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2 (10.15 am)
3 (Delay in proceedings)
4 (10.28 am)
5 THE CHAIRMAN: Good morning.
6 MR WOLFE: Our next witness is Dr Robert Scott-Jupp, please.
7 DR ROBERT SCOTT-JUPP (called)
8 Questions from MR WOLFE
9 THE CHAIRMAN: Thank you for coming back, doctor.
10 MR WOLFE: Good morning, doctor. Could I commence by
11 confirming that you have so far provided three written
12 reports to the inquiry, which are in the sequence
13 222-002, 222-004 and 222-005, and can I confirm that you
14 would wish to adopt those reports as part of your
15 evidence to this inquiry to be supplemented by your oral
16 evidence today?
17 A. Yes, I confirm that.
18 Q. I know that there's one factual correction you wish to
19 make in one of the statements, which we'll turn to in
20 a moment. But could we have up on the screen your
21 curriculum vitae, please? It's at 222-002-001. Within
22 that middle paragraph you set out what you say your
23 credentials are. You are a consultant general
24 paediatrician in a small district general hospital in
25 England. That remains the case. This was written in

1 work in my hospital.
2 Q. So I hesitate to use the words "perfect match", but it's
3 a similar situation to what appears to have pertained in
4 Altnagelvin in 2001, where you had a district general
5 hospital with one paediatric ward which attracted a mix
6 of paediatric and surgical patients.
7 A. Yes. It's similar. Our unit is a little smaller, but
8 not much, and we probably have slightly fewer patients
9 on the ward than in Altnagelvin, but a very similar
10 medical staffing set-up, yes.
11 Q. You in your reading and your preparing of reports would
12 have seen to some extent the potential for
13 paediatricians to become involved with surgical
14 patients. That's what happened from time to time over
15 the course of Raychel's care; is that something you have
16 experience of?
17 A. Yes.
18 Q. And we'll explore as we go through your evidence the
19 extent to which the surgical and paediatric disciplines
20 interacted in Raychel's care.
21 As you say in the last sentence of your credentials
22 section, you're familiar with the standards of practice
23 which were applicable in 2001.
24 A. Yes.
25 Q. Can we move just to the small factual correction which

1 2011.
2 A. That's correct.
3 Q. You qualified in 1990.
4 A. That is a typo. I qualified in 1980, I'm sorry.
5 I thought that had been corrected.
6 Q. You took up your consultant post in 1992.
7 A. That's correct. That is correct.
8 Q. It would have been a fast-track system if you'd
9 qualified in 1990 and achieved consultancy in 1992!
10 And you say:
11 "[Your] consultant post involves care of children
12 presenting acutely with a wide variety of conditions and
13 [you] have some experience of the conditions relating to
14 this case [that is Raychel's case]."
15 A. Yes.
16 Q. Could I just unpack that a little with you? Presumably
17 you've experience of appendicectomy patients being on
18 the ward in your general hospital.
19 A. Yes. Because I work in a small district general
20 hospital, we have only one children's ward, which takes
21 both medical and surgical children, and therefore
22 children who present with surgical conditions such as
23 possible appendicitis are admitted to our ward and we,
24 as paediatricians, to a greater or lesser extent, get
25 involved with them as well as the general surgeons that

1 you would like me to deal with? It's at 222-004-002,
2 1(d). Within 1(d), doctor, you reflect that your
3 interpretation of the prescription sheet -- which one
4 finds at 020-021-040 -- and I think you thought that
5 that was the struck-out or crossed-out prescription of
6 Mr Makar. You now appreciate that that was the crossed
7 out prescription of Dr Gund.
8 A. Yes.
9 Q. As we will see as we move through your evidence, he
10 wrote a prescription for Hartmann's to be continued
11 post-operatively and then struck that out.
12 A. Yes, that's now apparent from what the witnesses have
13 told us, but it wasn't apparent from the medical records
14 as they were.
15 Q. Yes. Moving on to the substance of your evidence, can
16 I ask you some questions in relation to the
17 decision-making at the Accident & Emergency department
18 and then into the decisions to operate? You have said
19 in your report, 222-004-002, that:
20 "Raychel's initial assessment and management in the
21 Accident & Emergency department and the decision made to
22 plan for an appendicectomy for her were, in [your] view,
23 entirely straightforward and in keeping with best
24 practice."
25 You say:

1 "The history and symptoms of appendicitis were
2 typical, with a typical duration of a few hours and
3 a history of localisation of pain moving from the whole
4 abdomen to the right iliac fossa. It is well recognised
5 that even when the appendix is not inflamed, these
6 typical symptoms can occur and because of the danger of
7 missing an acute appendicitis, routine practice would
8 have been to arrange an appendicectomy."

9 And that is your view, doctor? isn't that correct?

10 A. Yes.

11 Q. Let me now put to you a few points that appear to be in
12 contention. Dr Kelly was the doctor on duty in the
13 Accident & Emergency department when Raychel was brought
14 in by her parents. He observed that she was in pain and
15 decided, at or about 8.20 pm, to administer IV
16 Cyclimorph as an analgesic. And Mr Foster, who's the
17 inquiry's surgical expert, has considered this approach
18 and criticised the use of a powerful analgesic in these
19 circumstances because of the potential to compromise the
20 surgeon's ability to interpret findings on examination.
21 Have you thought about that issue?

22 A. Yes, I have. This has been a controversial area for
23 many years as to what extent, in both children and
24 adults, when somebody presents to hospital with
25 abdominal pain, one should give analgesia -- that is

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1 paediatric surgeons -- would think that it is acceptable
2 to give analgesia when the patient first presents to
3 hospital. Firstly to relieve suffering, because that is
4 what doctors are here to do, but secondly because it
5 might actually facilitate diagnosis. Children are often
6 very anxious and tense and when a child is anxious and
7 tense it's difficult to examine their abdomen. Some
8 analgesia is likely to make them more relaxed and it is
9 then actually easier to assess them.

10 Q. Yes. The inquiry has the evidence of Dr Kelly, who, if
11 you like, put up a spirited or aggressive defence of his
12 approach, based primarily on the view that as a doctor,
13 seeing a child in pain, it is his job primarily to take
14 that discomfort and pain away from her. But can I ask
15 you this -- and I should add to that Mr Makar's
16 evidence, the surgeon, was that he doesn't accept that
17 analgesia would have masked the peritoneal signs of
18 appendicitis. And both those views, I think, you appear
19 to have some sympathy or understanding of.

20 A. Yes, I would agree with both those views.

21 Q. Could I put two points to you? There would have been
22 other analgesic options available to the A&E doctor;
23 isn't that right?

24 A. That's correct, yes. I have to say, going straight for
25 morphine, which is what Cyclimorph is, without using

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1 pain relief -- because there was a view -- and there
2 still is a view in some quarters -- that by giving
3 powerful pain relief, the signs are masked. That is to
4 say, it makes it more difficult when assessing the
5 patient's abdomen to decide what the problem is. The
6 assessment of an abdomen in an adult or a child is
7 dependent on finding tenderness, areas of the abdomen
8 which are particularly painful or more so than other
9 areas. That's particularly true of appendicitis.

10 There is an argument that by giving powerful
11 analgesics, the areas of tenderness are not so apparent
12 and therefore it's more difficult to make a diagnosis.
13 The counter-argument is that by giving powerful
14 analgesics, the patient is obviously more comfortable
15 and more relaxed and that if there really is a problem
16 there, it will still be apparent even if there are
17 analgesics on board. In other words, some people argue
18 that it makes the diagnosis easier rather than more
19 difficult.

20 That has changed over the years in that, when I was
21 a student, we were taught that surgical patients should
22 not be given analgesia until they've been assessed and
23 a firm diagnosis has been made, but over the years that
24 view has changed and I think most paediatric surgeons --
25 I can't really speak for adult surgeons, but most

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1 less powerful analgesics, was ... Not unacceptable, but
2 perhaps going a little bit further than was strictly
3 necessary at the time because I don't believe Raychel
4 had had other analgesics such as paracetamol or
5 ibuprofen, which are commonly used in this situation
6 beforehand and they could have been given. Or morphine
7 could have been given by mouth rather than
8 intravenously.

9 Q. The second point is this: in terms of the
10 decision-making around which analgesic to give and in
11 this case the decision to give IV Cyclimorph, is that
12 something that would be better run past a senior
13 colleague as opposed to the relatively junior and
14 inexperienced Dr Devlin making that decision for
15 himself?

16 A. Dr Kelly, I think. Yes, it will obviously depend on the
17 experience of the doctor. In this case, it was the
18 first-line A&E SHO, I think, who saw Raychel. He may
19 have felt himself competent, he may have faced this
20 situation before, I don't know. But generally, because
21 of this difference of opinion amongst surgeons as to
22 what extent it masks the signs, I would think most
23 first-line doctors would want the surgeon, who might be
24 the person doing the operation, to agree to giving the
25 analgesic before doing so.

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1 Q. And it would appear that Mr Makar wasn't consulted
2 in relation to this; the analgesic was prescribed and
3 administered before he attended.
4 Can I move on to a second point that has raised some
5 controversy in, if you like, the preoperative stage, and
6 that concerns the evidence of protein in the urine?
7 That's an issue you have considered.
8 A. Yes.
9 Q. I think you have said at 222-004-003 that:
10 "Children of Raychel's age often complain of painful
11 urination just because they feel unwell without it being
12 indicative of a urinary infection. One or two of
13 protein in the urine may be normal."
14 A. Yes.
15 Q. Then you say -- is it "leukocyte"? Is that how you
16 pronounce it?
17 A. Leukocyte, yes. White cells, yes.
18 Q. "The leukocyte and nitrite tests were negative on both
19 occasions, which virtually rules out a urinary
20 infection. It would therefore be acceptable not to send
21 an urine specimen to the lab."
22 A. Yes.
23 Q. Could I now put Mr Foster's perspective to you? He has
24 said in his report that one sample -- at least one
25 sample -- should have been sent for culture and

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1 they can easily be tested for. Nitrites are a type of
2 chemical that are produced by bacteria when there are
3 bacteria present in the urine and they produce
4 a positive response as well. If both those things are
5 negative, whatever the protein is, that is a very strong
6 indicator that there is no urinary tract infection.
7 Q. Perhaps just to finally deal with this point, if we
8 could just illustrate that by putting the tests up on
9 the screen for you to comment on. 020-015-030. It's
10 a poor copy, Mr Chairman and doctor, but what we can see
11 on this one, this appears to be an urine sample taken
12 just at or about the time she's brought to theatre.
13 There was an earlier one. On this one we see "PRO" and
14 that's 2 plus of protein in the urine.
15 A. Yes.
16 Q. I think you've said that's not an uncommon finding.
17 A. It's not an uncommon finding at all. If I were to find
18 that in a child coming in for some other reason, I would
19 simply repeat it a day or so later and the likelihood is
20 it would have disappeared.
21 Q. And then you say there are a number of more specific
22 tests for the presence of infection. And we see --
23 is that "NIT, negative"?
24 A. "Nitrites, negative."
25 Q. And then "LEU" at the bottom --

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1 microscopy before deciding to operate. He goes on to
2 say that the surgeon here ignored an abnormal urine
3 result and that that, in his view, was bad practice,
4 that this issue should have been further investigated
5 before a decision was made to operate.
6 A. Yes.
7 Q. Is that a view you can understand?
8 A. I disagree with Mr Foster on that specific point. As
9 I said in my report, there are several points here.
10 First of all, to have a small amount of protein in the
11 urine -- 1 plus, 2 plus -- is a very common incidental
12 finding you see in children all the time when you test
13 for it. Often when you test them again later, it has
14 gone away. It comes and it goes. It is not --
15 absolutely not -- diagnostic of a urinary tract
16 infection. In fact, when a child does have a urinary
17 tract infection, frequently there is no protein in the
18 urine, so it is a very, very poor test for that.
19 The urine test that appears to have been used in
20 Raychel's case also contained two other much more
21 specific tests for urinary tract infection, which is the
22 leukocytes -- as you mentioned, that's an indicator of
23 the number of white cells in the urine. When somebody
24 has a urinary tract infection, white cells are excreted
25 from the bladder and kidneys and appear in the urine;

