it was necessary, so he was
13 effectively carrying out a pre-prescription, if I can
14 put it that way. So he's in a different position to
15 Dr Curran. But that was his view -- and I stand to be
16 corrected -- that he was very much as an assistant.
17 Would you characterise a JHO as that in 2001?
18 MR ORR: No. In 2001, I would characterise a house officer
19 as a trainee with certain prescribed clinical duties.
20 Q. And requiring close supervision and immediate access to
21 seniors?
22 MR ORR: Yes.
23 Q. Then if I ask you, Mr Foster. The system that Mr Orr
24 has characterised as how he interpreted what was
25 happening in Altnagelvin, how do you regard the system

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1 making that decision as to how we respond and where we
2 go from there?
3 MR ORR: It would only be appropriate if there was a very
4 clear line of communication and support to the SHO or
5 the registrar.
6 Q. And what did you mean in this part of your report where
7 you refer to how they must be closely supervised? In
8 what way would you see that as being achieved?
9 MR ORR: Through ward rounds, and ideally more than one ward
10 round a day, through regular communication between the
11 house officer and the SHO and registrar during the
12 working day, and perhaps supervision of interventions
13 that were being carried out if the house officer was
14 inexperienced in that area. So it's part of a training
15 programme.
16 Q. Yes. Dr Devlin, when he gave his evidence, who was the
17 first of the two, Dr Devlin and Dr Curran. He comes to
18 administer the anti-emetic at about 6 o'clock -- and
19 we're going to come to that in a minute -- but just so
20 you have this point: his view really was that he
21 regarded his position as being very much an assistant.
22 He certainly didn't think that he prescribed. He
23 effectively carried out that which had already been
24 established or directed to happen during the day or
25 evening. That was the role that he saw for himself.

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1 of the hierarchy and the flow of communication between
2 the nurses and the JHOs and the more senior colleagues
3 from what you have seen in the papers?
4 MR FOSTER: It was ramshackle. The junior doctors were --
5 the junior house officers were trainees, as Mr Orr has
6 said. The primary duties on a take day was to -- a duty
7 day was to look after the patients in the adult wards,
8 and that can be extremely time-consuming, as some of
9 these young doctors have said in parts of their
10 evidence. Tacked on to the side of that was this
11 commitment to be called to the paediatric ward, to
12 a specialty ward, of which they would have no knowledge
13 or training to carry out duties assigned to them largely
14 by the nursing staff. I believe a competent nurse would
15 probably have more of an idea of what should be done for
16 a particular patient problem than a pre-registration
17 house officer working a busy day with some stresses.
18 They would not be able to apply their mind properly and
19 closely to a paediatric problem. They would not be able
20 to write down clearly what they had done, which they did
21 not, and they would, I believe, have had to have some
22 supervision, so some command to approach their seniors,
23 as they would have been off to the adult wards to carry
24 on with their busy work there.
25 MR STITT: Sorry, I didn't mean to interrupt Mr Foster

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1 in the middle of a sentence, but when he's finished the
2 sentence, I would like to make a point.
3 THE CHAIRMAN: Sorry, had you finished your sentence?
4 MR FOSTER: I was just going to say, their duties were
5 primarily adult. They would have gone back to busy
6 wards where tasks no doubt awaited them and I think they
7 were placed in an impossible, vulnerable position,
8 and -- as I have said in my first report, I think -- I
9 cannot see how that got past the scrutiny of the
10 Postgraduate Deanery, who were responsible for
11 supervising these young trainees.
12 THE CHAIRMAN: Thank you. Mr Stitt?
13 MR STITT: The purpose of open and shared medical expert
14 reports in advance of the hearing is so that everybody
15 can see not only the main points, but the thrust and the
16 weight, of that particular expert's opinion and they can
17 then be considered and, if necessary, responded to.
18 It is, if I may say so, disappointing that this witness
19 has used, in my respectful submission, two pejorative
20 terms, the first being "afterthought", which I referred
21 to earlier and I shan't go back to, and now the
22 description of "ramshackle" without going into the
23 details of the line of communication, which was the
24 manner in which this was described. If that had been
25 the witness's view, it's disappointing it's not in

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1 THE CHAIRMAN: Okay. I think it is fair, however, to say
2 for Altnagelvin that one of the lessons that they learnt
3 almost immediately after Raychel's death was that
4 a referral to the JHOs was really inappropriate -- and
5 that doesn't necessarily mean that it was inappropriate,
6 but the new system they put into place with virtually
7 immediate effect was to say that from now on the SHOs
8 will be the first port of call and I presume that you
9 would each endorse that action being taken on foot of
10 the critical incident review?
11 MR FOSTER: It was excellent that instant action was taken,
12 and I think it supports the premise that I made that the
13 system of having the junior house officers was very
14 unsatisfactory.
15 THE CHAIRMAN: Okay. Mr Orr, do you agree with that?
16 MR ORR: I agree.
17 THE CHAIRMAN: Thank you.
18 MS ANYADIKE-DANES: Just for the record, Mr Chairman, the
19 reference to the report in which Mr Foster says that to
20 place pre-registration junior house officers in the
21 position of being first on call for post-operative
22 children was unsatisfactory and that he expressed
23 surprise that the situation escaped the scrutiny for the
24 Postgraduate Deanery is 223-002-011. We don't need to
25 pull it up, but just so that people have it for

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1 a report so that it could be specifically addressed
2 before being heard for the first time in testimony.
3 THE CHAIRMAN: I think that's an entirely unfair
4 intervention. I think that what Mr Foster's doing is
5 summarising in very concise and blunt terms the thrust
6 of what is already in his report. I repeat again: he
7 didn't say "afterthought"; he said "almost
8 an afterthought". There's something of a difference,
9 and this, I'm afraid again, Mr Stitt, is a running
10 commentary on the evidence and I won't accept it.
11 MR STITT: It's not meant to be a running commentary on the
12 evidence.
13 THE CHAIRMAN: Well, it is.
14 MR STITT: And I accept entirely the point about "almost an
15 afterthought" --
16 THE CHAIRMAN: Well, why did you repeat it then? Because
17 I corrected you the last time you were on your feet.
18 MR STITT: Turning to the question of adjectives such as
19 "ramshackle", that's a specific term and it's
20 unfortunate that it hasn't been used in the past in
21 any report, and we've got lengthy reports.
22 THE CHAIRMAN: I'm sorry, so he has to stick rigidly to the
23 language he used in his report or else you'll express
24 concern? Frankly, that's ridiculous.
25 MR STITT: With respect, I disagree.

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1 reference.
2 THE CHAIRMAN: Okay.
3 MS ANYADIKE-DANES: You have, both of you, talked about the
4 extent to which the nurses would have been expected to
5 either communicate with the junior doctors themselves
6 when they attended or to -- preferably, I think in your
7 view -- refer any departure from what was the expected
8 plan or Raychel's development to Mr Zafar, who was the
9 person who saw her during the ward round. This calls
10 into question for both of you, really, the extent to
11 which you would expect the nurses looking after Raychel
12 to have begun to appreciate that something was amiss and
13 perhaps not consistent with the plan that Mr Zafar seems
14 to have discussed with the sister. I think in
15 particular, Mr Foster, in your report at 223-002-019,
16 when you express yourself as being at a loss as to why
17 the nursing staff did not appreciate that this was
18 certainly not the expected course of events after mild
19 appendicitis. And that is, really, not becoming mobile,
20 as you thought she might, not taking on oral fluids, as
21 you thought she might, and so on.
22 Does that mean that you would have expected the
23 paediatric nurses or the nurses on that ward to have
24 recognised not just that she wasn't following the
25 pathway that Mr Zafar had mentioned, but the

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1 significance of the extent to which she was departing
2 from it?
3 MR FOSTER: I have no doubt of that. This should have
4 triggered a response of concern and a request,
5 preferably directly to Mr Zafar, who would, from his
6 evidence, have immediately come to the ward and begun
7 some treatment and investigations. As soon as it became
8 obvious that Raychel was not following the expected
9 trajectory of recovery, the nurses should have triggered
10 an intervention, yes. They must have seen many children
11 recovering from appendicitis. They must have realised
12 that the vast majority of them, unless they'd had
13 a complex appendicectomy, would be getting better by
14 lunchtime of the following day, and if that was the
15 case, they should have immediately pressed the button
16 for further activity and intervention.
17 Q. In terms of the extent to which she might be thought not
18 to be following the expected trajectory, I am going to
19 ask you what the indications for that might be. If one
20 looks at the vomiting, there's a recorded vomit at
21 8 o'clock, bearing in mind what the chairman has said
22 that it might not have been precisely 8 o'clock, but
23 some time at the early start of the morning. There is
24 another recorded vomit, which is described as a large
25 vomit, that's on the fluid balance sheet at 10 o'clock,

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1 I'd make a comment that looking at the evidence that
2 has been presented by the nursing staff, and indeed by
3 senior surgical staff, there seems to be an acceptance
4 that vomiting after appendicectomy is normal. I would
5 put it to you that it is not normal. I wouldn't accept
6 vomiting as normal. It does occur, but it is not
7 a regular occurrence post-appendicectomy. So therefore,
8 if you have a situation where the staff seem to accept
9 that vomiting is normal, that then places them in
10 a position where they're perhaps not as aware as they
11 should be of the seriousness of repeated vomiting after
12 what was the removal of a normal appendix, a routine
13 appendicectomy. So yes, alarm bells should have been
14 ringing by lunchtime, if not after lunch, when there was
15 the third vomit. Our usual advice is that if a patient
16 is vomiting on two occasions and it's unexpected, the
17 medical staff should be contacted.
18 Q. Is it relevant for you what's in that vomit? The fact
19 that she's vomiting partially-digested food, is that
20 relevant to know?
21 MR ORR: It's relevant to know volume and content because it
22 could be undigested food, it could be bile, it could be
23 blood or, as we heard later on, it could be coffee
24 grounds. So you are obviously interested in volume and
25 content.

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1 and then there is another one after Dr Butler has
2 erected the new IV bag at 1 o'clock in the afternoon.
3 So that's three recorded vomits.
4 MR FOSTER: Yes.
5 Q. Can I ask you first, is there anything there that
6 indicates Raychel is not following the expected
7 trajectory, which I think was your term?
8 MR FOSTER: I think she should have been beginning to drink
9 and wasn't. She was beginning, by lunchtime or soon
10 after, to be unwell and to have gone quiet and still.
11 This was not the expected clinical progress. Children
12 do tend to very much mirror by their behaviour how they
13 feel and something was not quite right here. And an
14 experienced nurse, I believe, should have spotted this
15 at or around this point.
16 Q. And can I then pause there and ask you, Mr Orr: these
17 vomits and perhaps a presentation of her being maybe
18 less active than she had been seen to be in the morning,
19 do you think these are the observations that an
20 experienced nurse should be recognising as perhaps
21 indicating a departure from the trajectory?
22 MR ORR: I would have thought that an experienced nurse,
23 after two or three vomits, would be contacting the
24 surgical staff to say, "I'm not happy with this
25 patient".

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1 Q. And what is the significance of it containing undigested
2 food at this remove from when she had her last meal and
3 when she had her surgery?
4 MR ORR: It's significant only to the extent that that would
5 be the food that had not passed beyond the stomach and
6 was not undergoing a digestive process. It's not
7 uncommon, post-operatively, for a patient to vomit their
8 last meal.
9 Q. And in terms of the volume of it, it seems that at least
10 two of those recorded vomits -- the one at 10 o'clock
11 and the one at 1 o'clock -- the one at 10 o'clock is
12 described as "large vomit" and the one at 1 o'clock is
13 "plus plus". They both are probably judgments, but
14 perhaps it's not quite as large as having described it
15 as a large vomit. Is it significant for you to know
16 that?
17 MR ORR: It would be enough to raise concerns because
18 it would appear that there is then significant fluid
19 loss through the vomit.
20 Q. I'll come, Mr Foster, to you in a moment. But following
21 through this theme, if the experienced nurse had
22 communicated that -- let's say to Mr Zafar because he's
23 the person who had outlined what he thought her plan for
24 the day would be -- that this had happened, what steps
25 do you think ought to have been taken at that stage?

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1 We're talking about 1 o'clock now.
2 MR ORR: First of all, he should have reviewed the patient,
3 taken a history, if the parents were there, talked to
4 the parents, talked to the nursing staff, examined the
5 patient, again look at the charts, assess the situation.
6 After three vomits, he should be drawing blood for urea
7 and electrolytes, et cetera, and he should be actively
8 considering replacing the vomitus, having assessed the
9 volume, with a solution such as normal saline and then
10 altering the maintenance fluids as well. So there would
11 be quite a lot for him to consider and act on at that
12 time.
13 Q. Mr Foster, if I turn now to you: three vomits
14 characterised in that way and I think the other record
15 is that there's only one apparent record of passing of
16 urine and that first happens at 10 o'clock. That's the
17 sort of observations and measurements that the nurses
18 have. In all other respects, her vital signs appear to
19 be normal. Is that a time at 1 o'clock when you think
20 the nurses should have been contacting Mr Zafar?
21 MR FOSTER: Yes, I have no doubt of it.
22 Q. What should have been the result of that in your view?
23 MR FOSTER: I agree with Mr Orr. I'm sure Mr Zafar would
24 have attended very quickly. His evidence would suggest
25 that he was well aware of what he would need to do, and

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1 pre-registration junior house officers should have felt
2 entirely free themselves to call a surgical registrar if
3 they were concerned. So there should have been an
4 openness there that permitted several different
5 pathways.
6 Q. If I take it from what you say on the last point, if
7 they can't reach Mr Zafar, then are you saying that the
8 nurses should have been capable of taking the initiative
9 and contacting another clinician?
10 MR FOSTER: Oh yes, yes, which Mr Bhalla, I'm sure, would
11 have been expected them to do.
12 THE CHAIRMAN: In other words, to summarise it, she's off
13 the expected recovery route and you want to see why
14 she's off the expected recovery route and get her back
15 on to the expected recovery route as quickly as you can;
16 is that it?
17 MR FOSTER: Oh yes. Quite an urgent process.
18 THE CHAIRMAN: Yes.
19 MS ANYADIKE-DANES: If I just come back to the vomiting
20 point, that's an issue that a number of the clinicians
21 have discussed and the experts too: post-operative
22 nausea and vomiting and the incidence of that. I think,
23 Mr Orr, you had said if she had vomited twice, that
24 would be enough for you to expect some -- at least you'd
25 expect the surgeons to be notified of that and then they

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1 that is examine Raychel, organise some bloods, change
2 the fluid replacements, highly probably involve
3 Mr Bhalla at this point, as the senior adviser, and
4 possibly involve paediatrics too to offer some further
5 suggestions as to how to further help the little girl.
6 Q. Why would you think that Mr Zafar ought to involve
7 Mr Bhalla, who was the registrar?
8 MR FOSTER: Because this wasn't a usual situation because
9 Mr Zafar, by his own admission, had not done a great
10 deal of paediatrics, whereas we know Mr Bhalla had done,
11 and I think it would be proper surgical common sense and
12 good practice to mention to his senior what he was
13 doing.
14 Q. If the nurses couldn't reach Mr Zafar or they could
15 reach him, but he couldn't respond immediately because
16 he was tied up, where do you think the onus lies? Is it
17 for Mr Zafar to make a suggestion for who to go to next
18 if they've reached him or should the nurses take it upon
19 themselves to seek paediatric input or maybe even the
20 registrar directly?
21 MR FOSTER: It could go either way. Mr Zafar could say,
22 "I'm tied up, please ring Mr Bhalla". It would take him
23 a moment, however tied up he was, for him to ring
24 Mr Bhalla himself, but the nurses on a ward such as
25 a paediatric ward with surgical children covered by

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1 would take their course following review as to what they
2 thought was appropriate to do about that. And I think,
3 Mr Foster, you were pretty much in agreement with that.
4 Can you help us with this as surgeons? There is no
5 real vomiting between 2 am and 8 am. Is that an
6 expected course or does the vomiting afterwards indicate
7 that something else is at play?
8 MR FOSTER: Raychel didn't arrive back in the ward until
9 1.30, if I recall correctly. 1.20 or something. The
10 four hours was probably post-operative residual effects
11 of her anaesthetic. And my understanding of
12 post-operative nausea and vomiting is that there is
13 usually a delay of a few hours before that starts. I do
14 wonder if we weren't here seeing a phenomenon related to
15 the Cyclimorph, where one of its effects is of
16 paralysing the neurons in the wall of the intestine and
17 this is why a side effect of opiates is constipation.
18 I do wonder if this is, in part, not explaining the fact
19 that her stomach had not emptied, as it would have been
20 expected to do, of solid food the day before. After
21 all, the medical team, probably quite rightly, on the
22 Thursday starved Raychel for 6 hours preoperatively for
23 an anaesthetic. But in those 6 hours, clearly we now
24 realise her stomach had not emptied. So that might be
25 guiding us just a little in the direction of what the

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1 original pathology was here, some form of constipation
2 with a functional disorder of the small intestine,
3 stomach and so on.

4 Q. Mr Orr, do you have a view as to what might explain the
5 fact that there's no vomiting noted until 8 o'clock
6 in the morning?

7 MR ORR: It certainly appears that this would fit into the
8 category of post-operative vomiting. Nursing staff are
9 usually very good, in elective cases, of assessing which
10 anaesthetists have been involved if there's problems
11 with vomiting. Sometimes you'll get a pattern where
12 more patients vomit and some less than others, but this
13 was an emergency, and there could have been a greater
14 risk of vomiting depending on what was prescribed by the
15 anaesthetists immediately post-operatively. I stand to
16 be corrected, but I'm not aware that she had ondansetron
17 immediately post-operatively and that's a method of
18 controlling post-operative vomiting.

19 And as has been said, she also had morphine, which
20 has an emetic effect. So I think that explains the
21 vomits over the first few hours as she recovers from her
22 anaesthetic. She's then emptied her stomach and there
23 is no more vomiting. But if she had been examined at
24 that time, there may have been an indication -- or I'm
25 quite sure there would be an indication -- that all was

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1 MR FOSTER: No, I agree. I think this is a multi-factorial
2 vomiting at this stage. It may be related to the
3 original pathology. It might be related to opiate
4 administration. It might well, at some point, be
5 related to post-operative ileus in the distal small
6 intestine, which would have been handled in its
7 manipulation at the time of in surgery. And as the day
8 progressed, it probably then became related to
9 hyponatraemia and the changes in circulatory water
10 volume that would happen after that.

11 Q. Let me turn now to you Mr Orr, because you said in your
12 view what really ought to have happened is that at
13 1 o'clock the nurses ought to have notified somebody in
14 the surgical team, hopefully Mr Zafar, he or his
15 registrar should have come, they should have carried out
16 a review of Raychel and that would have involved,
17 amongst other things, looking at her fluid management
18 regime, what she was on, and the rate at which it was
19 being administered to her. Would that be a fair summary
20 of what you were saying?

21 MR ORR: Yes.

22 Q. Does that mean, therefore, that you wouldn't have
23 considered it appropriate to have used Solution No. 18
24 to replace losses? You might have been content for it
25 to be used for maintenance purposes, but not for

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1 not well.

2 Q. Does that mean -- well, maybe I'll ask you -- if some of
3 this early vomiting, maybe the first two, can be
4 associated with the effects that both of you have
5 described and categorised perhaps as post-operative
6 vomiting, in your view, does Raychel move from a period
7 when that's what was happening to when the vomiting was
8 being brought about by some other cause?

9 MR ORR: I think it'd be unusual to have anaesthetic effects
10 greater than 6 to 12 hours -- an anaesthetist would be
11 in a better position to comment on what would be
12 expected, but I think that beyond 12 hours after the
13 operation, I don't think you should be getting the
14 anaesthetic effects or indeed the morphine causing the
15 vomiting.

16 THE CHAIRMAN: So let me put two things you've said
17 together. First of all, you don't accept that vomiting
18 is a common or normal occurrence after a fairly
19 incident-free appendicectomy, but if there is
20 post-operative vomiting, you would expect that to have
21 disappeared somewhere between 6 and 12 hours after the
22 operation?

23 MR ORR: Yes, that's correct.

24 THE CHAIRMAN: Thank you.

25 MS ANYADIKE-DANES: Mr Foster? Do you have a view on that?

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1 replacement purposes, or have I misunderstood you?

2 MR ORR: It would be inappropriate for Solution No. 18 to be
3 used for replacement purposes; for replacement you would
4 use normal saline.

5 Q. In your experience, is that something that either was or
6 should have been appreciated by the surgical team, even
7 at a junior level, in 2001?

8 MR ORR: It should certainly have been appreciated by
9 doctors who, at that time, had fellowships. They should
10 have known that if you lose fluid from the stomach it
11 has to be replaced by a solution such as normal saline.

12 Q. In fairness, Dr Scott-Jupp has not only given that as
13 his evidence, and he says the practice of replacing
14 gastric losses millilitre for millilitre with normal
15 saline rather than hypotonic solutions was
16 well-established long before 2001, at least in children.
17 He says it's mentioned in standard textbooks used at the
18 time and he referred to two of them. The reference for
19 them is 222-005-008. The only thing of note in that is
20 that they are standard textbooks. The first is Lecture
21 Notes On General Surgery, and that's dated 1994. The
22 second is the Sabiston Textbook of Surgery, dated 1997.
23 Would you agree with him that that practice that you've
24 just been describing is something that was well-known
25 long before 2001?

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1 MR ORR: It was well-known in 1974 when I sat my fellowship
2 examination, at least I sat my primary examination in
3 1973 and it was well-known then. So yes, these are
4 basic facts in relation to fluid balance in surgical
5 patients.

6 Q. And you have said that somebody sitting their fellowship
7 should have known that, but is that something that you
8 would have expected the JHOs to have been taught, just
9 as a fairly basic thing? If you are losing sodium-rich
10 fluids replacing them with sodium-dilute fluids, you're
11 not going to be in balance.

12 MR ORR: I would hope that there had been some emphasis
13 in the curriculum on fluid balance, but I can't comment
14 on the curriculum in place at that time.

15 Q. I understand. Mr Foster? In your experience is this
16 something that should have been appreciated by JHOs and
17 obviously those more senior in 2001?

18 MR FOSTER: Not necessarily JHOs. And to be fair to
19 them ... But certainly I used to always teach the
20 medical students about this because it was an important
21 way of explaining the principles of fluid balance and
22 water-containing rather than solute-containing fluids.
23 Because I used to think it was something that wasn't
24 taught well at medical school and I used to do that and
25 they used to understand what I was talking about, but

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1 earlier, but the earliest that Dr Devlin could attend
2 was 6 o'clock. So it seems that they may have
3 appreciated that Raychel required some sort of medical
4 intervention.

5 At 6 o'clock, Dr Devlin comes and he's asked -- or
6 at least he's coming, so far as he's concerned, to
7 administer an anti-emetic. By that time Raychel, has
8 had four recorded vomits, but she's also had another
9 vomit, which is not recorded, but which Dr Devlin sees
10 at six o'clock. So he has witnessed one -- so there are
11 five, if I can put it that way, vomits and there may
12 have been some others that the family see that don't
13 find their way onto her charts. But there's four on the
14 charts and one that he himself sees.

15 Can I ask you as to what you think should have been
16 his response when he comes? And maybe I'll start with
17 you, Mr Orr. When he comes at 6 o'clock, what should he
18 be doing?

19 MR ORR: We're dealing with an inexperienced JHO. I think
20 this is the difficulty. He did not have the experience
21 to recognise the potential problem with a patient who
22 had vomited four or five times. He should have examined
23 the patient which, as I understand it, he did do. He
24 examined the patient, he assessed that she was stable,
25 so that was reasonable, and he then prescribed the

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1 it would be difficult to expect all the JHOs to
2 understand that. Any grade above JHO should have most
3 certainly known about vomiting and the need to replace
4 electrolytes with electrolyte-containing fluids,
5 hopefully normal saline. They should certainly have
6 known about it.

7 Q. And so in your view, would it have been inappropriate to
8 call a JHO if the nurses were concerned about the
9 vomiting, unless they were calling the JHO to get in
10 touch with their more senior colleague, if I can put it
11 that way?

12 MR FOSTER: I absolutely agree. Continued vomiting should
13 have triggered with the nurses the need for a surgical
14 doctor to see Raychel. I'm quite sure Zafar, Makar,
15 Bhalla or any of them would have realised what the
16 problem was and would have taken action, the action that
17 Mr Orr has mentioned earlier, of changing the fluids,
18 organising electrolytes, by now of course they would
19 probably have an electrolyte result back, which would be
20 showing sodium falling down through the 120s.

21 Q. Let's move on to next medical intervention. So we've
22 had Dr Butler coming at 12, we've had the vomit at
23 1 o'clock. According to the nurses, they would have
24 wanted a doctor to have come earlier. In fact,
25 according to them, they tried to get hold of a doctor

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1 anti-emetic. So apart from recognising the potential
2 problems of four or five vomits, he acted appropriately
3 by examining the patient, talking to her, and
4 prescribing the anti-emetic.

5 Q. Do you think he should have contacted his SHO?

6 MR ORR: Ideally, ideally, yes.

7 THE CHAIRMAN: The problem was he didn't know enough to know
8 what he was missing; is that --

9 MR ORR: And I don't know what the arrangements were with
10 regard to communication with the SHO. Had he been told,
11 "Look, if you have any concerns at all, you must contact
12 me", so --

13 MS ANYADIKE-DANES: Sorry, is that something he should have
14 been told?

15 MR ORR: Yes. Yes, in my report I've said that the junior
16 house officers needed to be closely supervised and
17 supported.

18 Q. I'm not sure that he actually did examine Raychel.
19 I think in his evidence he thought it was unnecessary to
20 examine her. Do I take it from your evidence that he
21 should have examined her? Sorry, just to give the
22 reference for that, I think it's 6 March at page 64
23 in the transcript. Do you think he should have done
24 that?