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1 A. -- is leukocytes. I'm not sure what the thing beginning
2 with B is because it's blurred on this. That may be
3 bilirubin. I'm not sure.
4 THE CHAIRMAN: Your point is that in terms of the protein,
5 that's a minimal or a negligible indicator of infection?
6 A. Yes.
7 THE CHAIRMAN: And the other two elements, the nitrites and
8 the leukocytes, are in fact negative?
9 A. They're negative. They're very sensitive indicators and
10 for almost every child with an urine infection at this
11 age, either one of both of those will be positive.
12 THE CHAIRMAN: So that's actually pointing fairly strongly
13 away from infection in your eyes?
14 A. Yes, and I believe there was a repeat test later which
15 showed the same thing.
16 MR WOLFE: This is the later test. If we could please go
17 back one page -- I think it's to page 30 of the
18 sequence.
19 A. Sorry, that was the second test, yes.
20 Q. Maybe it's page 31 I need to go to.
21 THE CHAIRMAN: Page 31 is the first test and 30 is the
22 second test. 020-016-031. If you can highlight the
23 bottom left, please. Thank you.
24 MR WOLFE: Yes. I can't see a time on this, but it would
25 appear to be the earlier one. And following the listing

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1 which is consistent with the later test, we can see
2 1 plus of protein in urine and then we can just see the
3 "T" sneaking out there. That's the "nitrite, negative"
4 and then at the bottom the "leukocyte, negative".
5 A. Yes.
6 Q. And presumably these urine tests are run as an attempt
7 to get a baseline or to identify whether there's any
8 suspicion of infection in the urine?
9 A. Yes. It's routine for children coming into a children's
10 ward with a wide variety of conditions -- certainly
11 abdominal pain would be one of them, but a fever, many
12 other things -- for one of these urine tests to be done.
13 In some situations, if there is an abnormality on this,
14 then the urine needs to be sent to the lab for
15 confirmation because this is just a preliminary
16 screening test. However it's a very sensitive test,
17 which means that if it is negative, the likelihood of
18 finding anything on the full lab test is extremely low.
19 Q. So if you were running these tests, if you saw an
20 abnormal nitrate or an abnormal leukocyte, you'd be
21 wanting to send it off --
22 A. Yes.
23 Q. -- to the lab for urinalysis and culture?
24 A. Yes, absolutely, although I should add that in this
25 case, even if those tests had been abnormal -- and they

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1 if there any bacteria are growing on culture. That
2 takes time.
3 THE CHAIRMAN: So you would only delay the treatment if
4 there was something quite significantly abnormal on the
5 dipstick test?
6 A. Yes. If the clinicians suspect a urinary tract
7 infection, a decision has to be made then whether one
8 starts antibiotic treatment straightaway on the basis of
9 the dipstick test or whether one waits until the
10 confirmatory laboratory test is back and that would
11 depend on many factors, how bad the symptoms were and
12 how confident one was of the diagnosis.
13 THE CHAIRMAN: Thank you.
14 MR WOLFE: The decision to operate, doctor. You've
15 expressed the view that it was appropriate to operate.
16 A. Given the history and the examination findings described
17 both by Dr Kelly and Mr Makar, it sound as if Raychel
18 had fairly typical symptoms of appendicitis. Therefore
19 the decision to undertake an appendicectomy was
20 justified, yes.
21 Q. In your report -- I think I read it out at the start of
22 this segment -- the symptoms were typical:
23 "... typical few hours' pain over the peri-umbilical
24 region, then localising [you say] in the right iliac
25 fossa."

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1 frequently are even when there is no urinary tract
2 infection -- the laboratory result wouldn't have been
3 available for a couple of days anyway, so it wouldn't
4 have had any direct effect on management.
5 Q. Yes. Let me move then along to the decision on
6 management. The decision of Mr Makar was to go to
7 surgery, to perform an appendicectomy because in his
8 view -- and we have seen it in his written witness
9 statement and in his oral evidence -- he thought the
10 factors were there to support an operation that night.
11 THE CHAIRMAN: I'm sorry, just on your last point, doctor,
12 if these results don't come through then, what is the
13 value of the second test or even the first test result?
14 Are these tests really for reviewing after the event
15 rather than --
16 A. The tests that we're seeing in the notes are available
17 instantly. These are quick tests. With a sample of
18 urine, a dipstick, a little plastic stick is dipped into
19 the urine and then put into a device that reads it and
20 provides this printout. That takes less than a minute,
21 it's very quick. If there is an abnormality, then
22 either the same specimen or another specimen is sent to
23 the laboratory. The laboratory will look at the urine
24 down a microscope and make a more accurate count of the
25 whites cells and bacteria in there and subsequently see

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1 And you say:
2 "It's well recognised that even when the appendix is
3 not inflamed, these symptoms can occur. Because of the
4 danger of missing --
5 A. Yes.
6 Q. -- the indicator would be to go to surgery."
7 A. Yes.
8 Q. Could I put Mr Foster's perspective to you? He said
9 that the decision to operate was reached on tenuous
10 grounds. He says that the symptoms were of short
11 duration. Raychel had come home from school that
12 afternoon with some pain, had eaten a meal, her mother
13 encouraged her to go to the toilet. This is all
14 happening around 4 o'clock/5 o'clock. Then a decision
15 is made to bring her to the hospital. Mr Foster then
16 says there are no signs of inflammation, there was
17 normal temperature, normal pulse. Dr Haynes, who's an
18 anaesthetist, has provided a report saying the wisdom of
19 proceeding to surgery so rapidly has to be questioned
20 since she wasn't febrile, her white cell count was not
21 elevated, the pain had decreased. Observations at that
22 time that we're aware of show that the pain was in the
23 region of zero to 1, albeit that that was a reading
24 taken after the Cyclimorph had been administered.
25 So taking all those factors together, each of those

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1 experts have said that the decision to operate was
2 reached in haste and was premature.
3 A. I think, in 2001, things were different to how they are
4 now. There was a tendency to do more operations out of
5 hours at night than is currently the policy. It would
6 have been very common practice for a junior surgeon or
7 middle-grade surgeon to assess a child who came in at
8 that time of night to make a confident clinical
9 diagnosis of appendicitis and decide to take them to
10 theatre that night. There has been a change in policy
11 in that for a number of reasons there is now -- people
12 are more inclined to wait and see whether the symptoms
13 resolve on their own without surgery rather than taking
14 the child to theatre. So that has changed.

15 By what would have been fairly standard practice
16 at the time, what Mr Makar undertook was not unusual
17 and, I think, probably justified by the type of policy
18 that was being adhered to at the time.

19 Q. Was erring on the side of caution and deciding to
20 operate more particular to female patients than male?

21 A. The reason for your question, Mr Wolfe, I think is that
22 if there is peritonitis and if an appendix ruptures and
23 causes peritonitis there is, in theory, a threat to
24 fertility in female patients. I actually don't think
25 that's all that relevant because peritonitis is a fairly

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1 really quite unwell, require more extensive surgery and
2 a much more prolonged hospital stay. There is a risk --
3 the risk is small -- but there is a risk of that
4 happening if an appendix is not removed when it's
5 inflamed.

6 Q. Okay. So the decision is made to operate. Questions
7 have arisen before the inquiry about the process leading
8 to that decision. And Mr Foster again has cited the
9 findings of an NCEPOD report dating from 1989, "Who
10 operates when?". And if I could just put the summary of
11 those findings up on the screen, please? We have them
12 at 223-002-054. Could we just focus on the last of
13 those, the last bullet point:

14 "Consultant supervision of trainees needs to be kept
15 under scrutiny. No trainee should undertake any
16 anaesthetic or surgical operation on a child of any age
17 without consultation with their consultants."

18 If you like, it's a recommendation that applies both
19 to the operator and the anaesthetist. First of all, can
20 I ask you -- you're obviously thinking about these
21 matters from the paediatric medicine side of the house
22 and, to the extent that you can assist us, no doubt
23 you will. What was the status of NCEPOD recommendations
24 in terms of how they affected practice by 2001?

25 A. I'm probably not best qualified to answer that in

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1 unpleasant disease whatever gender you are and worth
2 avoiding, so I don't think that's so relevant, actually.

3 Has that answered your question?

4 Q. It has. And of course we have Mr Makar's evidence,
5 which says that there were various factors to support
6 a diagnosis of appendicitis and to move quickly that
7 night.

8 You have mentioned peritonitis, but what was the
9 risk, if any, of taking some time to review the patient
10 perhaps after the Cycloimorph effects had worn off?

11 A. I think by today's standards, a child such as Raychel
12 presenting with those sorts of symptoms would be more
13 likely to have been left overnight and reassessed in the
14 morning as to whether an appendicectomy was necessary.
15 And there are a number of reasons for that, why these
16 things have changed. However, when that happens, when
17 a surgeon makes a decision not to operate in somebody
18 where appendicitis is a possible diagnosis, they're
19 taking a risk, and the risk is that the condition can
20 develop very rapidly, the appendix can burst, and if the
21 appendix bursts -- and it can be quite difficult in
22 children to assess when that is about to happen. If the
23 appendix bursts then you have a much more unwell child,
24 you have peritonitis, which can cause a lot of
25 complications as I've mentioned and can make the child

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1 respect of the surgical confidential inquiry, which was
2 NCEPOD. If I just mention at the same time, there was,
3 if you like, a paediatric equivalent into unexpected
4 deaths in childhood and in maternity, which I was more
5 involved with, which a great deal of attention was paid
6 to. However, to answer your question, from talking to
7 surgeons I think people did take some account of it, but
8 much less than they do now. I think its status and
9 its ability to affect practice has changed over the
10 years.

11 Q. You have said in your reports for the inquiry that
12 it would have been common practice at the time for
13 junior surgeons at the level of Mr Makar to operate
14 unsupervised and, secondly, so far as the anaesthetist
15 is concerned, Dr Gund, you have found that he appears to
16 have been considered competent to administer a general
17 anaesthetic to a child unsupervised and that this was
18 usual practice at that time.

19 A. Yes.

20 Q. Obviously, these matters can be taken up with the
21 surgical experts and anaesthetic expert which the
22 inquiry's yet to hear from. But if I could ask you
23 this: you say that, in practice, NCEPOD recommendations
24 are more complied with now perhaps than they were.

25 A. Yes, and there are many other reports and policies,

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1 including NICE guidelines, which weren't around at that
2 time, which oblige clinicians to comply in a way that
3 NCEPOD didn't. Everything was optional then.

4 THE CHAIRMAN: So it's not that NICE wasn't there at the
5 time, whereas NCEPOD was there at the time? Why is
6 there more adherence to what NCEPOD recommends --

7 A. I think because the entire National Health Service has
8 become much more orientated towards best practice,
9 towards clinical governance. I could just sum it up in
10 one phrase: clinical governance, which was not widely
11 practised in 2001 in the way that it is now.

12 THE CHAIRMAN: Thank you.

13 MR WOLFE: If I can put this perspective to you: to the
14 extent that the senior clinicians at Altnagelvin were
15 aware of NCEPOD -- and that appears, on the evidence, to
16 be reasonably patchy -- but even if they were aware,
17 presumably it was a matter for the operational
18 discretion of the surgical hierarchy to work out whether
19 any particular operator was competent for the task.

20 A. Yes.

21 Q. Of course, the operator, Mr Makar, has given evidence
22 that he held a conversation or consulted with his
23 registrar, Dr Zawislak.

24 Can I move to the issue of fluid management in
25 Raychel's case because you've offered some comments in

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1 I'd also just like to mention that the difference
2 between 65 ml an hour and 80 ml an hour isn't that
3 great. It's only 15 ml an hour, which is less than
4 a tablespoon full or a few sips, if you look at it in
5 those terms. So in fact the difference in volume is not
6 that great. I think the point about this case isn't so
7 much that it was that there was a difference between the
8 65 and 80; it was that it was continued for so long
9 post-operatively. It's the total quantity given during
10 the day rather than the hourly rate that I think was the
11 problem here.

12 THE CHAIRMAN: So the 65 to 80 wouldn't matter so much or
13 might not matter at all if the rate had been reduced
14 post-operatively?

15 A. Yes. If the rate had been reduced post-operatively or
16 if a different type of fluid had been given, that would
17 be entirely irrelevant, I think.

18 MR WOLFE: Let me move neatly into that post-operative
19 phase. Starting with the preoperative prescriber, he
20 has given evidence that his prescription was intended --
21 and strictly intended -- for the preoperative phase.
22 But of course, post-operatively the same fluid and the
23 same rate was used, so Raychel receives Hartmann's
24 solution intraoperatively and is reconnected
25 post-operatively to the Solution No. 18 at a rate of

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1 your report in respect of that? With regards to
2 preoperative fluids, we know that by applying any of the
3 battery of formulae that are available for calculating
4 rate and volume that Raychel, applying that strictly,
5 should have been given 65 ml per hour: do you agree with
6 that?