25 MR ORR: If he'd been aware that a patient had vomited four

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1 or five times, he should have examined her. But again,
2 we have a very junior doctor who may not have been aware
3 of the importance of the vomitus.
4 THE CHAIRMAN: Sorry, Mr Orr, if I take the view on the
5 evidence which I've heard that he understood that, in
6 effect, he was being called to the ward to administer an
7 anti-emetic, then it might be harsh to criticise unduly
8 a young doctor who at that time was rather inexperienced
9 and maybe had not been given enough guidance by his
10 seniors in what his role was. But it raises the huge
11 issue about what the system was in Altnagelvin at that
12 time.
13 MR ORR: Yes. Yes, that's what -- I was trying not to
14 criticise the junior doctor, but emphasise his
15 inexperience and the fact that this shows why junior
16 house officers needed that close support from more
17 senior staff.
18 MS ANYADIKE-DANES: If I move to you, Mr Foster. Dr Devlin
19 arrives, he understands what the nurses want him to do
20 is to administer an anti-emetic. He would assume, if
21 he's administering an anti-emetic, the child is
22 vomiting, otherwise it wouldn't have been necessary.
23 But do you see that he should or ought to have done any
24 more, asked any questions, in your view?
25 MR FOSTER: Yes, I've thought about this. He's a busy young

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1 He did what he was asked to do. Someone should have
2 told him: this is not what little girls this long after
3 an appendix do; please, Dr Devlin, can you ask your
4 senior to see her? I think that's what should have
5 happened.
6 Q. Do you think he should have told the nurses that he had
7 witnessed a vomit so that that could be recorded?
8 MR FOSTER: It would be something he wouldn't know what to
9 do. He probably assumed that it was going to be
10 recorded somewhere, that it was probably going to get
11 into the system. He probably -- that's a simple thing,
12 as simple as I can say ... He probably wouldn't know.
13 He would assume that if somebody vomited, the system was
14 one where vomits were recorded.
15 THE CHAIRMAN: I think the problem why Ms Anyadike-Danes
16 asked you is that another unfortunate aspect of this
17 visit by Dr Devlin is that, when he saw Raychel, there
18 was no nurse with him and that only complicates things,
19 doesn't it? Because he's not getting the picture which
20 might lead him to start asking questions, even if he
21 doesn't know what the answers are.
22 MR FOSTER: It complicates things even more, sir, because
23 of course there should have been a nurse with him. He's
24 a surgical doctor, come to the ward, they happen to have
25 grabbed him to administer the ondansetron. Of course

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1 doctor. As I mentioned earlier, his primary duties
2 would have been on the surgical adult wards.
3 THE CHAIRMAN: He's actually grabbed in passing because
4 he wasn't the doctor who'd been bleeped earlier on. He
5 happened to be on the ward for some other reason when
6 the sister saw him and effectively diverted him to
7 Raychel.
8 MR FOSTER: Yes, of course. He's a busy young doctor, he's
9 inexperienced. A lot of the juniors, reading the
10 statements of them, had very little contact -- although
11 they were the first port of call for the nurses on the
12 surgical wards, I believe it says in more than one
13 statement that they had actually very little call to go
14 there. He probably would not have been in contact with
15 a vomiting post-operative case before and he would have
16 thought, when he went to the ward, "Oh well, they've
17 asked me to give an anti-emetic. That's already been
18 prescribed by anaesthesia, so they know what to do and
19 if they have that prescription, I'll go and I'll
20 administer the ondansetron". Unfortunately, he didn't
21 write a note that he did it, although he saw Raychel
22 vomiting, he didn't understand the significance of what
23 he was seeing and he didn't order some bloods. And
24 we're on a very fine line here of whether this fell
25 below the acceptable performance of a junior houseman.

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1 somebody should have gone to see the patient with the
2 doctor. And that goes for almost every visit by
3 a doctor to a ward, whatever rank of doctor, whatever
4 patient, if the doctor has been asked to visit, a nurse
5 should visit the patient with the doctor, even if only
6 transiently.
7 MS ANYADIKE-DANES: Do you have a comment on that, Mr Orr?
8 MR ORR: I would agree with that, in an ideal world.
9 Unfortunately, there has certainly been a trend over the
10 last 10 to 15 years for nurses not always to accompany
11 doctors to see patients because they have other nursing
12 duties and they may be under considerable pressure on
13 the ward. So what was normal 20 or 30 years ago is no
14 longer standard practice. So yes, ideally, particularly
15 if the doctor was going to administer an injection,
16 presumably into the intravenous fluids, it would have
17 been good practice to have a nurse there, but I can't
18 criticise the nursing staff if they were under
19 considerable pressure on the ward at that time.
20 Q. But may it have been a slightly different situation, if
21 the nurse is the person who's responsible for bringing
22 the doctor there, it's not part of Raychel's surgical
23 team as we understand it, and so you've actually brought
24 in a very junior doctor who has absolutely no knowledge
25 of this patient? If you know you're doing that, is it

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1 not incumbent on the nurse to at least give him the
2 briefest of details on the circumstances in which you're
3 asking him to administer this medication?
4 MR ORR: Yes, it would have been helpful for the nursing
5 staff to fully appraise Dr Devlin of what was happening
6 to Raychel at that time.
7 THE CHAIRMAN: And the fallback is that if she can't be
8 there for some good reason when he is with Raychel, then
9 he should do his best to speak to the nurse before he
10 leaves the ward to make sure he's got the right picture
11 and to make sure that anything that he has to add is
12 communicated to the nurse.
13 MR ORR: That is the case, but --
14 THE CHAIRMAN: Is that ideal world stuff again?
15 MR ORR: Again, I think what is -- I've got to be careful
16 that I'm not making too many assumptions, but I presume
17 that he administered the ondansetron and said, "Fine,
18 I've done what I've been asked to do", and then because
19 he has other duties elsewhere, he does not have that
20 discussion. Ideally, yes, he should have had
21 a discussion about Raychel.
22 MS ANYADIKE-DANES: Yes. Should he, whether ideally or no,
23 have made a note as to what he'd done and timed it?
24 Particularly, possibly, as the nurse isn't there when he
25 does it.

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1 THE CHAIRMAN: We now know that if that was said, it was not
2 said to a nurse who was with him when he was with
3 Raychel; isn't that right?
4 MR STITT: Yes. My recollection of his evidence was that
5 there wasn't a nurse with Raychel when he went to
6 administer the anti-emetic.
7 THE CHAIRMAN: Right. So if his statement is correct and he
8 did say to a nurse on his way out of the ward, "If
9 there's anything further, contact me", then that was
10 appropriate?
11 MR ORR: That's entirely appropriate, yes.
12 THE CHAIRMAN: But his written statement that he felt that
13 her vomiting was not significant enough to contact more
14 senior doctors is something, which by that point is
15 6 o'clock, you can't agree with?
16 MR ORR: There appears therefore to be contradictory
17 statements.
18 THE CHAIRMAN: No, sorry. He has been called to give the
19 anti-emetic. He says:
20 "I didn't feel that Raychel's vomiting was
21 significant enough to contact more senior doctors."
22 MR ORR: At that time?
23 THE CHAIRMAN: Yes. That's at about 5.30 or 6 o'clock.
24 That's something which you think, if that's what he
25 felt, he felt it because of his inexperience and lack of

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1 MR ORR: Again, I think I've referred to this in my report,
2 that he didn't make a note, but that appeared to be the
3 practice in the ward that that drug prescription or
4 administration wasn't noted in the clinical notes, and
5 that is a weakness.
6 Q. I was going to ask you about that. If that is
7 a practice, so that the junior doctor is simply doing
8 what he sees others do and what he understands is
9 acceptable to do, from your point of view is that then
10 a criticism that such a practice should be allowed to
11 continue?
12 MR ORR: It is not good practice.
13 Q. Mr Foster?
14 MR FOSTER: It isn't.
15 MR STITT: May I interject on one relevant point? It has
16 been assumed that Dr Devlin really didn't make any
17 contact. That's your fallback point.
18 THE CHAIRMAN: Yes, I think he says he may have said
19 something on his way out.
20 MR STITT: I'm quoting from his statement, not his evidence.
21 It's two sentences:
22 "I didn't feel Raychel's vomiting was significant
23 enough to contact more senior doctors. I did ask the
24 nurse to re-contact the surgical doctor on call if the
25 injection didn't work."

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1 familiarity with paediatrics?
2 MR ORR: Also, had he been told that Raychel had vomited
3 four or five times?
4 THE CHAIRMAN: Right.
5 MS ANYADIKE-DANES: Otherwise he might not have
6 appreciated --
7 MR ORR: If he hadn't been told that, one couldn't criticise
8 him.
9 Q. Mr Zafar's evidence was that he would have wanted to
10 know definitely that an anti-emetic had been
11 administered to Raychel at 6 o'clock and that she had
12 vomited the number of times that she had and that she
13 was still on the same IV fluids as when he saw her in
14 the morning and that she was effectively not really
15 tolerating anything by mouth and was not up and about.
16 All those things he would have wanted to know because
17 that would not have fitted with how he saw her recovery,
18 if I can put it that way. And so if the junior doctor
19 didn't appreciate the significance or wasn't told so
20 that he could alert Mr Zafar, would you consider that
21 there was some failure in the system in Altnagelvin that
22 such a situation could arise?
23 MR ORR: It would appear from what you have said that there
24 was a breakdown in communication between the house
25 officer and the senior house officer. The senior house

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1 officer clearly expected something and that didn't
2 happen. So one has to ask what was the communication
3 between the two of them earlier in the day?
4 Q. The likelihood is there wasn't any at all because
5 he wasn't actually part of Raychel's team. And so this
6 comes back to the point I think you were addressing
7 before, as to how the communication flows do, in fact,
8 work. Mr Zafar was clear: this is the trajectory
9 I think; I want to know if there's a problem or I expect
10 a senior nurse to be telling me if it isn't working out
11 quite like that. The nurses for some reason are not
12 contacting him directly; instead they are dealing with
13 each development as it arises. The first issue is we
14 need a new bag, the second issue is we need to stop the
15 vomiting and they're dealing with things discretely
16 in that way, using clinicians by which there is no
17 continuity of care. So they don't communicate anything
18 to Mr Zafar and that means that somebody more senior is
19 not alerted to her condition and does not therefore have
20 the opportunity to carry out the review that you
21 actually would have wanted to be carried out some time
22 in the middle afternoon, let alone by 6 o'clock.
23 So what I'm asking you is: if that happened, which
24 it clearly did, do you see that as evidence of some sort
25 of system failure or is it just unfortunate that on that

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1 didn't even think of letting Mr Zafar know. So the
2 system failed at that point. The ward was being run by
3 experienced nurses who would, I hope, have recognised
4 the significance of continued vomiting by the early
5 evening. I don't understand why they didn't then
6 themselves contact Mr Zafar or insist that Dr Devlin
7 did. In a situation that they were put into by junior
8 housemen being first on call, the nurses were the safety
9 net.
10 THE CHAIRMAN: Sorry, Mr Foster, I think the nurses who have
11 given evidence have been insistent that they regarded
12 this as vomiting which was not out of the ordinary.
13 I think Mr Orr's already commented on this; do I gather
14 that you find that difficult to accept?
15 MR FOSTER: Oh yes, this is a girl who had a straightforward
16 removal of a minimally, at most, inflamed appendix, and
17 by now we're into the early evening. It was certainly
18 very much out of the ordinary, sir.
19 THE CHAIRMAN: Thank you.
20 MR CAMPBELL: Mr Chairman, the issue of how long the
21 post-operative nausea and vomiting could or should have
22 gone on for is a matter of much debate. Perhaps it's
23 useful to throw into the mix an opinion expressed by
24 Mr Simon Haynes. For convenience, I'll refer to it from
25 a consolidated report, which appears at 312-002-014. In

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1 particular day the wrong call was made by certain
2 individuals?
3 MR ORR: Well, clearly there was a failure in communication,
4 so you're then going back from that, say, what was the
5 communication system in place in the hospital at that
6 time between the house officers and the senior house
7 officers and registrars. I don't know the answer to
8 that. But there should be, in every surgical ward, an
9 ease of communication, both vertically up the surgical
10 hierarchy and latterly into the nursing staff. And that
11 should occur at any level. There should be no
12 difficulty with a senior nurse contacting a registrar or
13 indeed a senior nurse contacting a consultant if
14 required.
15 Q. Yes. Mr Foster, if I ask you this: do you see those
16 events as I've just described them at around 6 o'clock
17 of evidence of any system failure or not?
18 MR FOSTER: Yes, it is, because this is the sort of
19 situation that is at risk of arising when very
20 inexperienced doctors are the first level on the ward.
21 Dr Devlin said he didn't consider her vomiting
22 significant. I can't really see how a pre-registration
23 houseman seeing a child with post-operative vomiting can
24 come to a decision as to whether vomiting is significant
25 or not. He gave the drug and went back to his job and

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1 paragraph 5.3.1, reference is made to the fact that he
2 states as follows:
3 "PONV usually settles within the first 6 hours after
4 surgery, but may be troublesome for up to 24 hours."
5 And I know that elsewhere in the papers I have seen
6 reference to post-operative nausea and vomiting lasting
7 as much as 48 hours, so opinions do vary.
8 THE CHAIRMAN: That's correct, they do vary, but the
9 starting point here, or a starting point, is Mr Orr says
10 he wouldn't expect post-operative vomiting after
11 Raychel's operation at all. Let's take that as one
12 point, but since Dr Haynes is coming tomorrow to give
13 evidence -- and I think you know from the report that
14 he's a paediatric anaesthetist. He says that it usually
15 settles within the first 6 hours, but may be troublesome
16 for 24 hours. Do you have a comment on that?
17 MR ORR: If I can comment, chairman, I wouldn't say that
18 I wouldn't expect vomiting at all. What I would say is
19 there seems to have been an assumption that
20 post-operative vomiting after a routine appendicectomy
21 is common. It occurs, but it is not common. I would
22 only expect it to occur in a small percentage of
23 patients and again, in most of these patients, for it to
24 be self-limiting within a fairly short period of time.
25 MS ANYADIKE-DANES: Mr Chairman, Dr Haynes is going to be