7 A. Yes.

8 Q. However, Mr Makar prescribed 80 ml per hour and he has
9 explained that he gave this extra because of a number of
10 factors, including the fact that Raychel had been
11 fasting since at or about 5.30, because of a concern
12 in relation to the ambient temperature of the ward,
13 which might affect her in terms of dehydration, and
14 thirdly, he thought that in any event the fluids that
15 he was prescribing were likely to be of short duration.
16 This was 10 o'clock at night and it was likely, in his
17 mind, that she'd be going to theatre within a short
18 period of time. Have you thought about the evidence
19 that he has given?

20 A. Yes. I think there is some justification for him giving
21 a little more than what would be the standard
22 maintenance amount of fluid. This is done not
23 infrequently. The business of going to theatre, having
24 an operate, does lead to fluid losses, as I'm sure he
25 explained.

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1 80 ml an hour, and it stays in place even to the point
2 of post-seizure, when her fluids were changed at or
3 about 5 am on 9 June.

4 THE CHAIRMAN: Can we just pause one moment, Mr Wolfe?

5 I think this is clear, but I think we should have it
6 because you're moving on to post-op fluids -- we should
7 have it on the record. It's quite clear from your
8 report, doctor, but just for the record, there is no
9 criticism of the conduct of the surgery itself. It was
10 a standard appendicectomy, which was perfectly well
11 performed.

12 A. Yes. I'm not a surgeon, so I can't really comment on
13 surgical technique, but as far as I can tell from the
14 records, there was no problem with that.

15 MR WOLFE: Mr Chairman, that helpfully reminds me of just
16 one point I wanted to raise with the doctor, arising out
17 of that, if he can help us at all.

18 The surgical report, which is in the papers at
19 020-010-018, says that the operation was performed. It
20 was an appendicectomy and the findings were
21 a mildly-congested appendix and a faecolith, then the
22 "peritoneal clean fluid reaction [sic]". What is the
23 significance of the finding of a faecolith?

24 A. Again, I'm probably not best qualified to deal with this
25 because that's something that surgeons deal with, but

24

1 that's a tiny amount of faecal material that has got
2 lodged in the appendix, which can be entirely benign.
3 It may not, I believe, cause any symptoms at all and is
4 frequently an incidental finding when an appendix is
5 removed.

6 Q. And the finding of a mildly-congested appendix, I think
7 you have said in your report -- correct me if I'm
8 wrong -- that with the benefit of that hindsight, an
9 operation may not have been strictly necessary, but the
10 finding of simply a mildly-congested appendix is only
11 something you can find after the operation.

12 A. Yes. The diagnosis of whether the appendix was inflamed
13 or not is based on the histology report. Surgeons will
14 quite often make a sort of rapid diagnosis just from
15 looking at the appendix as to whether they think it was
16 inflamed or not. In my experience, this is quite often
17 wrong and the histology frequently fails to confirm the
18 surgeon's initial impression as to whether the appendix
19 was inflamed or not. The surgeon will take the appendix
20 out anyway because it's an unnecessary organ, so in fact
21 what the surgeon's impression of whether it was inflamed
22 or not is to some extent irrelevant in terms of what
23 they do at the time.

24 Q. If this wasn't strictly speaking an appendicitis then,
25 can you help us at all in terms of what the alternative

25

1 a possibility of appendicitis are referred to hospital
2 and frequently admitted overnight in order to see
3 whether they develop into a more classic signs of
4 appendicitis where they might justify an appendicectomy.
5 So to answer your question of what the alternative
6 diagnoses are, many of these children don't really end
7 up with a very firm diagnosis. We have a term that
8 encompasses these, which is often referred to as
9 non-specific abdominal pain or idiopathic abdominal pain
10 of childhood, which isn't really a diagnosis; it is
11 a non-diagnosis, in a way, that you haven't found
12 anything else the matter.

13 There is another diagnosis that's sometimes used,
14 which is mesenteric adenitis. That refers to inflamed
15 lymph nodes within the abdomen, but not in the appendix,
16 which can often coincide with appendicitis. It's
17 sometimes possible to feel these or to find them on an
18 ultrasound scan. It's benign, it doesn't require
19 surgery, it's often caused by a virus infection and it
20 gets better. So mesenteric adenitis is another
21 diagnosis that's sometimes used. Much more rarely there
22 are other more serious diagnoses, of which there's
23 a long list, that can cause abdominal pain in children,
24 most of which are of a medical rather than a surgical
25 origin and require various investigations and treatment.

27

1 diagnosis for her symptoms might properly be?

2 A. This is extremely common. One of the commonest reasons
3 for children of any age, but particularly this age, to
4 be admitted to a children's ward anywhere in the country
5 is abdominal pain. One of the commonest reasons for GPs
6 to send children up for assessment is they present with
7 abdominal pain and the GP is concerned they might have
8 appendicitis or, much more rarely, some other acute
9 surgical problem. The majority of children that come to
10 hospital with abdominal pain, with suspected
11 appendicitis, do not have appendicitis. The problem
12 is that it's very difficult to make a firm clinical
13 diagnosis or sufficiently confident clinical diagnosis
14 to rule it out when they are first seen. And even after
15 the second and third examination, it can still sometimes
16 be difficult. To make it more difficult, the
17 investigations -- as we have already heard in this
18 inquiry -- often don't help. One will frequently do
19 blood tests, urine tests, but often they are
20 non-specific or completely normal and the normal tests
21 do not rule out appendicitis.

22 This really hasn't changed in the last 30, 40 years.
23 Appendicitis has always been a difficult clinical
24 diagnosis, even with modern technology. So for that
25 reason, many children with abdominal pain where there's

26

1 Q. Very well, thank you. That's very helpful.

2 Moving back to the post-op fluids, if we would. In
3 your report, you have noted what you've described as
4 an important point of confusion. If I could take
5 a little time to define that and you can say whether you
6 agree with me. It appears that Dr Gund, as we reflected
7 earlier, had written a prescription that was struck out.
8 He says it was struck out because he was told that, as
9 anaesthetists, they shouldn't be writing for the
10 post-operative phase, that this issue of post-operative
11 fluids would be looked at on the ward and he assumes
12 that a doctor would attend to Raychel. Whereas in fact
13 what happened was that no prescription was issued, the
14 nurses picked up the preoperative prescription and
15 continued with the fluids as they were preoperatively.
16 Is that the confusion you were thinking about?

17 A. Yes. Would it be possible just to bring up my report?

18 Q. Of course, I can do that for you. It's 222-004-005.

19 A. Could you just go back to the previous page, please?

20 THE CHAIRMAN: Or put the two pages together.

21 A. Yes.

22 MR WOLFE: The confusion point you can see at the top of
23 2(h). I'm going to come back and ask you a question
24 about 2(f), but if you could just help us with the
25 confusion point and why that was significant.

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1 A. The confusion as to whose responsibility it is to
2 prescribe the post-operative fluids?
3 Q. Yes.
4 A. This, I think, was not unique to this case or to
5 Altnagelvin. I think this happens not infrequently in
6 surgical children.
7 Q. Yes. You've said -- this is at 2(h) again -- that:
8 "In [your] experience, the post-op fluid regime
9 prescribed by the anaesthetists [that's presumably
10 intraoperatively] is continued for the initial few
11 hours, perhaps 4 to 6 hours, until the bag runs out."
12 That's your broad experience; is that right?
13 A. Yes.
14 Q. And then:
15 "In [your] experience, the nurses would normally
16 request one of the ward doctors to prescribe more fluids
17 if necessary or take the decision that IV fluids were no
18 longer necessary."
19 THE CHAIRMAN: When you say "ward doctors" there, is that
20 surgical doctors or paediatricians or either?
21 A. That statement was intentionally vague because the ward
22 doctor would depend on what the policy was on each
23 individual ward. In many departments it would be the
24 surgical doctors, in some it might be the paediatric
25 doctors. By that stage, it would probably not be the

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1 re-adjust the fluid rate given that the child was having
2 no significant oral intake. And I would imagine that
3 that was fairly prevalent at the time. There was less
4 understanding then, as you will be well aware, of the
5 issues with excessive fluid given post-operatively.
6 I think in most hospitals for a child who was not taking
7 in oral intake at the time, people would not have
8 reduced the IV fluids just because of an awareness of
9 increase in ADH secretion, reducing urine volume. They
10 might have been adjusted on the basis of abnormal blood
11 tests, which is what should have been done.
12 THE CHAIRMAN: Just before we get to that, there's a number
13 of issues there, but one of them is: should the rate of
14 fluid have been reduced after the operation anyway? Do
15 I understand that you agree that it should have been
16 reduced? 80 was to allow for losses during the
17 operation.
18 A. It was, yes.
19 THE CHAIRMAN: So post operation, do you agree that it
20 should have been reduced?
21 A. Well, it depends what you mean by "should have".
22 Physiologically, it should have been because the
23 requirement was less. In terms of local procedures and
24 practice, there was nothing in place that would have
25 reminded or prompted the doctors to take that action.

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1 anaesthetists because they would mostly only be
2 responsible for the immediate post-operative fluids.
3 THE CHAIRMAN: Thank you. So that depends on local
4 arrangements?
5 A. Yes.
6 MR WOLFE: Could I reflect to you a perspective that has
7 been put forward by a number of experts, including
8 Mr Foster and Mr Orr, whose report I understand
9 you haven't seen, but I can summarise the perspective?
10 That is that in the post-operative phase, there is
11 a requirement to consider the child's fluid needs
12 because it's different, potentially different, from the
13 preoperative phase. And the expectation is that you
14 would reduce intravenous fluids post-operatively,
15 primarily to take account of the increase in secretion
16 of antidiuretic hormone, which is a feature of surgical
17 patients.
18 A. Yes. In most cases what would have happened in the
19 immediate post-operative period after an appendicectomy
20 is that the child would have improved, would have
21 started drinking and the drip rate, the intravenous
22 infusion rate, would have been turned down as a result
23 of the child's improvement. Whereas, as in this case,
24 they didn't improve, there probably wouldn't have been
25 sufficient awareness and insight into the need to

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1 It wasn't standard practice in children at the time to
2 automatically reduce fluids post-operatively unless
3 there was some other indication.
4 MR WOLFE: Just pause there. So what you appear to be
5 saying is that Mr Foster and Mr Orr are absolutely
6 right: physiologically, the fluids should have been
7 reduced post-operatively.
8 A. Yes.
9 Q. Preoperatively, the fluids are deliberately too high.
10 Post-operatively, the theory is absolutely right: they
11 should have been reduced.
12 A. Yes.
13 Q. But what you're saying is that the local knowledge in
14 very many units in your experience just wasn't there to
15 do that, so the practice was perhaps to continue at the
16 preoperative rate?
17 A. Yes. That would have been standard practice in many
18 units, I believe, at the time.
19 Q. The experience that you have reflected, of course,
20 is that post-operatively, for 4 to 6 hours or until the
21 bag runs out, the fluid that was used was the
22 intraoperative fluid, which would in this case have been
23 Hartmann's.
24 A. Yes.
25 Q. So it appears that the local regime in Altnagelvin in

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1 the way it worked on the ground was, unless the
2 anaesthetist wrote for the continuation of Hartmann's,
3 they moved to Solution No. 18 at the preoperative rate.
4 Can I ask you this: does that approach then jar with
5 your experience, which is that the anaesthetist's fluid
6 should continue?
7 A. Well, there's really two separate questions there.
8 There's the type of fluid and there's the rate of fluid.
9 To deal with the type of fluid, for traditional
10 reasons -- and I'm not entirely sure why this is -- but
11 Hartmann's is used frequently in theatres, but rarely
12 used on the ward. Anaesthetists use it, paediatricians
13 don't. We almost never use it for paediatric medical
14 patients, and that just seems to have been custom and
15 practice for many years.
16 Then there probably would have been no bags of
17 Hartmann's actually available on the ward, I guess. The
18 question is --
19 THE CHAIRMAN: There was one, but it was in case rather than
20 the standard -- it certainly was not the standard.
21 A. It wouldn't have been and I doubt on my ward there would
22 have been bags of Hartmann's available. One could have
23 get them, of course, but it wasn't standard practice.
24 The question is: should it have been changed from
25 Solution No. 18 to a more isotonic solution? Well, this

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1 THE CHAIRMAN: Then the point that you mentioned in
2 passing -- and we'll come on to later -- is that the
3 bloods should have been checked?
4 A. Yes.
5 THE CHAIRMAN: Which didn't happen?
6 A. Yes.
7 THE CHAIRMAN: And that should have come about because of
8 the vomiting or the prolonged vomiting --
9 A. Because of the prolonged vomiting, yes.
10 THE CHAIRMAN: -- which you're not really sure was actually
11 post-operative vomiting at all? I think you suggest
12 that there might have been other causes for the
13 vomiting.
14 A. There could have been many other causes, yes.
15 MR WOLFE: You've said 80 ml an hour may not have looked
16 terribly abnormal. Of course, if there had been an
17 understanding of the physiological need to reduce
18 maintenance by -- from what Mr Foster says -- something
19 in the order of 20 per cent, bringing it down to 52 or
20 54, as compared to the 80 for maintenance, a difference
21 of that degree should have appeared abnormal if there
22 was an understanding of the physiology.
23 A. You're right, it should have done, but there was not
24 anywhere, I think, a widespread understanding of that
25 physiology.