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1 here tomorrow, but now that we're on his view, in his
2 report at 220-003-013, which we don't need to pull up,
3 he says:
4 "In my experience, post-operative nausea and
5 vomiting attributable to anaesthesia is usually
6 a phenomenon which rarely continues more than 12 hours
7 post-operatively."
8 So he then cites a relatively recent review, which
9 says that:
10 "It may be troublesome as a secondary phenomenon up
11 to 24 to 48 hours following anaesthesia."
12 By which, although he will explain that himself,
13 I take it to mean that something else is going on. But
14 as to post-operative vomiting itself, he was of the view
15 that that rarely continues on past 12 hours, which
16 I think roughly accorded with the time that Mr Orr gave
17 earlier.
18 THE CHAIRMAN: The document which is on screen for reference
19 is the adviser's summary report, isn't it?
20 MR ORR: That's right.
21 THE CHAIRMAN: Okay. It's 4.10, the stenographer's been
22 going from 2 o'clock. We're on the last lap, but we'll
23 take a break for 10 minutes.
24 MR STITT: May I make a final point in ease of the
25 stenographer and the witnesses? Apropos what the

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1 JHO has found himself in a position where he is actually
2 making an assessment, so he's exercised his judgment
3 in that way, is that something that you would have
4 expected him, just for the purposes of keeping his
5 senior in the loop, if you like, to have communicated
6 the fact of seeing the patient, "This is what I've done,
7 in my view she's not dehydrated", just to allow his
8 senior colleague to know what he has done and to satisfy
9 himself that what he has done accorded with appropriate
10 practice?
11 MR ORR: Yes, but that works both ways. Mr Zafar should
12 have communicated with him early on in the day to say,
13 "Look, if you're called to the surgical paediatric ward
14 to see a surgical patient, I would like to know your
15 findings".
16 THE CHAIRMAN: And the more important communication then
17 is that it's 6 o'clock and she's still on full IV fluids
18 and not taking anything orally.
19 MS ANYADIKE-DANES: Thank you very much.
20 THE CHAIRMAN: Ten minutes.
21 (4.15 pm)
22 (A short break)
23 (4.25 pm)
24 (Delay in proceedings)
25 (4.33 pm)

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1 statement of Dr Devlin had said, I had interjected once
2 before on this and I note also, and if I may quote one
3 sentence and it's this:
4 "When I saw Raychel, she was vomiting, she did not
5 appear to be dehydrated or distressed. I felt it was
6 reasonable for a child to vomit within 24 hours of
7 surgery."
8 I appreciate the witnesses' views on the 24 hours,
9 but my point, which I would maybe like to put to the
10 witnesses, is that he did form some form of assessment
11 that she wasn't dehydrated or distressed. Rightly or
12 wrongly, that was the view he came to.
13 THE CHAIRMAN: Can you comment on that?
14 MR FOSTER: Well, in all truth, I don't think a doctor of
15 Dr Devlin's seniority was senior or experienced enough
16 to make an assessment of dehydration or distress in
17 a young child.
18 THE CHAIRMAN: Mr Orr?
19 MR ORR: He assessed the patient and that's what you'd
20 expect from a junior house officer. We could argue that
21 his assessment was incorrect, but he assessed the
22 patient, came to a view, and acted accordingly.
23 MS ANYADIKE-DANES: You had talked very much about this
24 close supervision that has to happen between the JHO and
25 his more senior colleagues, the SHO probably. If the

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1 MS ANYADIKE-DANES: I wonder if I could go back to a matter?
2 I've been asked to draw this matter to your attention.
3 Extracts were taken out of Dr Devlin's evidence -- if
4 we can put up his witness statement. This is all about
5 who he may have discussed Raychel with. It's his
6 witness statement, 027/2, page 7. If you see at (u),
7 the answer to (u):
8 "Did you examine Raychel? I did not examine Raychel
9 as I didn't feel it was necessary. I felt the vomiting
10 was consistent with her recent operation and anaesthetic
11 and that the request by the nurse to give an anti-emetic
12 was reasonable."
13 And this, I think, is your point, Mr Orr: he has
14 exercised his judgment. Mr Foster's position was
15 whether he was sufficiently qualified to exercise
16 a judgment like that and then, from the point of view of
17 the system and communications, I think you're both of
18 the view that it's a matter of his training whether
19 he was taught that if he was going to form a view, then
20 it's a view that he should have communicated to his more
21 senior colleague, who could then have taken their own
22 view as to whether that was appropriate and whether any
23 further steps had to be taken.
24 MR ORR: And the senior colleague earlier should have
25 alerted him to the fact that he wanted to be notified

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1 about particular paediatric patients.
2 Q. The difficulty about that is in the circumstances that
3 happened. Mr Zafar couldn't have alerted Dr Devlin to
4 that because nobody thought that Dr Devlin would be
5 asked in the first place. But what he could have done
6 is what Mr Foster pointed out, he could have
7 communicated to the nurses what he expected to happen so
8 if they had brought in any JHO, they would know that
9 they're either communicating that fact to the JHO or
10 they themselves are taking the initiative and contacting
11 Mr Zafar.

12 But it may identify -- well, it's a matter for you
13 to comment -- a weakness in the system that you can have
14 different doctors being brought in, who haven't
15 necessarily been appraised of what the SHO's view of
16 Raychel's care is or should be.

17 MR ORR: Yes. It's a weakness in the system.

18 Q. Thank you. I wonder now if I could finalise this
19 element on Dr Devlin's attendance. I had referred to
20 Mr Zafar's evidence, which is that if a JHO was required
21 to come to administer an anti-emetic at 6 o'clock, he
22 would have wanted to know that. He's not particularly
23 specific as to who should tell him, but it's a piece of
24 information he would want to know because, had he known
25 that, his view was he would have come and conducted

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1 the house officers in the performance of their duties.
2 In other words, induction, et cetera.

3 Q. Yes. So you mean generally, not necessarily from case
4 to case, but that is one of the things that they should
5 have been taught, that if you're forming any view or
6 doing anything, you really need to run that by your SHO,
7 if that was the system that Mr Bhalla and Mr Zafar were
8 expecting?

9 MR ORR: Yes, it has to be clear to the house officers what
10 is expected of them by their immediate seniors and
11 above.

12 MR FOSTER: This is exactly the sort of situation where
13 a proper post-take round would have avoided -- in that
14 ideally Mr Bhalla, the registrar for the day, Zafar the
15 SHO, and one of the housemen would have gone round the
16 ward and between them have seen the little girl and
17 instead of Mr Zafar saying, "Let me know if she goes off
18 or deteriorates", they could have formed a proper plan
19 informally as to how to communicate with each other if
20 any problem arose on the ward and if they had had
21 a nurse with them on the ward round, all that would have
22 been communicated across the line and up and down the
23 line. This is the whole reason why post-take rounds are
24 important.

25 Q. Thank you. I want to put forward a point that

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1 a full review, he would have sent bloods off for
2 testing, he would then have looked at her fluid
3 management regime. And he would also, according to him,
4 have notified his senior, the registrar, that that was
5 happening, because that would have been completely
6 unexpected from his point of view, given Raychel's
7 presentation in the morning. So that's what he thought.

8 I asked a similar question to Mr Bhalla, who was the
9 registrar, and in evidence his view was that the JHOs
10 should in those circumstances have contacted the SHO and
11 then matters would have unfolded hopefully in the way
12 that Mr Zafar identified. So although you, Mr Orr,
13 don't necessarily put the onus on Dr Devlin to have
14 contacted Mr Zafar unless he was specifically told that
15 or had that communicated to him by the nurse, Mr Bhalla
16 is clear that Dr Devlin should have contacted the SHO.
17 Does that affect your view or are you still of the view
18 that you wouldn't put that onus on him?

19 MR ORR: The communication system should have been such that
20 if that was the expectation of the registrars that they
21 should be contacted, then the house officers, even
22 though a house officer who was, in a way, caught in
23 chance on the ward, should have been aware that that was
24 required of him. In other words, there should have been
25 some discussion previously as to what was expected of

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1 Sister Millar made, and she did it in evidence on
2 1 March 2013, page 58. We don't have to pull it up.
3 But the reason I put that to you is because during the
4 course of a discussion as to how matters were managed on
5 that ward, both of you, from time to time, have referred
6 to the fact that these were experienced nurses and they
7 were capable of and should have exercised their own
8 judgment as to when to notify the surgical team and
9 perhaps when to notify more senior members of that
10 surgical team. And I wonder if you might like to
11 comment on this view expressed by Sister Millar. She
12 says:

13 "I thought it was totally unfair that the nurses had
14 such responsibility for the surgical children. I felt
15 it was unfair. I felt that we had to be the lead all
16 the time in looking after the surgical children. We are
17 nurses, we're not doctors, and whilst we do our best
18 I don't think we should be prompting doctors. We would
19 now maybe, but 12 years ago, I don't think we should be
20 telling a doctor to do electrolytes. It's different
21 now, we're more knowledgeable, we've had quite a bit of
22 education, but in those days, really, we were leading
23 the care, I feel, in looking after children."

24 And that's a point that she took issue with.
25 Can you offer any comment on that?

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1 MR ORR: My comment would be that she's clearly expressing
2 the situation that was in place at that time. So she is
3 saying that it was unfair and, if it was unfair, then
4 we have to balance that against there appeared to be
5 some kind of expectation that the nurses would get
6 involved. So again, there's a lack of clarity about
7 this interface between the nursing staff and the medical
8 staff. And to say the least, that's unfortunate.

9 Q. And Mr Foster?

10 THE CHAIRMAN: Sorry, just to add to that, Sister Millar
11 also said that this issue about the unavailability of
12 the surgeons, because they were working elsewhere, had
13 been raised by her before this and had been pointed up
14 as a problem on the ward. Does this really lead back
15 into the point that you've both made about how, in
16 a hospital such as this, it would have been far better
17 if there had been a system that the paediatricians led
18 on the care of all the patients so that somebody like
19 Sister Millar wasn't left in frustration, complaining
20 about the absence of surgeons?

21 MR ORR: Certainly, obviously, using the retrospectroscope,
22 it sounds as if that would have been a better solution
23 because it sounds as if the nursing staff felt they were
24 exposed and that would have been unacceptable.

25 MR FOSTER: I do wonder why -- the nursing staff would

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1 paediatricians, whereas they felt that when it came to
2 the surgical children, because the surgeons were less
3 available, if you like, that role, which they regarded
4 as a medical role, pretty much fell to them, or at least
5 might fall to them. So that was another concern they
6 had. And then the third concern they had, which is to
7 do with the junior house officers, which was a grade
8 that really only happened for the surgical team, was
9 that they expected them, when they were called, to carry
10 out their own assessment of the child. They did not
11 expect their assessment to be a substitute for the
12 surgical member, however junior they were, for that
13 doctor's own assessment. They regarded them as doctors,
14 even if junior, and they should carry out their own
15 assessment, and they have in one way or another said
16 that in either their witness statements or in evidence.
17 They might tell them what they thought, "This child
18 needs an anti-emetic", but it was for the doctor to
19 carry out an assessment and form his or her view of what
20 that child needed and not simply rely on them to have
21 done that task for them, if I can put it that way.

22 So those seem to be the three things that the nurses
23 were expressing some concern about as to how the care of
24 surgical children was managed on Ward 6. I don't know
25 if that's something that you have had experience with in

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1 obviously have known much more closely the
2 paediatricians. They must surely have expressed this
3 frustration to their paediatric colleagues at the time
4 because I can appreciate their upset, trying to find
5 a surgeon in a busy hospital, particularly if through
6 some flaw in the system the surgeon was
7 a pre-registration house officer. But I don't
8 understand why the nursing staff had not, in some
9 informal -- and if necessary a more formal -- sort of
10 way, had not expressed their concerns to their
11 paediatric colleagues, who could have passed them on at
12 consultant level. The opportunity was surely there.

13 MS ANYADIKE-DANES: Yes. The concern that the nurses
14 expressed was possibly threefold really. One, at any
15 given time when you need surgical input, you can't
16 always obtain or have come to the ward a surgeon when
17 you need one. That was one. And you've seen that and
18 you've commented on it because to some extent it
19 happened with Raychel. The other point they were making
20 is, leaving aside that, they were pointing out the fact
21 that the medical patients had a different level of care
22 largely because the paediatricians were there. They
23 paid attention to their electrolyte testing and their
24 monitoring of their IV fluids and so that part of the
25 assessment of children was being carried out by the

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1 mixed wards in district hospitals in either of your
2 careers, if I can put it that way.
3 MR FOSTER: Nurses are quite a powerful group in
4 paediatrics. When I was a registrar in a paediatric
5 hospital, I was always terrified of the senior nurses,
6 who I'm sure knew far more paediatrics than I did.
7 I can't understand why they feel a junior house officer
8 is a doctor more qualified to give an opinion than an
9 experienced paediatric nurse. I don't know how that
10 feeling had come about. It just seems to me that there
11 was some dysfunction and lack of clarity between them
12 all, lack of the feeling that they could communicate
13 clearly between nurses and doctors, nurses and surgical
14 doctors in particular, and nurses to nurses, so they
15 couldn't establish themselves into a consensus group to
16 go along as a group and say, "Look, this is our problem,
17 can something be done to sort it out?". I feel so sorry
18 for them that they felt this way.

19 Q. Mr Orr?

20 MR ORR: I would agree with that. From what has been said
21 it sounds as if the senior nursing staff should have had
22 a discussion with the consultants, both medical
23 paediatric and general surgery, to try and resolve this
24 issue, because it is a serious issue. So I've no doubt
25 that discussion has subsequently taken place, but it's

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1 unfortunate that it hadn't occurred at the time when
2 they had raised concerns.
3 Q. Or if it had occurred, the matter hadn't been resolved.
4 MR ORR: Yes.
5 Q. I want now to move on to Dr Curran's attendance. He
6 comes at 10 o'clock. Dr Devlin has administered the
7 anti-emetic, it hasn't been entirely successful in the
8 sense that there is a further recorded vomit at
9 9 o'clock. There are some other vomits that don't find
10 their way on to the fluid balance sheet, if I can put it
11 that way. The 9 o'clock vomit is described as including
12 coffee grounds, so it's on the fluid balance sheet as
13 "vomiting coffee grounds, plus plus". And that seems to
14 be the first time that that is noted. And then at
15 10 o'clock there are small amounts, maybe three of them,
16 vomited at 10 o'clock. So that anti-emetic has not been
17 successful. Dr Curran attends to administer a further
18 anti-emetic. That's what the nurses want to have
19 happen.
20 I wonder if I can first ask you, when Dr Curran does
21 attend -- maybe if I start with you, Mr Foster -- what
22 do you think he should have done?
23 MR FOSTER: By this time, there had been a cascade of
24 problems through the day. This was the end of the day
25 and the vomiting had clearly got more serious. My

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1 would have become apparent as this is a serious symptom.
2 And he should have acted on that and called his senior
3 without delay. And I think one has to escalate it from
4 Dr Devlin to Dr Curran because I think at Dr Curran's
5 time of intervention, a brief reference to the charts
6 and, of course, to be told that coffee grounds had been
7 vomited -- and it's to be regretted that apparently this
8 didn't happen. But this was the last medical
9 intervention when something could have been done to
10 reverse this situation and it's a great pity that this
11 young doctor didn't just take it a little further. Yes,
12 I believe he should have communicated up the line to
13 Mr Zafar, who would have urgently attended.
14 Q. You mean, just to be clear about it, the last
15 intervention before her seizure?
16 MR FOSTER: Yes. I think this was the last intervention
17 where something could have been done to diagnose the
18 hyponatraemia. The sodium would have been seriously low
19 by this time, this was the last time that something
20 could be done to seriously reverse this situation.
21 MR CAMPBELL: Mr Chairman, just in fairness to
22 Nurse Gilchrist, I think from recollection of her
23 evidence, she was unclear as to whether she had
24 mentioned the coffee grounds to Dr Curran or not.
25 THE CHAIRMAN: Yes. Thank you.

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1 understanding is that the fluid balance sheet was
2 available to him where he could have read the words
3 "coffee grounds", and he should certainly have referred
4 to it, however junior. I also understand that it is
5 likely that one of the nurses told him there was coffee
6 grounds; am I right in that?
7 Q. No, I don't think --
8 THE CHAIRMAN: It's disputed.
9 MS ANYADIKE-DANES: His evidence is, had he been told about
10 coffee grounds, to him that would have been a red flag
11 and he would have notified the SHO about that.
12 MR FOSTER: Well, I think at this point in time, I think the
13 doctor called, however junior, should have been a little
14 bit more proactive.
15 Q. If I pause there and ask you why. Because I think when
16 we were dealing with Dr Devlin, I'm not sure that you
17 necessarily thought he ought to be looking at the
18 charts. Why is it you think at this time that Dr Curran
19 ought to be at least looking at the fluid balance chart?
20 MR FOSTER: Because I think someone should have caught on to
21 the fact that vomiting had been frequent all day and if
22 it was coming to this sort of time of the day, he should
23 have looked at it and seen how much vomit there was.
24 As a side issue, of course, the fluid balance chart
25 should have been shown to him. Then the coffee grounds

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1 MS ANYADIKE-DANES: If I can just continue with you for
2 a little bit in this way, Mr Foster. If all that
3 Dr Curran was told was, "Look, here's Raychel, she had
4 her surgery roughly 24 hours ago and she's vomiting and
5 I would like an anti-emetic to stop that, it's
6 unpleasant and uncomfortable for her", let's assume
7 that's all he was told. What do you think he ought to
8 have done in those circumstances?
9 MR FOSTER: Well, I've already said he should have looked
10 at the charts. He should have examined her and he would
11 have seen a drowsy, sleepy girl, who was plainly not
12 well. He may not as a junior doctor have known exactly
13 why, but he should have seen a little girl who wasn't
14 what you'd expect to see at this point after an appendix
15 operation. I do believe so at this point. He's
16 a doctor, he's had a medical training, here was an
17 unwell little patient. And if he says he thought she
18 was well, then I think that was a clinical error.
19 Q. And do you think he should have done that because of the
20 sheer passage of time from her surgery when she's
21 vomiting?
22 MR FOSTER: Yes.
23 Q. Is that enough to have prompted him to have a look
24 at the charts to try and understand what's happening?
25 MR FOSTER: I do think so. This has now gone on and on for

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1 not far off 24 hours. But it's not just Dr Curran.
2 I think between them Dr Curran and the nursing staff
3 should have really been alarmed at this point.
4 Q. And does it make it any more serious for you if he had
5 learnt that she had a headache and that her parents had
6 been concerned about her demeanour? She had been
7 extremely listless -- and not just her parents, but
8 there are others in the ward, her friends and others
9 in the ward who had noted the change in her demeanour.
10 MR FOSTER: Of course it should.
11 Q. Is that the sort of thing that should have been explored
12 or communicated with them?
13 MR FOSTER: These are alarm bells here. This is a problem.
14 This is not normal. The nurses must surely have
15 realised that. Between the nurses and Dr Curran, there
16 should have been urgent collaboration and the phone
17 should have been picked up to the SHO as soon as
18 possible.
19 Q. Sorry, Mr Orr, can I ask you then: if Dr Curran arrives
20 at this time, very nearly 24 hours after surgery, the
21 child is vomiting, well, he did not know, I don't think,
22 that she had had a previous anti-emetic, but he knows
23 that an anti-emetic is being required, so she is
24 obviously vomiting. What do you think he should have
25 done at that stage?

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1 patient and decides to proceed to prescribe another
2 anti-emetic, perhaps being unaware that she earlier on
3 had ondansetron.
4 THE CHAIRMAN: Yes, and with the anti-emetic having
5 effectively been left out for him to give.
6 MR ORR: Yes. So we have a scenario again where you've got
7 this very experienced doctor summoned, he does what's
8 been asked of him. Yes, in retrospect, sitting here
9 looking at all the facts that we've been given, yes, he
10 should have assessed the patient thoroughly, taken
11 a history, been alerted to the issues of headache and
12 lassitude and contacted his senior. But again, we're
13 talking about ideal circumstances and it's quite
14 possible that these ideal circumstances were not there
15 and he was an inexperienced doctor and therefore, sadly,
16 he acted inappropriately.
17 MS ANYADIKE-DANES: Well, if one leaves out whether he
18 should have known to examine her and all those sorts of
19 details and focus on the thing that he says he would
20 have been concerned about, he says he would definitely
21 have been concerned had he known there were
22 coffee-ground vomits. If, as the chairman has just
23 described to you, there wasn't much in the way of charts
24 kept with the bed, but the one thing that is there is
25 the fluid balance chart. What I'm trying to ask if you

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1 MR ORR: Before I answer that, I'd like to be reminded about
2 how much information he was given about the patient at
3 that time.
4 Q. I don't think that's entirely clear because I think
5 there's a difference in the evidence.
6 THE CHAIRMAN: He says, for instance, that he didn't know
7 about the coffee-ground vomiting. The nurse thinks she
8 may have told him but she's not sure; is that right?
9 MR CAMPBELL: She not clear as to the content of that
10 conversation. She couldn't recall the details.
11 THE CHAIRMAN: At the end of the bed there were only a few
12 pages. The main records were kept elsewhere and at the
13 end of the bed there were effectively about four or five
14 pages: fluid balance chart, observations chart, and the
15 kardex. And if you could build this into the answer
16 because, from when he arrives at Raychel's bedside,
17 there were only three or four pages of records for him
18 to look at.
19 MR ORR: This again is a very junior, very inexperienced
20 doctor who, as I understand it, this is the first time
21 he has seen Raychel.
22 THE CHAIRMAN: It is, which is a problem.
23 MR ORR: So faced with that, he would have to try and gather
24 as much information as was available to him through the
25 charts and from the nursing staff. He then assesses the

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1 can help us with is whether you think, in those
2 circumstances, at the very least, he should have had
3 a look at it?
4 MR ORR: Yes, he should.
5 Q. And if he had seen it, then of course he would have seen
6 the coffee-ground vomiting. And his view is, had he
7 known about coffee-ground vomiting, rightly or wrongly,
8 in his mind, that's a red flag and that means I need to
9 contact my SHO.
10 MR ORR: Yes. So he's said that himself and I would agree
11 that coffee grounds is a real alert and you need to
12 contact somebody more senior to discuss how you're going
13 to manage this patient.
14 Q. So had he not known to do anything else, if he'd simply
15 done that simple task, which you say would have been
16 appropriate for him to do, which is to look at the fluid
17 balance sheet, that might have set off a whole chain of
18 circumstances that would have perhaps culminated in
19 a more senior member of the surgical team seeing Raychel
20 at that stage?
21 MR ORR: Yes, it should have.
22 Q. And can I ask you a little bit about coffee-ground
23 vomiting because there's been some evidence about that,
24 not all of it entirely consistent.
25 THE CHAIRMAN: If we get the short version: you think it is

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1 a real alert, was your term.
2 MR ORR: Yes, but it can occur with even a small amount of
3 gastric bleeding into the stomach. You can get a small
4 amount of bleeding which results in a coffee-ground
5 vomit. It doesn't necessarily mean that the patient is
6 critically ill, but it does alert you to the fact that
7 something unusual and abnormal is happening.

8 THE CHAIRMAN: Thank you.

9 MS ANYADIKE-DANES: If you see it after that period of time
10 of vomiting, does that help you to form the view that
11 perhaps something really unusual is happening?

12 MR ORR: I would be concerned with a patient who's now
13 almost 24 hours post-op and has developed coffee-ground
14 vomitus.

15 Q. The reason I put it in that way, Mr Orr, is because --
16 I was coming on to ask you what the causes of it were
17 but actually you started to answer that question. And
18 one of the things that we heard was that you can get
19 traces of blood in the vomit from all sorts of things.
20 It might have been when they put the endotracheal tube
21 down, a little bit of trauma caused by that, but some of
22 those causes as I understand it from the evidence, you'd
23 have expected to see traces of blood in the vomiting
24 earlier if it had been anything to do with that.

25 So the other alternatives are it could have been as

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1 communication with the SHO?
2 MR FOSTER: Yes, because I'm sure in a child it signifies
3 prolonged and repetitive vomiting over a period of time.
4 The abundantly most likely reason for it is an injury to
5 the gastric mucosa, causing some bleeding -- it doesn't
6 have to be much -- that gets into the gastric acid
7 in the stomach and turns black. And that tends to
8 irritate the stomach even more and it comes up in the
9 vomit. It signifies prolonged and repetitive vomiting
10 and, of course, some action should be taken.

11 Q. Well, in fairness, I had indicated that there were
12 different views about that. So I should put to you
13 Dr Scott-Jupp's view. We don't need to pull it up, but
14 it's 222-004-012 at 5(e). He says that in his view
15 coffee grounds are not in themselves diagnostic of
16 severe or prolonged vomiting, and he says that he has:
17 "... not infrequently seen coffee grounds produced
18 in children who have vomited only two or three times
19 previously with a mild vomiting illness. In this case,
20 it is the frequency and severity of the vomiting which
21 is critical, not the occurrence of coffee grounds."

22 So that was his concern.

23 MR FOSTER: I'm not sure I agree with that. From the point
24 of view of a surgical patient, I think this is
25 different. I don't know, he may be talking about

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1 a product or as a result of the strenuous vomiting or
2 prolonged vomiting, that might have produced
3 a Mallory-Weiss tear or something of that sort. And
4 even if that in and of itself wasn't hugely serious in
5 terms of her condition, it's the fact that it indicated
6 that she had been vomiting in that strenuous way for
7 some time, and that's the thing that ought to have been
8 of concern. That's the evidence we've heard to date.
9 Can you comment on that?

10 MR ORR: It's difficult to know what an inexperienced doctor
11 would think about the causation of coffee grounds other
12 than that there's been some bleeding in the stomach and
13 we've therefore got coffee-ground vomitus. A more
14 senior doctor would go through a differential diagnosis
15 and I think at the top of that would be a stress
16 reaction with tiny ulcers -- not fully-developed ulcers,
17 but a stress bleed with coffee grounds as a result.

18 Q. You mean from the action of vomiting?

19 MR ORR: Either from the vomiting or from the general stress
20 of Raychel's condition at that time if she was, as she
21 was undoubtedly then, hyponatraemic, developing cerebral
22 oedema, there would be a stress reaction and that would
23 be reflected in a gastric erosion and coffee grounds.

24 Q. And Mr Foster, in your view, firstly, is coffee-ground
25 vomiting a significant thing that should warrant

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1 medical children. I've always been cynical about coffee
2 grounds in elderly patients. I was forever being called
3 to the geriatric wards for coffee grounds and it really
4 rarely was. It was a stasis of gastric juice in the
5 stomach, the very opposite of persistent vomiting.
6 I think in a child who had been vomiting all day, coffee
7 grounds was a significant finding that was yet another
8 alarm bell ringing, which meant action.