35

1 is the entire crux of this inquiry, of course, and
2 of course, again, the answer is, physiologically, yes,
3 it should have been, but the standard practice at the
4 time at Altnagelvin -- as with almost every other
5 hospital in the UK, I believe -- was to use
6 0.18 per cent or Solution No. 18 as the standard fluid
7 for children for reasons that I think you may have
8 already heard about.

9 So what the staff did was standard practice. In
10 terms of the rate of infusion, yes, I would agree that
11 some attention maybe should have been given to reducing
12 the rate of infusion because children need more when
13 they're actually in surgery and in the very immediate
14 post-operative period than they might do afterwards.
15 But the difference between what she was given and what
16 she would have been given in terms of hourly rate wasn't
17 that great, and so any doctor or nurse looking at an
18 infusion rate of 80 ml an hour, it wouldn't have
19 appeared on the face of it to be very abnormal.

20 In other words, you would have had to have got
21 a calculator out to work out whether it was wrong or
22 not; it wouldn't have been instinctively wrong. If,
23 say, she had been getting 120 or 150 ml an hour,
24 somebody would have thought, "That seems an awful lot",
25 but for 80 ml an hour, not really.

34

1 Q. Could I ask you another question just about process and
2 fluids post-operatively? It would appear on Dr Gund's
3 account that his expectation was that the child would
4 be, if you like, assessed or examined on the ward when
5 she got out of recovery for the purposes of
6 post-operative fluids going forward, and of course that
7 didn't happen. There was the ward round, which we will
8 come to in a moment, but in terms of Raychel being
9 released from recovery at or about 2 am and going to the
10 ward, it was 6 or perhaps 7 hours before her fluids were
11 looked at again by a doctor.
12 A. Yes.
13 Q. Could you comment on that? Was that poor practice?
14 A. It was not ideal practice, but I can imagine that a very
15 similar thing would have happened in many children going
16 to theatre at night for an appendicectomy. It's
17 unlikely that their IV fluids would have been reviewed
18 by anyone in the middle of the night until the ward
19 round in the morning. Certainly the concept of reducing
20 fluids post-operatively because of more ADH being
21 secreted wouldn't have occurred to anyone to have
22 adjusted the fluids because of that in the first maybe
23 six to eight hours post-operatively.
24 Q. Let me move then to the ward round briefly, please.
25 You have commented in your report that the ward round

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1 conducted by Mr Zafar, the surgical senior house
2 officer, was not untypical of your experience of your
3 surgical colleagues.
4 A. Yes.
5 Q. You say:
6 "Routine surgical ward rounds are usually rapid as
7 most of the patients are straightforward and decisions
8 are simple. As they usually occur at the same time each
9 day, a timing in the notes is generally unnecessary."
10 You go on to say that there's often time pressure to
11 see all the ward patients early in the morning because
12 of a full day's operating list:
13 "Surgeons will often rely on a quick report from the
14 nurses on the patients' condition without necessarily
15 consulting all of the charts."
16 So that's your experience of a surgical ward round?
17 A. Yes. Surgical ward rounds are very different to medical
18 ward rounds. In a medical ward round it is the main
19 business of the day, that's what we do, and we spend
20 longer going through the notes, seeing the patients,
21 examining them, speaking to them, and so on. For the
22 surgeon, it is just something that has to be fitted in
23 around everything else they do because the great
24 majority of post-operative surgical patients,
25 particularly children, do very well, don't require that

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1 took it over with her nurses -- that during the course
2 of the morning Raychel should start sipping and, as she
3 sipped and absorbed those fluids orally, then the
4 IV fluids could be reduced and eventually stopped.
5 A. Yes.
6 THE CHAIRMAN: That must happen hundreds of times for
7 children after appendicectomies.
8 A. It's absolutely standard procedure for children after
9 appendicectomies and the nurses would normally be given
10 the discretion to reduce the IV fluids as they saw fit
11 as the child tolerated oral fluids without necessarily
12 a doctor being involved.
13 THE CHAIRMAN: So although one could say: well, it would
14 have been better if he had written something formally,
15 in reality that would not have guided the nurses any
16 more than they were guided by what he said orally.
17 A. Yes, that's correct. I think an experienced paediatric
18 nurse should be able to make her own judgment to the
19 extent to which the IV fluids could be reduced.
20 MR WOLFE: You have commented specifically in your report
21 in relation to the non-attendance of Mr Gilliland, the
22 consultant under whose care Raychel was admitted. At
23 222-005-005 of one of your reports, you say:
24 "In my view, his non-attendance, by the standards of
25 the time, was acceptable practice."

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1 much attention; they just get better, recover from their
2 surgery and go home. So there are usually fewer
3 decisions to be made and less to be done on a surgical
4 ward round compared to a medical ward round.
5 Q. Could I ask you a number of specifics about this?
6 Mr Zafar attended. His advice it appears, in the round,
7 was Raychel should have sips of fluid orally, and then
8 if she's tolerating that, then you can proceed to reduce
9 intravenous fluids.
10 A. Yes.
11 Q. Is that typical advice?
12 A. Absolutely typical. That's exactly what you would
13 expect a surgeon to say on the first day post-operative
14 ward round for a child who had had a straightforward
15 appendicectomy.
16 Q. Applying general medical practice, is that plan for
17 fluids something that should have been recorded by him?
18 A. Yes, it would have been best practice to record
19 something in the notes to that effect, yes.
20 THE CHAIRMAN: But I think, to be fair to him, the note
21 would have been almost equally vague, wouldn't it?
22 A. Yes.
23 THE CHAIRMAN: It wouldn't say, "Reduce fluids by 11 am",
24 or, "Reduce fluid by 50 per cent by midday". The plan
25 was -- and was clearly understood by the sister who then

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1 This was a child who had been admitted overnight
2 under the care of a consultant and had intra-abdominal
3 surgery. Was it satisfactory by the standards of the
4 time that she would be seen by a senior house officer
5 without a registrar, without a consultant?
6 A. Well, again, like many issues here, this is something
7 that it's easy to criticise judging by today's
8 standards, and certainly today I think all children
9 would be at least discussed and the greater majority
10 seen either by a consultant or a senior surgical trainee
11 and I believe that most surgical departments that see
12 both children and adults would prioritise the children
13 over the adults if there were a lot of patients to see,
14 given that the juniors may have had less experience with
15 children than they have with adults. In this case it
16 appears that the opposite happened and the consultants
17 saw the adults and the more junior surgeons saw the
18 child. But that would have been common practice at the
19 time, yes.
20 Q. Could I touch on one point that you might help us with?
21 You've reflected your experience on the difference
22 between a paediatric medical ward round and the
23 surgical. The paediatric ward round more intensive, it
24 was the work of the day.
25 A. Yes.

40

1 Q. The inquiry's heard evidence that in Altnagelvin one of
2 the staples of the day for a child being on intravenous
3 fluids on the paediatric medical side was an electrolyte
4 profile, whereas on the surgical side if a child was on
5 intravenous fluids, electrolyte profiling would rarely,
6 if ever, be done.
7 A. Do you mean in an adult on the surgical side?
8 Q. On children's surgery.
9 A. I see what you mean. So comparing a medical child of
10 the same age on IV fluids as against a surgical child on
11 IV fluids? Clearly, if a medical child comes in and
12 requires IV fluids, they've got a condition that has
13 required them to need that. Most commonly
14 gastroenteritis, but many, many other things as well.
15 And one would most often be doing bloods to monitor the
16 progression of the underlying condition with which they
17 came in as well as checking their electrolyte status as
18 a consequence of them being on IV fluids. So one would
19 have really two reasons. For a child that is a simple,
20 straightforward surgical case, because the diagnosis has
21 been made and the treatment has been already given,
22 doing bloods in order to help with diagnosis is
23 unnecessary, and therefore the only reason to do bloods
24 is to monitor their hydration, their response to
25 IV fluids. So it's not quite a fair comparison in that

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1 investigate electrolytes?
2 A. Yes.
3 Q. And we'll look at whether the factors were in place in
4 Raychel's case as we move through your evidence for
5 conducting electrolytes.
6 Just moving along the chronology, Raychel, the
7 evidence shows, suffered a vomit at 8 o'clock. It's
8 unclear whether Mr Zafar was aware of that. She
9 suffered a further, a large vomit at 10.30, and on her
10 mother's account, vomited undigested food at midday,
11 a vomit that has not been recorded in the fluid balance
12 chart. The fluids have continued to run at 80 ml per
13 hour and, at or about 12 o'clock, the nurses recognised
14 that the bag is about to run out and that, given the
15 presence of vomiting, she's going to need further
16 IV fluids.
17 With that context, I want to ask you some questions
18 about Dr Butler, who attended, and she was a senior
19 house officer on the paediatric side, so I think this is
20 the first paediatrician, if you like, that I'm going to
21 ask you to comment on. In your report -- and if I could
22 have it up on the screen, please, at 222-004-023 --
23 you have commented on the role played by Dr Butler;
24 isn't that right?
25 A. Yes.

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1 there are other reasons for doing blood tests in medical
2 children on drips than there are in surgical children.
3 Q. Yes. You do refer in your report to a practice --
4 I hesitate to call it a 24-hour rule, but a practice
5 which seemed to be in play at the time that if a child
6 on intravenous fluids is still on intravenous fluids
7 after 24 hours or so, the practice ought to have been to
8 conduct electrolyte profiling. Could I perhaps have
9 that up on the screen, please? 222-004-019. It is your
10 answer to question 2.2.
11 A. Yes. This was custom and practice and has been,
12 I think, for many years, long before 2001, that after
13 24 hours there is a greater likelihood of there being an
14 abnormality in the urea and electrolytes that requires
15 some change in the IV fluid regime. But as I've said
16 here, that is not a rigid threshold. There may be many
17 reasons why you'd want to do it before 24 hours, and in
18 particular if 24 hours happens to fall in the middle of
19 the night when the child's sleeping, it's not very nice
20 to wake them up just to do a blood test when it probably
21 should have been done earlier in the evening rather than
22 later.
23 Q. And of course, short of 24 hours, if a child is, for
24 example, vomiting or has diarrhoea, or what have you,
25 that might cause a conscientious practitioner to want to

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1 Q. And I think it's in answer --
2 THE CHAIRMAN: I think it's 009, 222-004-009.
3 A. Yes that's the one.
4 MR WOLFE: I must have had some rogue referencing. You say,
5 doctor, that:
6 "It's a very common situation on any children's ward
7 that a passing doctor will be asked by the nursing staff
8 to write up routine prescriptions."
9 A. Yes.
10 Q. And indeed, that appears to be the picture that has
11 emerged in this case. Dr Butler has had no previous
12 dealings with Raychel's case and is passing through,
13 perhaps dealing with other paediatric medical patients,
14 and she's grabbed, if that's not too indelicate
15 a phrase, by a nurse.
16 A. Yes.
17 Q. What in your experience would you expect of the trainee
18 paediatrician in those circumstances when asked to renew
19 the prescription or continue the prescription for
20 intravenous fluids?
21 A. Well, I think this is very difficult. Can I just give
22 you an impression of how the average children's ward
23 functions in order to answer that question?
24 Q. Sure.
25 A. The majority of patients on any children's ward in

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1 a hospital like this, where there's only one children's
2 ward, will be medical. The paediatric staff will be
3 there virtually the whole day. The nurses will know
4 them as well. They'll know them personally, they'll
5 know them by name. The surgical teams will be much less
6 involved. There may be many different surgical teams --
7 because there's not just general surgeons, there's
8 orthopaedic, ENT, et cetera, et cetera; there'll be many
9 different surgical teams -- and the most accessible
10 doctors to the nurses will always be the paediatric team
11 at any level, whether from SHO right up to consultant.

12 Surgical doctors can sometimes be difficult to get
13 hold off for very good reasons because they may be in
14 theatre, but even if they're not in theatre, they will
15 be tied up with adults in a different part of the
16 hospital, which may be a long way away and they may be
17 extremely busy dealing with very sick adults on the
18 surgical side and the children's ward is often quite
19 a long way down their list of priorities. Part of the
20 reason the children's ward is a long way down the list
21 of priorities is perhaps, to some extent, they rely on
22 their paediatric colleagues to do these minor tasks,
23 these little things, for them without them having to
24 spend a lot of time going there just to simply write up
25 a simply prescription or carry out some fairly minor

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1 questions, she could perhaps have glanced at the notes
2 and she could maybe have briefly examined the patient
3 and that would have been ideal best practice, but the
4 everyday practicality is that that can't happen.

5 Q. So what you're balancing is practicalities with, if you
6 like, theoretical good practice?

7 A. Yes.

8 THE CHAIRMAN: In essence, there wasn't anything which was
9 so obviously wrong with Raychel at about midday that
10 Dr Butler might have been expected to do more?

11 A. Well, that depends on what she was told by the nurses
12 and I know this is something else that you have
13 discussed in this inquiry. But if she was told by the
14 nurses that it was all straightforward, straightforward
15 post-appendicectomy, not yet drinking enough oral fluids
16 to come off the drip, surgeons are busy, please could
17 you just continue the fluids, there would have been an
18 element of trust on Dr Butler's behalf that her
19 colleagues who had written up the original infusions had
20 got the numbers right. One wouldn't necessarily have
21 expected her to get out a calculator and recalculate the
22 amount. That, I think, is reasonable, although ideally
23 one could argue she should have done, I think it is
24 excusable that she didn't.

25 MR WOLFE: There's briefly a second point, and I think

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1 task. That is how children's wards tick over. I think
2 they always have done and they continue to do to this
3 day.

4 This then leads to difficult questions of
5 responsibility and accountability, this sort of thing,
6 not just for IV fluids but many other things as
7 well: taking blood tests, resiting cannulas, prescribing
8 analgesia, pain relief, prescribing antibiotics, and
9 many other routine tasks that have to be done. Not
10 making big decisions, but just doing the routine tasks
11 that the junior doctors do all day and every day.

12 If one were to institute a universal rule that no
13 prescription, procedure or anything could ever be done
14 on a surgical patient except by a surgical doctor, that
15 would be highly disruptive to the running of every
16 children's ward in the hospital, and I think that's
17 an important point.

18 So although in theory accountability should be
19 hierarchical in that each patient is under a consultant
20 and that consultant's team, in practice it doesn't work
21 like that. So I think in this particular case,
22 Dr Butler was entirely -- her behaviour was entirely
23 excusable in doing what the nurses asked her to without
24 going into a lot of detail on a patient she didn't know.

25 One could say, yes, she should have asked a few

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1 you've captured Dr Haynes' criticism there that -- I'll
2 move on to the second point in a minute, but just to
3 have it on the record: Dr Haynes makes the point that
4 it is his expectation that the majority of paediatric
5 trainees, medical trainees, would get the calculator out
6 and assess accurately the fluid prescription before
7 writing it and if that had been done, he says, then the
8 excess of rate might have been identified.

9 A. The majority -- I don't know. Some would, some
10 wouldn't. It would depend on how busy they were,
11 it would depend on to what extent they trusted their
12 colleagues who had written up the original prescription.

13 Q. There is a second point which I said I would come on to.
14 That is, by this stage, taking all of the evidence
15 in the round, Raychel had vomited three times: two that
16 are recorded, and one noted by the mother, which isn't
17 recorded. So if those three vomits happened, is the
18 basis for the question: if she had been told that,
19 is that the kind of feature that ought to have triggered
20 contact with the surgical team by the junior
21 paediatrician?

22 A. Well, if she had been told that, it could have justified
23 continuation of the IV fluids because the usual decision
24 to make -- in fact more often, if one is asked as
25 a paediatrician to write up fluids for a surgical

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1 patient, usually the question one asks is: do they
2 really need it? Are they drinking enough now to
3 actually come off the drip? So had Dr Butler been told
4 that, her decision might have been, "Oh well, that
5 actually is a good reason to continue the IV fluids".

6 The other question of whether because Raychel by
7 this stage was vomiting was sufficient for her to tell
8 the nurses to contact the surgical team for that reason
9 is really a different question. By midday, which was,
10 what, about 12 hours post-op, it's arguable whether that
11 was long enough after the operation to cause concern or
12 not.

13 THE CHAIRMAN: If it's arguable, that means you're beginning
14 to get into the timescale for bringing in the surgical
15 team.

16 A. Yes.

17 MR WOLFE: We will, in a short while, move on to what can be
18 said about whether and at what time Raychel's condition
19 ought to have attracted concern, but just one further
20 fluids point, if we can, before we move on. In your
21 reports you've reflected upon the fact that you haven't
22 been presented with any written document giving guidance
23 on the prescription of IV fluids that might have been
24 applicable at Altnagelvin at that time. And you say
25 that that was not untypical of most NHS hospitals at the

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1 say:

2 "However, in this case it would have required
3 someone to make an estimate of the volume of Raychel's
4 vomits to enable this to happen. This was not done --"

5 And then you surmise, if I'm right:

6 "-- because none of the staff considered them large
7 enough to justify it."

8 A. Yes.

9 Q. That's a point I want to come back to, but can I tidy up
10 the textbooks you cite? If I can go to 008 of this
11 document. Those are the references and a brief
12 quotation from each. The Lecture Notes on General
13 Surgery; just on that, is that a standard publication
14 used by surgeons?

15 A. The Lecture Notes on General Surgery is actually the
16 standard student textbook, not even a postgraduate
17 textbook, so that is a very sort of basic level
18 textbook, which was I was able to find an edition dating
19 from before that time. I think that one would have
20 found similar advice even in older textbooks than that.

21 Q. And I think Mr Foster deals with that in his report.

22 What the Lecture Notes publication contains is:

23 "Any additional losses should be replaced. For
24 example, excessive drainage from a naso-gastric tube
25 should be replaced intravenously by a similar amount of

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1 time.

2 A. Yes.

3 Q. You then go on to deal with what Mr Gilliland says at
4 page 17 of his second statement. I don't need it up on
5 the screen, but what he says is that:

6 "An estimation of the amount of vomiting and
7 replacement of that fluid with 0.9 per cent saline or
8 Hartmann's would have been better management."

9 You examined that. If we could have up on the
10 screen, please, 222-005-005. At the very bottom of the
11 page, what you say is:

12 "However, neither an estimate of the volume of
13 vomiting nor the use of high solute-containing fluids
14 was common practice in the paediatric surgical unit at
15 Altnagelvin at that time."

16 I think that's citing what Mr Gilliland says, just
17 to put it in context.

18 A. Yes.

19 Q. You go on to say:

20 "The practice of replacing gastric losses millilitre
21 for millilitre with normal saline rather than hypotonic
22 solutions was well established long before 2001, at
23 least in children. This is mentioned in standard
24 textbooks used widely at the time."

25 Then you cite those textbooks. And you go on to

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1 normal saline or hyponatraemia and metabolic acidosis
2 are likely to develop."

3 And then Sabiston, "A Textbook of Surgery",
4 a typical textbook of that time; is that right?

5 A. Yes.

6 Q. "GI losses are usually isotonic or slightly hypotonic
7 and are replaced with an essentially isotonic solution."

8 So going back then to 005 in the sequence, what you
9 appear to be saying, doctor, is that, first of all,
10 steps have to be taken, is that right, to identify --

11 A. Yes.

12 Q. -- gastric losses or an electrolyte imbalance?

13 A. Yes.

14 Q. And once that's done, then the job of the clinician is
15 to work out how to replace those losses?

16 A. Yes. If I can just go a step back. It has been
17 standard teaching and practice for many years before
18 this, that where a child has had more major surgery than
19 we're talking about here -- major bowel surgery or
20 a situation where the intestine doesn't work at all for
21 a few days -- to put a naso-gastric tube down and then
22 to aspirate the tube, that is suck the stomach contents
23 out of the tube. There are two reasons for doing that.
24 One is to stop the child vomiting -- this is where the
25 fluid from the stomach doesn't empty down into the

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1 intestine because the intestine isn't working. So if
2 you don't do that, the fluid will accumulate in the
3 stomach and the child will vomit, which is unpleasant
4 for the child. But also, when a child vomits, it's very
5 difficult to quantify how much because it goes all over
6 the place. By putting a naso-gastric tube down --
7 although putting the tube down is a thoroughly
8 unpleasant procedure -- once the tube is down, it
9 actually makes the child more comfortable and one can
10 then quantify the amount of stomach fluid.

11 Gastric fluid varies in its composition, but it
12 contains a much higher proportion of electrolytes than
13 other types of fluid loss, and so although the child
14 might be losing fluids from various mechanisms, gastric
15 losses are particularly high in sodium and chloride and
16 therefore it has been recognised for a number of years
17 that part of the fluid loss when one is estimating how
18 much fluid needs to be replaced, that part of the fluid
19 loss should, even back then, have been replaced with
20 normal saline as opposed to a hypotonic fluid. The
21 problem in a case like Raychel's is, of course, there
22 was no quantification of the quantity of gastric losses.
23 I think it was justified not to put a naso-gastric tube
24 down, but we can come on to that in a minute. Where
25 there isn't a naso-gastric tube, staff tend not to

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1 they should have known about it and where there was
2 a need to replace, the appropriate replacement was
3 a higher-solute fluid?

4 A. Yes.

5 Q. Just over the page, there's a point I wanted to pick up
6 on before we move on to Raychel's condition. That is
7 where you say, before we move on to Mr Zawislak:

8 "In this case it would have required someone to make
9 an estimate of the volume of Raychel's vomits to enable
10 this to happen. This was not done because none of the
11 staff involved considered them to be large enough to
12 justify it."

13 A. That's an assumption on my behalf. That may not be
14 true, actually. That was my assumption.

15 Q. Can I ask you about that in these terms, while
16 recognising that you might be speculating: the degree of
17 vomit that was reflected on paper by the nurses was not
18 an accurate reflection of the number of vomits that
19 there were, and I think the evidence on that before this
20 inquiry is fairly clear. So on the one part, you have
21 Dr Devlin reporting a vomit at or about 6 o'clock that
22 isn't recorded and you have Staff Nurse Gilchrist
23 reporting that she has cleaned the bedclothes or changed
24 the bedclothes at or about 8 o'clock and that vomit
25 wasn't recorded. But apart from that and going back

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1 quantify the vomit. That is a fairly general failing
2 in that, for very obvious practical reasons, it's
3 difficult to do it. But there probably should be
4 generally -- and certainly in this case -- a greater
5 attempt to quantify the amount, how many millilitres of
6 vomit have been lost. It is difficult.

7 Q. Yes. Just going back to the replacement issue, where
8 Mr Gilliland is reflecting the view that replacement
9 with 0.9 or with Hartmann's wasn't common practice
10 at the time in Altnagelvin, are you saying that their
11 practice was out of step with teaching that had been in
12 place for many, many years?

13 A. I'm not sure what he meant by that, and it's something
14 you may need to ask him. When he says "it wasn't common
15 practice", what he might mean is that they didn't have
16 many of the types of children that required that sort of
17 treatment because they were treating fairly simple,
18 straightforward cases. In other words, a child who had
19 a much more severe and complicated surgical case would
20 presumably have been transferred to Belfast and they
21 wouldn't have managed them and therefore the staff
22 wouldn't have been so accustomed to that procedure of
23 giving normal saline replacements. So that may be what
24 he means by that rather than they didn't know about it.

25 Q. But what you're saying is that, to avoid any ambiguity,

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1 earlier in the day, Mrs Ferguson reports the vomit at
2 12 o'clock that she says wasn't recorded, two or three
3 vomits in the afternoon, which she claims haven't been
4 recorded and equally Mr Ferguson has said there were
5 three vomit fulls of a kidney dish that weren't recorded.
6 I suppose the question comes to this: accurate recording
7 of vomit in the fluid balance chart is essential to
8 effective treatment of a child; is that fair?

9 A. Yes, it is. It depends what you mean by "accurate".

10 Perhaps I'm appearing a little pedantic here, but on an
11 intensive care unit, fluid balances are kept extremely
12 accurately, so every millilitre that goes in
13 intravenously and every millilitre that comes out
14 through urine, faeces, or through a naso-gastric tube is
15 accounted for and is very accurate. On a children's
16 ward, that doesn't happen and it doesn't happen firstly
17 because the need to do it isn't usually there because
18 the children usually aren't that sick so it really
19 doesn't matter, they sort themselves out. And secondly
20 because there isn't the intensity of nursing care to
21 enable that to happen to -- there isn't the manpower, if
22 you like, to actually be able to do all that, which is
23 very time-consuming.