9 Q. In terms of what Dr Curran should have done, I think
10 certainly Mr Orr has said, well, he should have looked
11 at his notes at the very least. When he saw the coffee
12 grounds, then he should have notified his senior.
13 I think you, Mr Foster, have also thought he should, at
14 least, have notified his senior. The nurses in their
15 evidence have said what they would have expected him to
16 do and Staff Nurse Noble -- we don't need to pull it up,
17 but her evidence is on 27 February at page 121 -- she
18 thinks that:

19 "... Dr Curran should have carried out a full
20 assessment when he came before giving the anti-emetic
21 and reporting his assessment to the nurses."

22 So although their view was what was required was an
23 anti-emetic, in Staff Nurse Noble's mind, Dr Curran
24 nonetheless should have carried out a full assessment.

25 Staff Nurse Gilchrist, in her evidence on 11 March

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1 of this year, page 89, said she thought it would be part
2 of his role to look at the charts and examine Raychel
3 and she goes on to say that she thought he would make an
4 assessment and determine whether she, Raychel, needed
5 more senior input. Can you express a view on the
6 nurses' position?

7 MR FOSTER: They're saying what would be ideal, but the
8 evidence was already there without an assessment. I'm
9 not sure what they mean by "an assessment". The
10 assessment is in the charts, the assessment is in the
11 appearance of the little girl, and it's in the history
12 throughout the day. That's the assessment. I'm not
13 sure a physical examination would add a great deal to
14 what is already obvious. And I think the nurses and
15 Dr Curran together were clearly concerned and they
16 should have between them, if you like, as a collective
17 decision, made sure Mr Zafar was contacted and
18 investigations and treatment urgently commenced because
19 I think this was the last opportunity to reverse this
20 problem.

21 Q. In your view, by that time, would you have characterised
22 Raychel's vomiting as severe and prolonged? Can I ask
23 you that first, Mr Foster?

24 MR FOSTER: Yes.

25 Q. Mr Orr?

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1 with his senior colleague Mr Zafar or an SHO, what
2 do you think would have been appropriate to have
3 happened at that stage once the SHO is aware of the
4 situation?

5 THE CHAIRMAN: Sorry, I think you've already told me what
6 you would have expected to have happened at 6 o'clock
7 when you think the SHO might have been called.

8 Can I take it that you would have assumed
9 effectively the same course of action at about
10 10 o'clock if they had been called at that time, though
11 perhaps with a greater degree of urgency because the
12 position had deteriorated?

13 MR ORR: Exactly.

14 THE CHAIRMAN: Yes, thank you.

15 MS ANYADIKE-DANES: Are you of similar mind, Mr Foster?

16 MR FOSTER: Yes.

17 Q. What Mr Bhalla says he would have done is that if he had
18 been contacted as the registrar -- and Mr Zafar's
19 evidence was he would have contacted Mr Bhalla --
20 Mr Bhalla says that he would have come and made sure
21 that the blood tests were taken for electrolytes and he
22 would have stayed there on the ward or about so that he
23 could become more closely involved in the management of
24 Raychel's treatment and certainly until those results
25 came back and he could see the way forward. Is that

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1 MR ORR: I would agree. We're almost 24 hours

2 post-operative and she's had a large number of vomits,
3 approximately eight, so that is severe and prolonged.

4 Q. Is that a view that you think should have been reached
5 in 2001?

6 MR ORR: Yes.

7 Q. Dr Sumner, as you know, or you may not know --

8 THE CHAIRMAN: Sorry, you don't need that.

9 MS ANYADIKE-DANES: Thank you.

10 If I can then go on to having contacted his senior,
11 it may be that you might not have expected Dr Curran to
12 have done very much more than perhaps read the fluid
13 balance charts, noted the coffee-ground vomiting, maybe
14 had some sort of discussion with the nurse, but in any
15 event contacted his senior. Would you have expected him
16 to have administered the anti-emetic as well, Mr Orr?

17 MR ORR: I would have expected him after all of that to have
18 examined the patient, then discussed it with his senior
19 and then, if there had been a discussion, give the
20 anti-emetic. But it sounds as if he was almost
21 presented with this anti-emetic to give, already drawn
22 up.

23 Q. Yes.

24 MR ORR: A difficult situation for a young doctor.

25 Q. Assuming that he had, at the very least, got in touch

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1 something that you would have regarded as appropriate,
2 Mr Foster?

3 MR FOSTER: Absolutely. I have no doubt that Mr Bhalla
4 would have acted with great urgency and would have done
5 exactly as he has said.

6 Q. Mr Orr, would that have been appropriate in your view?

7 MR ORR: I would have hoped that that's what would have
8 happened.

9 Q. At any stage so far, do you think that the consultant,
10 whether it be the consultant on call or whether it be
11 Raychel's consultant, ought to have been notified of her
12 deterioration?

13 MR ORR: I would have expected, if Mr Bhalla had come to the
14 ward, assessed the patient along with the junior house
15 officer, at that stage he would have undoubtedly been
16 concerned and he should then have informed the
17 consultant.

18 Q. When you say "the consultant", do you mean whichever was
19 the surgical consultant on call, or do you mean
20 Raychel's consultant, Mr Gilliland?

21 MR ORR: I would expect it would be the consultant on call.

22 Q. And Mr Foster?

23 MR FOSTER: I agree, Mr Bhalla would have got involved.

24 He's a very experienced surgeon and, in a proper
25 training scheme which led to a consultant exit

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1 qualification, he would have been a consultant. And
2 I suspect Mr Bhalla would have been quite capable of
3 dealing with this situation a long way and to the point
4 where the hyponatraemia might have been reversed. But
5 this was a serious event in a little girl and, yes, at
6 some point in all this, even if it was only to advise
7 a consultant on call, he should have done so.
8 Q. There's a matter that I omitted and I apologise for it.
9 One of the things that I wanted to ask you about is
10 whether you thought Dr Curran should have made any entry
11 into Raychel's notes. Mr Foster?
12 MR FOSTER: I think this was quite a serious event now and
13 yes, he should have written in the notes, something like
14 "prolonged and severe vomiting all day" or "vomiting all
15 day" and expressed his concern in the clinical file and
16 the next decision, of course, should have been to take
17 the bloods and call his senior.
18 Q. Mr Orr?
19 MR ORR: He didn't put anything in the notes and I think in
20 my report I said that appeared to reflect again custom
21 and practice in that ward, which is unfortunate because
22 at this stage things were developing and there should
23 have been some comment made in the notes.
24 Q. Does that mean if that's how he was being taught, you
25 regard that as poor practice?

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1 are passing on the information as to what has happened
2 with the care of the child to the incoming staff, or
3 would that be a separate thing?
4 MR ORR: I think they're separate, but they would achieve
5 the same end, that the patient had been reviewed and
6 everyone who was on for the night was aware of patients'
7 statuses and what their condition was and if there were
8 any concerns about individual patients.
9 Q. Mr Foster?
10 MR FOSTER: Well, I can't remember that far back about
11 evening rounds. It's certainly done these days. But if
12 they were anticipating doing something like that,
13 neither Mr Bhalla nor Mr Zafar knew by this time that
14 anything was amiss. Whether they would have taken it on
15 themselves to have trekked around the hospital to see
16 someone they didn't know from the morning and to check
17 on her, I'm not sure. I don't think it would have been
18 normal practice at that time. But I honestly can't
19 remember. I suspect what should have happened, as I've
20 said many times, is they just needed to know.
21 THE CHAIRMAN: I thought Mr Orr's point was this was
22 a relatively common practice in 2001 and had that been
23 in place in Altnagelvin then whether Mr Bhalla and
24 Mr Zafar knew, this was a way of them finding out; was
25 that your point?

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1 MR ORR: Yes.
2 Q. Thank you.
3 MR ORR: Is it appropriate I can make another point? We may
4 come on to this, but there is something missing from
5 this in terms of how the patients on the ward are
6 managed and how they are observed. It would be ideal if
7 there was a second ward round during the day on
8 a children's ward. It is pretty well standard practice
9 on most surgical and medical paediatric units. I'm sure
10 many other general surgical units, when they're looking
11 after children, make sure that there is an evening ward
12 round to check on all the patients before everyone
13 retires for the night, if they can retire for the night.
14 That is something, again, which may have resulted in an
15 intervention at an earlier stage.
16 THE CHAIRMAN: In 2001, how common would a second ward round
17 have been on a paediatric ward in a hospital such as
18 Altnagelvin?
19 MR ORR: I can't comment specifically about Altnagelvin, but
20 certainly in other units that I'm aware of second ward
21 rounds by someone of experience -- and it would normally
22 be the registrar -- would do a ward round of all their
23 surgical patients.
24 MS ANYADIKE-DANES: Does that provide the same function as
25 perhaps an evening handover so that the daytime staff

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1 MR ORR: Yes. What I'm saying is that, in my experience in
2 Scotland, it was certainly a common practice. I'm not
3 saying it happened in every unit, but it was certainly
4 a common practice in many of the units that I visited
5 that there was a regular evening ward round because what
6 it did, it prevented or forestalled problems emerging
7 later on in the night.
8 THE CHAIRMAN: Thank you.
9 MR FOSTER: It's a very important point Mr Orr's making, but
10 my recollection of this is that the evening round, when
11 there was one, was round the patients who had come
12 in that day. They would have started to come, at
13 8 o'clock, under the new admitting consultant. My
14 recollections of an evening round that I recall was of
15 a round of that day's patients in the evening.
16 THE CHAIRMAN: Maybe that's an indication of different
17 practices. Thank you.
18 MR FOSTER: Oh yes, yes.
19 MS ANYADIKE-DANES: Leaving aside, Mr Foster, whether there
20 was or should or might have been an evening ward round,
21 do you think there should have been a way of Mr Zafar
22 finding out what had happened to Raychel over the day?
23 I mean leaving aside his expectations in terms of what
24 Dr Butler might have done or Dr Devlin might have done,
25 but here's a child who he hasn't seen since the early

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1 morning or had any information on. Routinely, should
2 there have been a way of him finding out what had
3 happened to her over the day?
4 MR FOSTER: He was no doubt very busy during the day because
5 we know that later on in the night he was extremely
6 busy. What would have been to me good medicine was that
7 the operating surgeon, Mr Makar -- and my understanding
8 is that during the day he was doing something until
9 around lunchtime or 1 o'clock. That's my recollection
10 from his statement. What would be the normal practice
11 of a conscientious doctor would be, as you're putting
12 your coat on to go home in the afternoon, you call on
13 the ward and see the patient you'd operated on the night
14 before. That would be what I would have expected from
15 a good surgical SHO. He was the operator, he was about
16 to go, he wouldn't be coming back probably until the end
17 of the weekend, and the last thing he should therefore
18 have done was call in at the ward to see the little
19 girl. And if he'd called in, around 1 o'clock or so,
20 I am sure he would have suspected a problem.
21 Q. We're going to come on to it towards the end of your
22 time, but in terms of communication with the family, the
23 evidence from the Trust has been that in Altnagelvin
24 they practised family-centred care and much of what
25 you've said is to do with information flows, how the

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1 advise you about a patient's condition, but it is very
2 important to listen to a parent's view, particularly if
3 the parents have been sitting with their child
4 throughout the day.
5 Q. Mr Foster?
6 MR FOSTER: I couldn't agree more. The parents' view and
7 concerns and fears are paramount and should be listened
8 to with great seriousness.
9 Q. If I ask you now on something that you had said earlier
10 when you talked about the involvement of somebody more
11 senior in the surgical team, perhaps Mr Bhalla. You
12 said that that 10 o'clock intervention was really the
13 last time that steps could be taken maybe to avert the
14 deterioration that led to the seizure at 3 o'clock. Can
15 I ask you, what are the steps that you had in mind that
16 could have been taken? I'm not saying by the JHO who
17 may not have had the experience to know what to do, but
18 assuming that they had successfully involved the senior
19 surgical clinicians, what are the steps that you think
20 could have been taken at that stage or should have been?
21 MR FOSTER: Yes, what would Mr Bhalla have done? I think
22 he'd have come and very quickly realised something was
23 amiss. He would have, I'm sure, changed the fluids. He
24 would have urgently done the necessary blood tests. He
25 would, I suspect, have realised this was a serious

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1 relevant people know what the concerns are so that they
2 can bring their expertise to bear on it. So far,
3 we haven't mentioned the potential role of the parents
4 in this. Do you think that there was a role for the
5 parents being alerted to the fact that they could
6 participate, if I can put it that way, in Raychel's care
7 by communicating to the nurses and even helping with the
8 administration of oral fluids in the way that Mr Zafar
9 had indicated? Mr Orr.
10 MR ORR: In paediatric hospitals for many years, parents
11 have been involved in the care of their children.
12 That is relatively easy to say about chronic patients
13 who have been in the ward for some time. For a patient
14 who's only been admitted for less than 24 hours,
15 it would be difficult to be prescriptive about how the
16 parents were involved in care. But good practice would
17 be that they could become involved in the sort of
18 general care of their child. And reading the evidence,
19 it would appear that Raychel's parents were involved to
20 some extent with looking after some of her requirements
21 post vomiting, things like that.
22 Q. And how important is their view as to how their child is
23 presenting in your experience?
24 MR ORR: In my experience, it's very important. Obviously,
25 you're listening to your nursing staff, who are going to

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1 situation and involved paediatrics also. But he may not
2 if he felt in control of the situation because a blood
3 result would have been back about 22.30 or even before
4 and could have shown -- it's purely guesswork --
5 a sodium somewhere in the low 120s. And that's a level
6 I'm sure which is recoverable from. He might have
7 wanted to seek some advice from someone else,
8 a paediatrician or an anaesthetist, about how to
9 administer fluid in this situation -- because it's so
10 rare, I think I'd need advice as to what best to give
11 and at what rate to give it -- and naso-gastric tubes,
12 possibly, not necessarily. Just attention to the drip,
13 attention to the bloods, a change of the fluid, and then
14 you are on the way to reversing the situation.
15 Q. And Mr Orr?
16 MR ORR: I would agree with all of that.
17 Q. Thank you. Then we come now to the next intervention,
18 which is immediately after she suffers her seizure,
19 which is about 3 o'clock in the morning. And the person
20 who once again literally happens fortuitously to be
21 there is a paediatric SHO, Dr Johnston. He responds, he
22 stabilises her, and he immediately contacts Dr Curran
23 again and his evidence is he asked him to do two things.
24 He wanted him to come and take the bloods because his
25 suspicion was that the seizure that she'd had was

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1 electrolyte-related and he also wanted him to contact
2 his more senior colleague. In his evidence, it's at
3 least involving the registrar. The medical notes that
4 he made of that indicate perhaps the consultant as well.
5 We don't need to pull it up, but for reference purposes
6 it's 020-007-013 and he has "registrar/consultant". So
7 it's clear he wanted Dr Curran to get in touch with
8 somebody quite senior from the surgical team.