24 Put another way, one reason to transfer a child to
25 an intensive care unit is precisely so you can keep

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1 a very close watch on their fluid balance. But on an
2 average children's ward -- and I think that Ward 6 at
3 Altnagelvin was probably no different to many other
4 wards -- fluid balance is done poorly. I think it was
5 done poorly here, but that was not abnormal for the time
6 or even, I have to say, now.

7 Q. Yes.

8 THE CHAIRMAN: Sorry, I think there's really two points
9 about your last point at the top of page 006, which
10 says:

11 "None of the staff considered them to be large
12 enough to justify it."

13 Well, they did in the sense that, in a rather
14 imprecise way of doing it, but they had "vomit plus" or
15 "vomit plus plus", and they had a scale which you may be
16 familiar with from your own hospital in Salisbury of the
17 number of pluses gave at least some idea of the volume
18 of vomiting.

19 A. Yes.

20 THE CHAIRMAN: Even without the parents' view being taken,
21 there are vomits which the staff acknowledge occurred,
22 which are not recorded, and then the parents say there's
23 even more than that. So there's some measurement of
24 a volume of vomiting and there are undoubtedly
25 unrecorded vomits. So I think your assumption in that

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1 weight.

2 THE CHAIRMAN: Yes.

3 MR STITT: We have our chart showing the various vomits, but
4 the evidence which we've just heard -- and is confirmed
5 in statements -- is that there is a 12 o'clock vomit,
6 which I'm going to turn to in a moment to formulate the
7 question, and then it was put by Mr Wolfe that there
8 were two or three unrecorded vomits, according to
9 Mrs Ferguson, in the afternoon, and then Mr Ferguson
10 will say that he witnessed three vomits in a kidney dish
11 and that those weren't recorded. So that's generally
12 the background to the unrecorded vomits.

13 If I may refer to this entry, there's a small vomit.
14 I'll read it if I may:

15 "I now recall that, even before the 12 noon vomit,
16 that at around 11 am Raychel vomited then as well.
17 I think it was just a small vomit, but I cleaned this
18 with a tissue. It was more like a slime."

19 So leave that to one side, that was just a read-in,
20 as it were. This is the bit that I wanted to focus on:

21 "Then at 12, I remember carrying Raychel to the
22 toilet with the intravenous drip also pushed by me as
23 well. No one offered to help. She did use the toilet.
24 Then I took her over to the sink in the toilet to wash
25 her hands, but she said, 'I'm going to be sick'. Her

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1 sentence looks a bit difficult to stand over.

2 A. I'm very happy to withdraw that comment because that was
3 an assumption I probably shouldn't have made. However,
4 I would just say that if anyone thought that the vomits
5 were really that large so as to cause a significant
6 fluid loss, then they should have been considering
7 putting down a naso-gastric tube in order to measure
8 them. If it had got to that stage that a more senior
9 doctor was involved to make that decision, then they
10 should have been checking blood tests at the same time.

11 MR STITT: Might I interject on this point? There is
12 a matter which has been concerning me, and it is to do
13 with the size of the vomits and, accompanying that, the
14 type of the vomit because it's clearly going to be
15 something which will be exercising your mind in due
16 course, Mr Chairman, and perhaps now is a good time to
17 bring this up. Could I ask for a document to be pulled
18 up and then I'll put to you a question which, through
19 Mr Wolfe, perhaps could be put to the witness? The
20 document is Mrs Ferguson's statement, which is WS020/1,
21 page 8. It's the paragraph (a) at the top, if that
22 could be highlighted or magnified.

23 The background to my point, before I descend into
24 the particulars, is this. This witness is an expert in
25 paediatrics and we know that Raychel was 25 kilograms in

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1 face was really red and I could see the sweat breaking
2 out on her, although her head was cold to touch."

3 This is the bit:

4 "Then there was a huge vomit into the sink. I could
5 see all the rice that she had eaten had come up. My
6 first thought was that she had vomited because she was
7 operated on with a full stomach."

8 Of course Mrs Ferguson is doing her best. She
9 doesn't know if it's all the rice or not, but it's
10 clearly a large vomit and it's undigested rice because
11 it's identifiable as rice and it's still in the stomach.
12 My question is this -- and if it could be put to the
13 witness rather than me questioning the witness -- from
14 his position of expertise, bearing in mind the age and
15 size of Raychel, how much vomit as opposed to bile or
16 other stomach contents can one reasonably expect? If
17 one was looking for some form of telltale as to where
18 the accuracy lies as to what happened later in the day
19 as regards the vomits, we have nurses who have given
20 their evidence and I know the Fergusons will give their
21 evidence also. Because we have that reference from
22 Mrs Ferguson and then there are further references in
23 her statement to what are fairly significant vomits
24 in the afternoon. And my question is: how much vomit
25 per se can a child of Raychel's weight and size be

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1 expected to produce?
2 THE CHAIRMAN: Is that a question you can answer, doctor?
3 A. Do you want me to respond directly to Mr Stitt?
4 MR WOLFE: Yes.
5 A. I'm tempted to say, "How long is a piece of string?",
6 which is probably not a very helpful reply. Small
7 children can produce surprisingly very large vomits in
8 my experience. The stomach is a remarkably distensible
9 organ and if enough fluid accumulates, even in a small
10 child's stomach, and it all comes up at once, it can be
11 quite impressive, even in a baby. A child can produce
12 as much in a single vomit as a full-grown adult very
13 easily. As I've said already, it is very difficult to
14 quantify just from a vomit that goes in a sink or a
15 toilet or all over the bed in terms of how much there is
16 in terms of millilitres. If it's in a bowl, it's
17 obviously much easier to quantify the amount. I'm not
18 sure if that answers your question, Mr Stitt.
19 MR STITT: Well, it does give us a good physiological
20 description of how these things operate. But I'm
21 thinking more if one eats a meal at 5 o'clock on the
22 7th, is it likely that more stomach contents can be
23 produced than was in the meal? Because presumably
24 anything that was eaten before dinner time at 6 or
25 7 o'clock, 6 o'clock at night, will have gone through

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1 THE CHAIRMAN: Yes, thank you.
2 MR STITT: Thank you.
3 MR WOLFE: The point in your report that I was getting to
4 was where you've said that none of the staff involved
5 considered the vomits to be large enough to justify the
6 investigations that you talked about. The point I wish
7 to put to you is this: presumably, if all of the
8 vomiting that did occur was reported, then it's less
9 likely as a matter of common sense that a doctor would
10 make that assumption.
11 A. Yes. Yes, I'd agree with that.
12 Q. In other words, it's important that the doctor has full
13 information with regards to the vomiting so that he's in
14 a best position to understand the severity of what he's
15 dealing with and, in turn, that dictates the kinds of
16 investigations he would want to do?
17 A. Yes.
18 MR WOLFE: Sir, it's 12.10. I was going to move on to a new
19 section.
20 THE CHAIRMAN: Okay. I think you know the system, doctor.
21 We'll break for 10 minutes and resume at 20 past.
22 (12.10 pm)
23 (A short break)
24 (12.20 pm)
25 (Delay in proceedings)

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1 the digestive system.
2 A. Just an interesting little sideline on this is
3 Mrs Ferguson's very interesting observation that Raychel
4 was bringing up what she had eaten maybe
5 18 hours previously, perhaps more than that, quite
6 a long time previously, which should not still be in the
7 stomach. The stomach should normally empty within 4 to
8 6 hours. I don't think it helps us very much with this,
9 but it does suggest that Raychel had an illness that
10 caused the abdominal pain in the first place that was
11 associated with delayed gastric emptying. In other
12 words, her stomach wasn't emptying as it should have
13 been, presumably due to whatever illness it was that
14 caused the abdominal pain because that's not normal to
15 bring it up, undigested food, that long afterwards. To
16 answer your question about can they bring up more than
17 they had eaten, anybody's stomach is constantly
18 producing gastric secretions, so you can have eaten
19 nothing for many days and still vomit a considerable
20 quantity of fluids which the stomach is producing all
21 the time -- a mixture of acid, bile, mucus, all sorts of
22 stuff. You can't really produce any more solid matter
23 than you've eaten because the stomach doesn't produce
24 its own solids; it only produces its own liquid matter.
25 Is that satisfactory?

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1 (12.25 pm)
2 MR WOLFE: Doctor, I want to move on to examining Raychel's
3 condition during the day and into the night of 8 June.
4 As we move along the narrative, we'll look at the
5 interaction between the nurses and the junior house
6 officers who came to attend Raychel.
7 I want to start by asking you a question about what
8 might have been expected as the recovery pathway for
9 Raychel. It's oft been said before the inquiry that no
10 two children are the same and no recovery is the same.
11 But could I ask you the question in this way? Raychel
12 had had a mildly-congested appendix, a straightforward
13 operation, had a good night post-operatively, and the
14 expectation at the ward round, if Mr Zafar's evidence is
15 to be accepted, is that he anticipated that the fluids
16 would be gradually reduced during the day. Does that
17 all fit with your experience of such matters?
18 A. Yes. The great majority of children with
19 a straightforward appendicectomy, whether or not the
20 appendix was inflamed, would expect, on the first
21 post-operative day, to start taking some oral fluids,
22 initially small sips, then greater amounts. As that
23 happened, the infusion rate would have been decreased.
24 I would expect, on average, that by the middle of the
25 first post-operative day, the child would be off

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1 intravenous fluids completely and, by the end of that
2 day, on average, would be starting some solid food and,
3 by the following day, possibly eating and drinking well
4 enough to go home.

5 THE CHAIRMAN: Sorry, can you put that into this time
6 sequence? If Raychel's operation was on Thursday
7 night/Friday morning at about midnight/1 am, when might
8 you expect her to be off fluids? Mid-afternoon or --

9 A. I'm intentionally being vague because I'm talking in
10 generalities and averages.

11 THE CHAIRMAN: Of course.

12 A. So I would ... Obviously, a child doesn't eat and drink
13 when they're asleep, so one tends to get them
14 established on food and drink during the day, during the
15 night, so even if the operation had been earlier the
16 previous evening, one wouldn't really have expected her
17 to start to eat or drink until the following day. So
18 say even if the operation had been at 6 pm or 7 pm or
19 something like that, then it wouldn't have been until
20 later, so -- just because of normal day/night cycles.
21 So -- but, yes, 12 to 24 hours post-operatively, if you
22 want to put it in numbers.

23 THE CHAIRMAN: Thank you.

24 MR WOLFE: Of course, post-operative vomiting is not an
25 uncommon phenomenon with children, we've heard,

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1 early hours of the Friday morning. So the fact that the
2 first vomit was at 8 am doesn't suggest that that was
3 not post-operatively vomiting. What do you think of
4 that?

5 A. There are many different causes of post-operative
6 vomiting. Sometimes one doesn't know the cause. Some
7 of them will be less likely to happen when the child is
8 asleep. If you, for example -- I think I gave a list in
9 my report. Anxiety, which is one of the reasons,
10 children are just anxious about being in hospital.
11 Children can often vomit just because they're anxious.
12 They're not going to vomit when they're asleep, if
13 that's the reason. If it's something more physical,
14 then they may do.

15 THE CHAIRMAN: So the fact that there isn't a vomit until
16 8 am doesn't really give us a steer in either direction
17 about the nature of --

18 A. No. It's less likely to be one of the immediate
19 operative causes of vomiting, ie the anaesthetic itself
20 or the manipulation of the abdomen during the operation.
21 That would cause, one would think, more immediate
22 post-operative vomiting, but the other things, the
23 delayed reactions to the analgesic drugs, antibiotics
24 and, of course, the underlying problem of whatever
25 caused the abdominal pain in the first place, which

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1 particularly in the 5-to-12-years age bracket, where
2 Raychel fell. You have said in your report at
3 222-004-017 that some children seem to be much more
4 susceptible to post-operative vomiting than others and
5 it is quite unpredictable.

6 A. Yes.

7 Q. And you think it's entirely reasonable that all staff
8 should initially have attributed Raychel's vomiting to
9 normal post-operative vomiting?

10 A. Yes.

11 Q. And there would have been no reason for them to consider
12 any more serious diagnosis until much later?

13 A. Yes.

14 Q. So we have on the one hand, if you like, on the law of
15 averages, smooth recovery, on oral fluids within
16 a period of 12 to 24 hours, but it is not unusual to
17 have vomiting, which might interrupt that recovery
18 process; is that fair?

19 A. Yes. Some children get no post-operative vomiting at
20 all of course. It's not universal. Some do and it
21 generally settles 6 to 12 hours post-operatively.

22 THE CHAIRMAN: When that point was raised last week, it was
23 then suggested to me: well, of course, she is asleep for
24 the first 4 to 6 hours post-operatively, therefore you
25 would not expect any post-operative vomiting in the

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1 might actually not be anything to do with the surgery.

2 MR WOLFE: And presumably an adequate response to the
3 commencement of vomiting is for a nurse to observe,
4 monitor and, if there is recurrence, to get a doctor
5 along to carry out an assessment --

6 A. Yes.

7 Q. -- and perhaps consider for an anti-emetic?

8 A. Yes.

9 Q. Again, all cases are different, but thinking about
10 Raychel's case: vomiting three, maybe four, times in the
11 morning up to lunchtime, up to 1 o'clock, but a doctor
12 isn't called along until 6 o'clock, a doctor doesn't
13 attend until about 5.30/6 o'clock; is that too long
14 a wait?

15 A. I think that's a very long time. Can I just tell you,
16 knowing I was going to be appearing today, I did a straw
17 poll amongst the nurses on my own ward the day before
18 yesterday just out of interest. I gave them the
19 hypothetical situation of a 9 year-old girl who had had
20 a straightforward appendicectomy and I asked each of
21 them how many -- I gave them a scenario: if a child was
22 still vomiting 6 hours post-operatively, 12 hours
23 post-operatively, 24 hours post-operatively, when would
24 you call a doctor, if the child was on a drip, all other
25 things being equal in a previously well child? They all

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1 said they would call somebody at 24 hours and at
2 12 hours. At 6 hours, it was divided. Some said they
3 would, some said they would wait a bit, and that's
4 across a range of experiences of quite junior and quite
5 senior. That doesn't prove anything, of course; it's
6 just a straw poll I did. What I'm saying is most
7 children's nurses would expect a degree of vomiting up
8 to 6 hours at least and possibly a bit longer.

9 THE CHAIRMAN: But your own view is that not to call
10 a doctor until whatever time it was -- mid to late
11 afternoon on the Friday in Raychel's case -- was a very
12 long time?

13 A. Yes, I think that was a long time.

14 MR CAMPBELL: The straw poll was conducted in 2013 and so
15 much more knowledge of hyponatraemia is now at large.

16 A. Yes. I don't think so much knowledge of hyponatraemia,
17 it's general awareness of a whole number of
18 complications, but absolutely right. And I wouldn't
19 want to make too much of my straw poll. I was perhaps
20 hesitating whether I should have mentioned it or not and
21 if you want to strike it from the record, please feel
22 free.

23 MR WOLFE: And we have your own view, which is perhaps the
24 more important view.

25 In your report, doctor, you have reflected upon, if

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1 is that fair?

2 A. Yes.

3 Q. Could you elaborate a little on that for us?

4 A. Yes. If I might just make a slightly more general
5 point, Mr Chairman? Assessing a child, how unwell
6 a child is -- and I obviously would say this as
7 a paediatrician, but it's something which can be quite
8 difficult and requires a certain amount of experience.
9 It's more difficult than it is with adults. Of
10 particular note in Raychel's case is that actually her
11 observations, her vital signs were normal, and you need
12 to look at more than just the vital signs when assessing
13 a child of any age, but particularly younger children.
14 Feeling that a child is not quite right, that there's
15 something more than there should be for the illness that
16 they've come in with is somewhat instinctive and
17 somewhat subjective.

18 I would like to think, if you'll forgive
19 a paediatrician's slight indulgence here, that we as
20 paediatricians are quite good as that and I think we are
21 better at it than our colleagues in other specialties
22 because that's what we do. I think doctors who have
23 very little experience of children -- and possibly
24 nurses as well -- can miss these very subtle signs of
25 a child being -- and people use words like "listless",

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1 you like, the divergence of views in terms of just how
2 unwell Raychel appeared to be by the late afternoon of
3 8 June.

4 A. Yes.

5 Q. If I can put it in this way. You have the parents'
6 views and the views of some of the visitors that
7 Raychel, by late afternoon on 8 June, appeared very
8 unwell. So you have the vomits that they were saying
9 were happening, which the nurses hadn't for whatever
10 reason picked up upon, you had the mother coming back to
11 the hospital after doing a school run, I think it was,
12 at or about 4 o'clock and finding the child listless,
13 retching, wanting to sleep, not being able to sleep,
14 vomiting blood at 5 o'clock or a vomit with traces of
15 blood. That's one perspective.

16 Then on the other hand you have the nurses saying
17 the vomits that were recorded were the vomits that
18 we were aware of and the child wasn't listless so far as
19 we can tell. And that's your knowledge; is that right?

20 A. Yes.

21 Q. In light of that knowledge, you've offered if you like
22 a nuanced view of what should have been done by late
23 afternoon. You seem to be saying that, if you like, if
24 the parents are right objectively, more should have been
25 done in terms of investigating Raychel's condition;

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1 "not quite right", "not themselves", and, in fact, all
2 the things Mrs Ferguson used in her witness statement.
3 And it would appear to me that these factors were not
4 picked up on, quite apart from the issue of the
5 vomiting, and that her general condition, in a subtle
6 and quite difficult to define way -- which is nothing to
7 do with numbers and figures -- was not what it should be
8 for a child who's recovering from a simple
9 appendicectomy.

10 My view, if I might just take it a stage further, is
11 that if a paediatric doctor had been involved at an
12 earlier stage, even a relatively junior paediatric
13 doctor like Dr Johnston, it is possible -- and I'm
14 speculating here -- that that doctor might have picked
15 up on Raychel being not quite right in a non-specific
16 way, in a way that a junior surgical doctor who was not
17 used to dealing with children would not have, and
18 I think that's a very important aspect of this case.

19 THE CHAIRMAN: Thank you.

20 MR WOLFE: Can I attempt to confront what you've just said
21 with a number of points? First of all, there's
22 an important role for good communications between
23 nursing staff and the parents of a child; isn't that
24 right?

25 A. Absolutely, yes.

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1 Q. And I think it was a cornerstone of nursing practice at
2 that time that you had family-centred nursing care.
3 A. Yes.
4 Q. And it's oft said that parents are more capable of
5 detecting subtle signs than nurses who don't know the
6 child.
7 A. Yes, yes.
8 Q. So although you make the point that a degree of
9 experience on the paediatric side is perhaps important
10 and is what is perhaps missing from this case,
11 experienced paediatric nurses have devices or equipment
12 at their disposal, such as communication, such as
13 observing the child more frequently, if they think it's
14 appropriate, which can bring in the information which
15 you think important.
16 A. Yes, and the parents' own instinctive feelings are
17 vitally important as well. If I could just add
18 something else that might be of interest, which is that
19 in recent years something has been introduced of
20 children's wards called PEWS, Paediatric Early Warning
21 Score. This wasn't in use at the time. But the reason
22 I'm mentioning that is that that is a mechanism whereby
23 abnormal observations can trigger a nurse to contact
24 a doctor if a child is causing concern, and things like
25 a heart rate, blood pressure, et cetera, as you might

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1 apprehended that this child was, if you like,
2 deteriorating rather than getting better?
3 A. Yes. Well, I think this is one of the critical points
4 of this case and I know witnesses have already discussed
5 this. It all depends on what was made known to
6 Dr Devlin at the time. I can't remember whether
7 Dr Devlin said he examined Raychel or not from his
8 statement.
9 Q. Let me help with you that. What he said was that he was
10 told that Raychel -- there's a degree of vagueness about
11 what precisely was told, but his impression or his
12 memory is he was told this was an appendix patient who
13 had been vomiting, please give the child an anti-emetic;
14 he attended the bed without the nurse, so far as he can
15 recall, the child was vomiting; he carried out a fairly
16 perfunctory -- by his own admission, I think --
17 examination or assessment, and reached the view that it
18 was okay to give the anti-emetic, which had earlier been
19 prescribed on an as-required basis by the team in
20 theatre.
21 So it comes to this: in his evidence, he said that
22 the nurses weren't raising concerns with him. He would
23 have hesitated about simply giving an anti-emetic if he
24 appreciated that there were concerns.
25 A. Yes.

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1 imagine. However, added to those things is parental
2 concern and that is the, if you like, the added extra
3 that goes on top of the numbers, the objective signs,
4 that should in itself trigger concern.
5 Nothing like that was in use at all in 2001, so I'm
6 not telling you that that's something that should have
7 been done in this case. But I'm just making the point
8 that parental concern is now considered to be much more
9 important than it was then and it's something that can
10 trigger a review of a child.
11 Q. It's useful then to build into this stage of the
12 narrative the role played by Dr Devlin. Dr Devlin was
13 a junior house officer on the surgical side and the
14 evidence is that he had very limited paediatric
15 exposure. So this perhaps comes back to the point that
16 you've just made that he would not necessarily have had
17 the experience or skill set to detect the things that
18 needed to be detected.
19 A. Yes.
20 Q. Having said that, this was a child who the senior house
21 officer at the start of the day expected to progress on
22 a smooth or upward trajectory towards consuming oral
23 fluids by about that time, I would have thought.
24 A. Yes, that's what would have been expected.
25 Q. So by the time Dr Devlin attended, should he not have

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1 Q. So can I ask for your impressions of that and perhaps
2 focus on the question which I just raised? Obviously,
3 communications from the nurses and what they say is
4 important. The doctor also has an assessment role;
5 is that correct?
6 A. Yes.
7 Q. And should he also have known that, by that time in the
8 afternoon, things were not going according to how you
9 might have foreseen it earlier in the day?
10 A. To answer your last question, I would have thought that
11 even at JHO level, the doctor should have been
12 sufficiently aware that post-operative vomiting -- and
13 this would apply to adults as well as children -- that
14 long after, which by 5 o'clock was, what, 18 hours or so
15 post-operatively --
16 Q. Yes.
17 A. -- is a very long time to attribute it to
18 post-operatively vomiting. I think even at that level
19 there should have been awareness. I would not have
20 expected Dr Devlin or Dr Curran for that matter to have
21 had the skills to assess Raychel. Going back to what
22 you said about how he said he thinks he did
23 a perfunctory examination, which may sound inadequate,
24 but my feeling is that had a paediatrician done that
25 perfunctory examination, they might have picked up the

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1 subtle signs that Dr Devlin and Dr Curran didn't, as
2 I have said previously. But I think there should have
3 been an awareness that that was a long time
4 post-operative vomiting to have been going on. It
5 doesn't mean that it couldn't have been, but at that
6 junior level it would have been worth considering other
7 possibilities.
8 THE CHAIRMAN: I think the fairly basic question with
9 Dr Devlin is whether he was brought in to do what the
10 nurses were effectively telling him to do --
11 A. Yes.
12 THE CHAIRMAN: -- or the extent to which he had an
13 independent role.
14 A. Yes. That's really important to the clinical governance
15 aspect of this case, a little bit related to what I was
16 saying earlier about passing doctors being asked to
17 prescribe things is that when a doctor is asked to
18 prescribe something, whether it's IV fluids or an
19 anti-emetic, if they're being asked -- basically used
20 almost as a technician to do it -- what is their line of
21 responsibility? In many ways Dr Devlin was in a similar
22 situation to that which Dr Butler was in earlier in the
23 day in that he was a passing doctor. I don't think
24 he was even a doctor on the team that Raychel was under;
25 I think he just happened to be on the ward.