9 That's what he wanted and the reason he wanted
10 that is because he was concerned that there may also be
11 something happened that was related to her surgery which
12 he may not appreciate because this was his first time
13 being involved in Raychel's care. Dr Curran responds
14 and he takes the bloods and then he contacts the SHO,
15 Mr Zafar, and this is the part that I want to ask you
16 about.

17 Mr Zafar's response is he's in A&E and is unable to
18 come immediately, and apparently he tells Dr Curran
19 that. And nothing else happens about seeking more
20 senior surgical intervention than that until Mr Zafar
21 comes and Mr Bhalla comes, having been bleeped by the
22 nurse.

23 So there is a period of time from roughly some time
24 shortly after 3.30, to about 5 o'clock, when they are
25 waiting for the involvement of more senior surgical

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1 anxieties were expressed and I'm certain Bhalla would
2 have gone there straightaway.
3 Q. And if for any reason he doesn't do that or rather
4 Dr Curran doesn't get the assurance, "Don't worry about
5 that, I can't come, but I'm going to get hold of
6 Mr Bhalla", if he doesn't get that kind of assurance, do
7 you think that Dr Curran should have used his initiative
8 and himself contacted Mr Bhalla?

9 MR FOSTER: If Mr Bhalla hadn't turned up within about
10 a quarter of an hour, if Dr Curran had the time -- of
11 course, the situation would have been getting pretty
12 busy and hands-on there -- he should have tried himself,
13 yes. But it would have been ideal if Zafar had taken
14 that task off the already frantically busy team on
15 Ward 6.

16 Q. And if we just stick with the actions of the surgical
17 team for the moment. That doesn't happen, there's a bit
18 of running around to try and get the electrolyte results
19 back and, as I say, no senior member of the surgical
20 team arrives until almost together, I think, or very
21 close in time, Mr Zafar and Mr Bhalla arrive.

22 Mr Bhalla says when he came he carried out an
23 examination of Raychel. He suggested that they
24 catheterise her, which they did, insert a naso-gastric
25 tube, which they did, and I think he also agreed they

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1 staff. And if I ask you about that first, Mr Orr.

2 Can you comment on that? Should something more have
3 been done?

4 MR ORR: Well, given the extreme condition that Raychel was
5 in and the possibility that there was a surgical problem
6 as well as a medical problem, if Mr Zafar couldn't
7 attend then Mr Bhalla should have been contacted as
8 a matter of urgency.

9 Q. And who do you think should have done that? Should it
10 have been Dr Curran, recognising that his SHO can't
11 attend, or should it have been Mr Zafar?

12 MR ORR: Mr Zafar should have said, "I can't attend,
13 I suggest you contact Mr Bhalla". And that should have
14 happened.

15 Q. And if for any reason he hasn't said that, do you think
16 Dr Curran should have exercised his initiative and
17 actually contacted Mr Bhalla himself?

18 MR ORR: Well, I would have thought he should have.

19 Q. And Mr Foster?

20 MR FOSTER: For an emergency call like that, Zafar should
21 have handled it. He can't have been incapable of taking
22 a second to get Bhalla on the phone and say, "Please go
23 to Ward 6, there's a problem there".

24 So I think that Zafar, as next up the line, it was
25 his job to make sure his senior was informed and his

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1 really should be having a CT scan done of her. And in
2 terms of his direct involvement, that was it. Do you
3 think that once he's performed those tasks, he should
4 have made any attempt to contact the consultant to let
5 the consultant know what was happening?

6 MR ORR: Yes. Yes, he should have contacted the consultant
7 on call to ensure that he knew what was happening with
8 this patient.

9 Q. And why do you say that?

10 MR ORR: Because the patient was critically ill. It was
11 a patient who had previously had been thought to be well
12 and making satisfactory progress. She's now collapsed,
13 is extremely ill, and although the medical
14 paediatricians are involved, there is no certainty as to
15 what other conditions that may be surgical are involved.
16 So I would say it was essential that the consultant on
17 call knew that this collapse, this fit, had occurred.

18 Q. And is that notwithstanding the fact that, by that
19 stage, or soon thereafter, you would have had
20 a consultant paediatrician there and you'd have had
21 a consultant anaesthetist there? Do you still say that
22 notwithstanding that it would have been appropriate, in
23 fact should have happened, that Mr Bhalla contact the
24 consultant surgeon?

25 MR ORR: Well, the consultant surgeon should have been made

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1 aware. It's then up to the consultant surgeon to decide
2 what actions he then takes, but he then has an
3 opportunity to make a decision about his actions at that
4 stage.

5 Q. And Mr Foster?

6 MR FOSTER: I agree with Mr Orr completely. This was
7 a major clinical event, once in some years in most
8 hospitals, and of course Mr Bhalla should have picked up
9 the phone to the consultant on call. What happened
10 after that would be up to the consultant on call. But
11 in the correct situation, he should have come in,
12 exercised leadership of the team, which was already, I'm
13 sure, extremely involved, extremely concerned and upset
14 at what was going on. A senior surgeon was, after
15 all -- Raychel was under the ownership of the surgical
16 department when she arrived and throughout the day of
17 the 8th. And the senior surgeon on call for the day
18 should, I believe, have certainly come in and spoken to
19 the family.

20 Q. And if that step had been taken, or even at the level of
21 the registrar, when Raychel was taken to have a CT scan
22 done and the CT scans were done, the first one showed
23 the cerebral oedema, but suggested at some point that
24 there might be a show of blood there and that gave rise
25 to a second CT scan being carried out, an enhanced one,

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1 team and you should come in there and give encouragement
2 to the others, the other consultants, and I believe the
3 absence of a senior member of the surgical team must
4 have been noticed by everybody.

5 Q. Mr Gilliland was asked about that, whether the
6 consultant should have come in, and I think his view
7 is that he didn't think that that was necessary that the
8 consultant should have come in. In fact, I think --
9 I'll be forgiven if I've misinterpreted his evidence,
10 but he regarded that as a pattern of care that he didn't
11 recognise because what that amounted to -- and this is
12 from his evidence on 14 March at page 200 -- was that:

13 "Whenever there is a medical problem which happens
14 to a patient which causes their death or very serious
15 deterioration, as in this case, that you expect the
16 surgical consultant to come in and speak to that
17 parents' relatives."

18 And he said:

19 "That doesn't happen within the NHS. That's not
20 a pattern of care that I've ever seen. There were
21 senior clinicians there who could speak to the parents
22 and who perhaps understood the situation better than
23 a consultant would at that point."

24 Can you comment on that?

25 MR FOSTER: I don't accept that at all. This was a serious

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1 which eliminated that possibility, but there was some
2 suggestion that there might be some sort of surgical
3 intervention that could be carried out by neurosurgeons
4 in the Children's Hospital if there was a haemorrhage
5 there. Do you think that the surgeons should have been
6 engaged in those sorts of discussions with the
7 Children's Hospital or is that a matter that really
8 should have been carried out by the anaesthetists and
9 the paediatricians?

10 MR FOSTER: As long as someone was in touch with the
11 Children's Hospital, I think that was quite right, and
12 it was important to do the CT scans. At that point
13 Raychel's pupils had become fixed and dilated and this
14 was a very, very serious sign. And I think that's where
15 a senior person, preferably surgical, should have spoken
16 to the family and appraised them of the fears and
17 anxieties of the whole of the team.

18 Q. When you say that the consultant surgeon should have
19 been notified, in your first report, Mr Foster, you are
20 of the view that the consultant surgeon on call should
21 have actually come in, should have been notified, yes,
22 but should have responded by coming in. Are you still
23 of that view?

24 MR FOSTER: Oh, yes. Yes, it is proper professional
25 leadership. It is being the person in charge of the

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1 clinical event. A little girl had come in, not many
2 hours before, and had her appendix out and was now in
3 a very critical state. He had made attempts to compare
4 this to major medical episodes that can occur to
5 patients and I don't think he really means that and I do
6 hope that Mr Gilliland, on reflection, wishes he hadn't
7 perhaps made that statement. I think he should have
8 come in and exercised appropriate responsibility.

9 MR STITT: I'm sorry, I have to interject here. There's
10 a difference between Mr Gilliland, the named consultant,
11 and the consultant on call.

12 MR FOSTER: Yes, I accept that.

13 MR STITT: Well, I'm sorry for interrupting you, sir. It's
14 perhaps --

15 THE CHAIRMAN: Sorry, let me just get it clear, Mr Stitt.

16 Am I to understand that when Mr Gilliland made
17 a statement, he was saying that it wasn't him who should
18 have come in, but that he accepts that the on-call
19 consultant should have come in?

20 MR STITT: No, no, my interjection is not on that point. My
21 interjection was on the answer that was being given and
22 that is why I rather abruptly interrupted the witness,
23 for which I apologise. The witness was saying that
24 Mr Gilliland may wish to reflect upon this and maybe say
25 that maybe he should have come in. But he was not the

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1 consultant on call.
2 THE CHAIRMAN: Right. He was the named consultant.
3 MR STITT: Yes. That's completely different and all the
4 questions so far having dealing with the consultant on
5 call.
6 THE CHAIRMAN: What's the Trust position about the on-call
7 consultant? Would it be appropriate for the on-call
8 consultant to come in in this scenario?
9 MR STITT: I'm going to have to take instructions on that.
10 I do recall when Mr Gilliland was giving his evidence
11 there appeared to be considerable confusion as to
12 whether we were dealing with a consultant on call or the
13 named consultant. And the questions, from my
14 recollection, seemed to bounce between the two.
15 THE CHAIRMAN: I would like to know what the Trust position
16 is.
17 MR STITT: That has led to this confusion, innocent
18 confusion.
19 THE CHAIRMAN: I'd like that to be clarified because if
20 Mr Gilliland is saying, "Insofar as the criticism is
21 aimed at me as the named consultant for not coming in,
22 that is a pattern I don't recognise in the NHS", then
23 that's one thing. But if Mr Gilliland is saying that no
24 consultant, either the on-call consultant or the named
25 consultant should have been contacted or should have

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1 communicate with Belfast and, of course, to talk to the
2 parents. And Raychel was still a surgical patient,
3 although she was being managed, because of this serious
4 complication, by the medical and anaesthetic team. So
5 there should have been all the consultants required in
6 at that time.
7 MS ANYADIKE-DANES: Mr Chairman, I have just pulled up to
8 assist Mr Stitt -- one sees the start of it at the
9 bottom of page 199. I am taking this from Mr Foster's
10 report and he says:
11 "I have no doubt whatsoever that the consultant
12 surgeon on call should have come in. He should have
13 noted events, made a clinical note and, above all, seen
14 the parents."
15 And then it goes on to talk about whether
16 Mr Gilliland was or was not on duty. Picking up again
17 at line 7:
18 "So Mr Foster's view, as expressed there, is that
19 the consultant surgeon on call should have been
20 contacted. He goes on to express the view that he
21 should have come in."
22 Then if one looks at the answer to that proposition
23 being put, which is at line 23:
24 "That's a pattern of care that I don't recognise
25 from practice, the pattern of care that Dr Foster puts

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1 come in, that is significantly different from what
2 Mr Foster is saying.
3 MR STITT: Of course it is. Two points. Firstly, my
4 interjection was to do with a specific answer. Dealing
5 with your point, sir, I'm slightly disadvantaged because
6 I do not have the transcript from the relevant day --
7 MS ANYADIKE-DANES: I can call it up. It's 14 March at
8 page 200. If you can pull up 199 and 200 together.
9 MR FOSTER: Sir, may I say one thing?
10 THE CHAIRMAN: Of course.
11 MR FOSTER: This is such a serious situation. If you're
12 a consultant surgeon, it doesn't matter whether you're
13 on call or not; if something like this has happened to
14 a patient under your care -- and it has happened to me
15 over the years in various serious events -- whether
16 you're on call or not, if you're physically capable of
17 doing so, you go in. That is part of the job we signed
18 up to.
19 THE CHAIRMAN: Mr Orr?
20 MR ORR: I'm about to ignore what's on the screen. My view
21 would be in that situation, it should have been the
22 consultant on call that was contacted and the consultant
23 on call should have come in because you are managing
24 a critical situation which requires all the consultants
25 involved not only to manage the patient, but to

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1 out here. What he's effectively saying ..."
2 And then it goes on in the way that I had led into
3 with Mr Foster before.
4 So it seems that what Mr Foster was clearly talking
5 about then is the consultant surgeon who was on call
6 being notified and that surgeon coming in.
7 THE CHAIRMAN: If we go to line 17, your question is:
8 "So if the consultant on call is notified in terms
9 of ... would you have expected or wanted the consultant
10 to have spoken to the parents, given that she's
11 a surgical patient?"
12 And his answer is:
13 "That's a pattern of care that I don't recognise
14 from practice, the pattern of care that Dr Foster puts
15 out there."
16 MS ANYADIKE-DANES: That's exactly it.
17 THE CHAIRMAN: He refers to Mr Foster's report and
18 Mr Foster's report is about the consultant on call.
19 MS ANYADIKE-DANES: Thank you, Mr Chairman. That's exactly
20 the point.
21 THE CHAIRMAN: Unless this is to be corrected in some way,
22 Mr Stitt, Mr Gilliland's evidence is that the consultant
23 on call should not have come in because that's a pattern
24 of care that he doesn't recognise from practice. Okay?
25 MR STITT: Whatever his evidence is is his evidence and I'm

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1 reading it and I'm being reminded about what it was.
2 I do remember there was apparently, I remember,
3 a confusion between a consultant, named consultant, and
4 a consultant on call. I accept that that passage which
5 Ms Anyadike-Danes has referred to is quite clear.

6 I do go back to my point, however. My intervention
7 was on a quite separate point. I take your point, sir,
8 but my intervention was that the witness had mistakenly
9 believed -- maybe he hadn't mistakenly believed, but he
10 said in his report and he has said again throughout all
11 of these questions up until two or three questions ago
12 that it was the consultant on call who was the one who
13 should have been contacted and who should have come in.
14 Whether or not he had a physical role to play, he might
15 at least have been able to speak to the parents.

16 I haven't interrupted or interjected or made any point
17 during any of this series of questions to do with the
18 consultant on call. I have no basis for so doing, but
19 when it gets transposed into Mr Gilliland, that's
20 different.

21 THE CHAIRMAN: Since you represent the Trust, I'm taking
22 that observation as meaning that the Trust accepts this
23 criticism about the absence of the consultant on call
24 and the failure to contact a consultant on call because
25 that person had a role to play in the events after 3 am.

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1 THE CHAIRMAN: Thank you.
2 MR STITT: There are really two responses. In answer to
3 your point, sir, that there were two consultant surgeons
4 here -- one who is qualified in paediatrics and one who
5 has an interest in paediatrics -- who take a certain
6 view, and on the other hand you have a paediatrician,
7 Mr Scott-Jupp, who looks at it from a different angle,
8 and Mr Gilliland -- albeit an involvement witness, he is
9 nonetheless a consultant surgeon -- takes a different
10 view. I wouldn't presume to say which you would prefer,
11 but I am saying there is obviously room for different
12 views, which I know I'm confident that you will balance
13 in the fullness of time.

14 THE CHAIRMAN: Yes.

15 MR STITT: My second point is this. When you look at
16 page 200 and at line 7, as Ms Anyadike-Danes sums up
17 Mr Foster's view as she sees it, it reads:

18 "So Mr Foster's view, as expressed there, is that
19 the consultant surgeon on call should have been
20 contacted."

21 That's my understanding of the context of that
22 question.

23 THE CHAIRMAN: Yes.

24 MR STITT: And I will stand corrected if somewhere else in
25 Mr Foster's report he's saying that the named consultant

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1 MR STITT: I've indicated I'll come back on that point.

2 Mr Gilliland's given his view: that is not practice
3 which he recognises. We know that Mr Scott-Jupp gives
4 a different version. He did not see any real role that
5 a surgical team could play after the fit as it was
6 essentially a paediatric and medical matter.

7 THE CHAIRMAN: And we have the two expert surgeons here.

8 Mr Orr says the consultant on call should have been
9 contacted and should then have come in. And Mr Foster
10 says effectively -- are you saying the consultant on
11 call and/or the named consultant? Mr Orr's saying that
12 in terms of contacting a consultant surgeon and bringing
13 that person in, the surgeon on call should have come in,
14 had he been contacted. Are you saying that it's the
15 consultant on call and/or the named consultant?

16 MR FOSTER: I think there are two things. If I had been the
17 registrar, I would have rung the consultant on call and
18 I would also have rung Mr Gilliland because this was
19 a critical event and I would have felt that he should be
20 appraised of it at the earliest opportunity. He may
21 have been away or something.

22 THE CHAIRMAN: Because Raychel was his patient?

23 MR FOSTER: Yes. Oh absolutely. And he has expressed
24 a view that he considers a consultant's responsibility
25 is to be in overall charge of a patient's care.

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1 should have been contacted and should have come in.
2 There is a reference further down the page to the named
3 consultant possibly not being available.

4 But I go back to my initial interjection point
5 in the middle of an answer, which is unusual for counsel
6 to do, and that is that that was my first and only
7 interjection and because it was crossing the line
8 between the named consultant and the consultant on call.

9 THE CHAIRMAN: Thank you.

10 MS ANYADIKE-DANES: Just to tidy up that point for Mr Stitt,
11 Mr Foster's report, 223-003-014, it starts off:

12 "I have no doubt that a senior doctor like Mr Bhalla
13 rarely called a consultant ..."

14 He goes on to say:

15 "However, in this case, he failed to recognise that
16 he was facing an impending serious clinical incident and
17 because of this, he should have informed the consultant
18 on call, Mr Neilly, and also, if possible, Mr Gilliland,
19 under whose care Raychel had been placed."

20 THE CHAIRMAN: Thank you.

21 MS ANYADIKE-DANES: Can I just tidy that point up with you,
22 Mr Orr? Is it your view that Mr Gilliland should have
23 been notified that his patient had deteriorated to this
24 level so that her pupils were now fixed and dilated and
25 there was a proposal that she be transferred to the

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1 Children's Hospital?
2 MR ORR: I think on the evening or the night it was the
3 consultant on call who should have been contacted.
4 I think it would have been appropriate the next day that
5 Mr Gilliland was informed of what had happened since the
6 patient had originally been admitted under his care.
7 Q. Yes. And if he had been informed of what had happened,
8 do you think he had a role to play in talking to
9 Raychel's parents? At that stage, of course, Raychel
10 was still alive in the sense that she was still under
11 care in the Children's Hospital.
12 MR ORR: Well, I think that he would have had to have had
13 a discussion with his colleague, who was the on-call
14 surgeon, and between them decided who was the most
15 appropriate person to discuss events with the parents.
16 Q. By that, do I understand you to say that a consultant
17 surgeon should have been discussing matters with
18 Raychel's parents?
19 MR ORR: Yes. I'm not saying in isolation, but obviously in
20 discussion with the paediatric anaesthetist, with the
21 medical paediatricians, and by that stage, if Raychel
22 had been transferred to Belfast, there would be
23 involvement with the consultants in Belfast as well. So
24 it's a complex scenario, but I think it is important
25 that there was surgical involvement and representation

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1 MR FOSTER: Well, it's quite simply back to the position
2 that Mr Gilliland, at the time of Raychel's admission to
3 the hospital, was the consultant in charge of her care.
4 At some point or other, I think in the ideal world, he
5 would have made contact with Raychel's family before
6 this meeting on September 3rd to express his condolences
7 and attempt to explain a little of what had happened.
8 Not even in the ideal -- sorry, sir.
9 THE CHAIRMAN: I think Mr Gilliland has actually accepted
10 the position on this. He said that so far as the
11 meeting in September is concerned, he was invited, he
12 thought it was inappropriate for him to attend, he had
13 never met Raychel or her parents and he thought it might
14 be easier for them to meet the people who they had met
15 and I think, most importantly, he thought that there was
16 nothing that he might be able to contribute from the
17 surgical point of view. He said just last week he now
18 knows that there was, although he doesn't believe he
19 could have answered the questions better than Dr Nesbitt
20 did, but he regrets if his presence could have helped
21 the Ferguson family and assuage their grief. So I think
22 he's now accepting that really there was something he
23 could have contributed and it would have been better had
24 he been there and he regrets the fact that he wasn't.
25 If I interpret those as concessions which Mr Gilliland

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1 by the consultant under whom she was admitted.
2 Q. I asked Mr Bhalla about that, about contacting the
3 consultant, and he said that when he went off duty he
4 told the incoming registrar, Mr Date, that he should
5 contact Mr Gilliland to let him know what had happened
6 to Raychel, and his intention in doing that was so that
7 Mr Gilliland would speak to Raychel's parents. And
8 that's at the transcript of 14 March, and those
9 references are at pages 52 and 59.
10 In fact, Mr Gilliland was -- and this is perhaps the
11 last point I want to raise with both of you -- aware
12 that there was to be a meeting with Raychel's parents
13 some time after the event. Ultimately, it was set up
14 for 3 September, by which time, of course, she had died.
15 He said that he did not attend that meeting because he
16 didn't think that it was appropriate for him to do so.
17 There was represented there the consultant paediatrician
18 and the consultant anaesthetist, who had treated her and
19 they were in a position to, if the parents wanted it, to
20 describe what had happened in Raychel's last moments, if
21 I can put it that way, in Altnagelvin. And he wasn't
22 in that position and he didn't see it as appropriate
23 therefore -- I hope I'm accurately summarising his
24 evidence -- for him to be there.
25 Can I ask you, Mr Foster, your response to that?

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1 has made, would you regard those as appropriate
2 concessions for him to make?
3 MR FOSTER: Yes, I think it must have been something that
4 bothered him and I'm pleased to see he has said that.
5 His presence would have been appreciated.
6 THE CHAIRMAN: I think, Mr Coyle, I understand that the
7 family has welcomed that; is that right?
8 MR COYLE: It's belated, but welcome.
9 THE CHAIRMAN: Thank you.
10 MS ANYADIKE-DANES: One final point which I omitted and
11 I should have mentioned: Mr Bhalla was asked, as other
12 clinicians were asked at that time before Raychel was
13 transferred to the Children's Hospital, what he regarded
14 as the prognosis for Raychel in view of what had
15 happened since her seizure at 3 o'clock. Do you have
16 a view, Mr Orr, as to what the prognosis was for her?
17 MR ORR: This is prior to her being handed over to the
18 neurosurgeons for management?
19 Q. Yes, while she was still at Altnagelvin, but after her
20 seizure.
21 MR ORR: Well, there should have been a best informed
22 opinion from the consultants who were involved. I would
23 doubt that they could be absolute in their opinion until
24 they knew what the assessment was of Raychel in the
25 Children's Hospital, but that would be an opinion,

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1 a view, that should have come from the consultants, not
2 from an experienced registrar.
3 Q. And Mr Foster, do you have a view of what the prognosis
4 was for her?
5 MR FOSTER: I think when Raychel had a seizure,
6 a respiratory collapse and a fixed dilatation of the
7 pupils, the prognosis was extremely grave, and I cannot
8 recollect a patient that I have seen with this kind of
9 event who has recovered.
10 Q. You really were the one who felt quite strongly that
11 somebody, a senior consultant member of the surgical
12 team, should come in, and part of what they should be
13 coming in to do was to speak to the parents. I know you
14 said that as well, Mr Orr, but you have that in your
15 report. What is it in your view that such a senior
16 member should be saying in those circumstances to
17 Raychel's parents?
18 MR FOSTER: This was a very important time to speak to them
19 because these were absolutely horrific events that no
20 parent wants to see and as an attending senior doctor,
21 you have got to do your duty and be honest and upset
22 yourself, which I certainly would be, and appraise them
23 of what you think is going to happen. It's part of the
24 job.
25 THE CHAIRMAN: Thank you.

1 9.45 you'll have the chance to buy coffee and buns so
2 that Rachel McAdorey's fund-raising for the hospice can
3 be supported by the inquiry. 10.15 tomorrow.
4 (6.00 pm)
5 (The hearing adjourned until 10.15 am the following day)
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1 MS ANYADIKE-DANES: If we finalise that, what would you have
2 meant by being honest? What does that mean in those
3 circumstances with the parents on the information that
4 you have?
5 MR FOSTER: I would say, as gently as I could, that I didn't
6 think she was going to survive.
7 MS ANYADIKE-DANES: Thank you.
8 THE CHAIRMAN: Thank you very much. Mr Campbell? Mr Stitt?
9 Gentlemen, thank you very much, it has been a long
10 day, we're indebted to you for your contributions, both
11 in writing and today. As you will be, I'm alert to the
12 fact that the Fergusons are sitting listening and they
13 must wonder why so many lessons are learnt after the
14 event rather than things being better at the time.
15 Let's hope at least if there's any small consolation to
16 be seized from Raychel's death that the lessons are
17 learnt now.
18 MR FOSTER: Sir, may I say one thing to the family? I feel
19 over the last 18 months that I've got to know Raychel
20 and it has upset me to see what happened and I would
21 just like the family to accept from me my personal
22 condolences in your sad loss.
23 THE CHAIRMAN: Thank you very much.
24 Ladies and gentlemen, tomorrow morning we're going
25 to start at 10.15. On a slightly lighter note, from

1 I N D E X
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3 MR GEORGE FOSTER (called)1
4 MR JOHN ORR (called)1
5 Questions from MS ANYADIKE-DANES1
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