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1 A. Yes.
2 Q. -- broadly speaking for two reasons: the continued
3 intravenous fluid and the fact that Raychel had been
4 vomiting. Whether or not we judge that Dr Devlin should
5 have done that, do you agree with those other expert
6 views that that should have been done?
7 A. That Dr Devlin should have taken a blood test for
8 electrolytes before giving an anti-emetic?
9 Q. No, I'm separating that out. The expert view is that
10 electrolytes should have been performed by that time
11 in the afternoon.
12 A. Yes. I think, in my report, I was slightly more vague
13 about that. But if the vomiting was as severe as it has
14 now been revealed to have been and if Raychel's
15 condition was as poor as we now know it was, then
16 certainly it should have been done.
17 Q. Then just to go back to Dr Devlin, your impression
18 is that even a JHO with limited experience in the nature
19 of things should have been appreciative of the fact that
20 to be vomiting 18 hours after surgery was unusual.
21 A. Well, yes. I mean, at a junior level, he should have
22 spoken to a senior, I think, probably before doing
23 a blood test or even -- although this wasn't common
24 practice at the time -- gone straight to
25 a paediatrician. In my honest view, that is actually

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1 THE CHAIRMAN: No, there had been an inability to obtain
2 a doctor from the team and he happened to be passing
3 through Ward 6 doing something else.
4 A. So he was almost a random, passing doctor who was asked
5 to perform this task, to give an anti-emetic, which of
6 course surgical junior doctors spend an awful lot of
7 their time doing in adults. That's one of their roles,
8 to write up anti-emetics. And he just considered it
9 presumably to be a routine thing that he was being asked
10 to do by the nurses.
11 MR WOLFE: If I could be more precise about something that
12 I've just said. I think I suggested he carried out an
13 examination, albeit I used the word "perfunctory". His
14 actual evidence was that he thought an examination was
15 unnecessary when he gave evidence on 6 March. The
16 impression certainly left with me -- and we can check
17 the transcript on this -- he at least went through the
18 rudiments of working out for himself that an anti-emetic
19 was the proper approach. So perfunctory in all of those
20 senses.
21 A. Yes.
22 Q. Could I ask you this then: the other experts who have
23 looked at this have said that, objectively, by that
24 stage in the afternoon an electrolyte profile was
25 something that should have been done --

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1 what should have happened rather than going to
2 a surgical senior, but that wouldn't have been the
3 procedure at the time, there or anywhere else.
4 Q. Just to be clear, you wouldn't necessarily expect this
5 doctor to be thinking, "Right, I need to get
6 electrolytes done", he should have realised that the
7 vomiting was unacceptable and thought, "I need advice
8 from a senior colleague --"
9 A. Yes.
10 Q. -- to work out what should be done next?
11 A. Yes.
12 THE CHAIRMAN: One of the points that has concerned me over
13 the last few weeks is that the nurses have insisted that
14 the vomiting which Raychel endured was not really that
15 unusual and that's one of their explanations for failing
16 to raise more significant concerns at the time. If
17 that's right then what they're saying is that
18 it wouldn't be unusual for a child after a standard
19 operation, in inverted commas, like this to be vomiting
20 through the morning, through the afternoon and through
21 the evening. While accepting that that can happen,
22 surely that would be unusual?
23 A. I think it's relatively unusual. You can have -- and
24 some children do vomit unaccountably for no apparent
25 reason for a long time after an operation. But I would

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1 think they're a fairly small minority and the point is
2 that you can't assume it's post-operative vomiting until
3 you've ruled out other causes.

4 THE CHAIRMAN: And even if it is, as they think, not all
5 that unusual, it's still worthy of investigation?

6 A. I would say so, yes.

7 THE CHAIRMAN: Thank you.

8 MR WOLFE: If we can then move along the chronology a little
9 bit more, leaving Dr Devlin behind us, there is again
10 some debate in the evidence about how quickly Raychel
11 became unsettled after the anti-emetic was prescribed
12 and administered. Mrs Ferguson, Raychel's mother, would
13 have it that Raychel was vomiting within the hour. We
14 know that Nurse Gilchrist cleaned up a vomit at or about
15 8 o'clock, shortly after that perhaps, which is two
16 hours after the administration of the anti-emetic. More
17 context for you: the father arrives at the hospital at
18 or about 7 o'clock and is concerned about his daughter;
19 a visitor arrives to see his daughter who's sitting
20 nearby or lying nearby Raychel and witnesses vomiting at
21 that time.

22 Can I ask you this: in terms of the anti-emetic that
23 was administered, it was Zofran or ondansetron.

24 A. Yes.

25 Q. Is that considered to be a potent anti-emetic?

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1 Raychel had received visitors and the description was
2 that she didn't converse or communicate with a young
3 friend who had visited, and you said that was far from
4 normal behaviour.

5 A. Yes.

6 Q. So by the time of the vomiting on to the bedclothes at
7 8.15, or thereabouts, observed by Staff Nurse Gilchrist,
8 was that a time for further action?

9 A. Yes. It was interesting reading Mrs Ferguson's witness
10 report. 9 year-old children love their friends and for
11 a little girl of that age not to react to a little
12 friend coming to visit her, I think is quite striking.
13 Even if she was really quite poorly and still not
14 feeling all that well having just had an operation the
15 night before, one would expect her to show some
16 response. And similarly to other relatives visiting.
17 So that struck me that things weren't right with her at
18 that time.

19 Q. Of course again, it's proper for me to reflect that even
20 around that timing, there's a conflict in the evidence
21 in that Staff Nurse McAuley said in her evidence that
22 she observed Raychel at or about 7.30 pm standing out
23 in the ward with her brothers discussing the pictures on
24 the wall, or some such effect, the impression being that
25 Raychel was mobile and well at that point, a point

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1 A. It's a relatively newer one. It hadn't been around for
2 all that long. Cyclizine and Stematil and Maxolon,
3 which have been around for a lot longer ... So it's ...
4 It is thought to be more potent. I'm sorry I don't know
5 the evidence of that, but it's often preferred in
6 children because it has fewer side effects compared to
7 some of the older ones.

8 Q. We know that Dr Curran prescribed and administered
9 Valoid later in the evening.

10 A. Yes.

11 Q. I'm not asking for the science of it, but is there
12 a difference in potency between the two?

13 A. Cyclizine has been around a long time and is a different
14 class of drug to ondansetron. What would normally
15 happen is one might use a first line one, what would
16 have happened then, something like cyclizine or
17 Stematil, which is prochlorperazine, as a first line and
18 then moved to ondansetron if that wasn't working.

19 Dr Devlin, for whatever reason, decided to bring out
20 the heavy guns first, if you like, put it that way
21 round.

22 Q. And the heavy guns, on either account, if you like --
23 the mother's account or the nursing account -- hadn't
24 settled the vomit, at least by 8 o'clock if not earlier,
25 and I think you've reflected in one of your reports that

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1 aggressively denied, if I may say so, by the parents,
2 who were with her at that time. Is it possible for you
3 to help us given what you know of the condition and how
4 it's been described, even in the nursing notes?

5 A. I think that is an almost irreconcilable conflict
6 between those two views. I don't know if this helps the
7 inquiry or not, but if Raychel was at the very early
8 stages of developing cerebral oedema as a consequence of
9 the hyponatraemia, that doesn't always develop in
10 a linear fashion. In other words, it can fluctuate, it
11 comes in waves. It's possible that Raychel at the time
12 that her friend visited was going through an early stage
13 of diminished awareness, diminished conscious level and
14 then later in the evening she was a bit better, well
15 enough to walk around, but that seems quite unlikely to
16 me.

17 Q. And then, building further factors into the picture, by
18 9 o'clock Raychel has had a medium coffee-ground vomit,
19 followed some short time later by three small vomits and
20 at or about that time was noticeably pale with
21 a headache. Presumably the correct response then was to
22 summon a doctor.

23 A. Yes. The issue of the coffee-ground vomit is actually
24 significant. It's not significant, I think, inasmuch as
25 the coffee grounds -- as I think has been explained to

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1 you -- is altered blood that's been produced into the
2 stomach, altered by the stomach acid and vomited up and
3 it looks like coffee grounds. It's significant not
4 in that the bleeding was of itself inherently harmful.
5 It's unusual to lose significant amounts of blood that
6 actually makes you unwell in that way; it's an indicator
7 that there had been significant or moderate or
8 moderately severe vomiting going on in order to produce
9 this bit of bleeding in the stomach. Usually, but not
10 always, that is as a result of fairly prolonged and
11 fairly forceful vomiting, what's known as
12 a Mallory-Weiss tear.
13 Q. Nevertheless, it's the presence of blood in the vomit
14 that is an indicator, on one view, that vomiting has
15 been severe and prolonged.
16 A. Yes, it can be.
17 Q. Albeit you have reflected in your report that you have
18 seen such tears --
19 A. Yes. In my reflection, if you were to ask me: is it
20 possible to get a Mallory-Weiss tear having vomited only
21 once previously, I'd say yes, it is, and I've seen it.
22 So it doesn't of itself prove that there has been
23 prolonged vomiting, but normally it happens after there
24 has been prolonged vomiting.
25 Q. And the headache, you say, was one of a range of

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1 to find the reference. My note of the question and the
2 answer was the question was -- it was a reference to the
3 coffee-ground vomit and the answer was that it was
4 significant. The witness then went on to say that it
5 was indicative of significant vomiting. I hope that's
6 a correct note that I've taken.
7 THE CHAIRMAN: It is an indicator of moderately severe
8 vomiting, prolonged and fairly forceful, and normally
9 a Mallory-Weiss tear follows prolonged vomiting but it
10 doesn't necessarily follow prolonged vomiting.
11 MR STITT: The propensity of the evidence was it probably
12 related to moderate and prolonged vomiting.
13 THE CHAIRMAN: Fairly forceful as well, moderately severe.
14 MR STITT: I think it's only reasonable for me to suggest,
15 if I may pull up a reference --
16 THE CHAIRMAN: Go on.
17 MR STITT: 222-004-012.
18 THE CHAIRMAN: This is the witness's own report.
19 MR STITT: This is from the witness's second report. If we
20 could highlight the top paragraph, 5(e), and magnify
21 that. It's dealing with the observation of
22 coffee-ground vomit:
23 "It occurs when there has been a small amount of
24 blood ... It may occur in vomiting of any cause. In my
25 view of itself it is not diagnostic of severe or

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1 symptoms which, put together, should have prompted
2 action --
3 A. Yes.
4 Q. -- albeit of itself it's not necessarily diagnostic --
5 A. Yes.
6 Q. -- of a big problem.
7 A. Of course headache is a terribly common symptom and
8 children get headaches for all sorts of reasons and
9 sometimes just say they've got a headache when they're
10 feeling generally unwell for whatever reason. Cerebral
11 oedema is a long way down the list of causes of
12 headache, but it is certainly true that in the early
13 stages someone who's developing increased pressure
14 inside the head will complain of severe headache. But
15 I don't think anyone would have made a diagnosis of
16 cerebral oedema at that stage purely on the basis of
17 Raychel complaining of a headache.
18 Q. Yes. So by this time in the evening -- and we're
19 talking about that window between 9 o'clock and
20 10 o'clock -- Raychel had been on intravenous fluids for
21 coming up to 24 hours; isn't that correct?
22 A. Mm.
23 MR STITT: Might I interject? I do apologise, but I hope it
24 is in a constructive way. Could we just go back to two
25 answers ago? It has taken me the two or three minutes

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1 prolonged vomiting."
2 I have difficulty -- and I note the words "in
3 itself" are put in there, but I had difficulty
4 reconciling that statement with the answer given to
5 Mr Wolfe.
6 THE CHAIRMAN: Is that not because the doctor said a few
7 moments ago that he has seen it occur after a single
8 vomit? Is that right, doctor?
9 A. Yes, it's very simple. It's not diagnostic is that it
10 can occur when there hasn't been severe and prolonged
11 vomiting, but it frequently does when there has. The
12 "diagnostic" means that it definitely indicates that
13 there has been. It frequently does, but not always.
14 MR STITT: So if I may put it this way: the witness is not
15 saying that the coffee-ground vomiting is diagnostic in
16 this case. In other words if you're looking, sir, for
17 evidence to put in the balance as to whether there was
18 prolonged and severe vomiting, this is not diagnostic of
19 that, but not inconsistent with it.
20 A. Yes.
21 THE CHAIRMAN: I have to say, Mr Stitt, I would be
22 astonished if it is the Trust's case that Raychel did
23 not suffer prolonged vomiting. I would be utterly
24 astonished.
25 MR STITT: No, I'm certainly not saying that, but I want to

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1 going to the strength of the amount of weight that
2 coffee-ground vomiting is being given in this case. I'm
3 certainly not saying that there wasn't prolonged
4 vomiting in this case.

5 THE CHAIRMAN: On that theme, doctor, Dr Curran said in his
6 evidence that had he known that Raychel had
7 coffee-ground vomiting, which he said he didn't know
8 when he arrived, he would have regarded that as a red
9 flag.

10 A. Yes.

11 THE CHAIRMAN: Dr Johnston wasn't quite on the same
12 wavelength as him. Dr Johnston, who obviously got so
13 many things right when he intervened, he thought: let's
14 be a bit more careful about that. Is it something of
15 a red flag?

16 A. Ironically, Dr Curran, as an adult -- primarily adult --
17 junior surgical house officer, would have learnt as
18 a student that when a patient of any age vomits blood,
19 it's a serious thing. He had no knowledge of
20 paediatrics, so, yes, it should have been a red flag for
21 him. A paediatrician with a bit more knowledge would
22 have known, which Dr Curran wouldn't have known, that in
23 children specifically, a small Mallory-Weiss tear
24 following a relatively minor vomiting illness is
25 actually quite common and not of any great significance.

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1 you would have expected in terms of his actions and what
2 you might have expected from the actions of a senior
3 colleague if a senior colleague arrived. What should
4 a senior colleague then have done if brought to
5 Raychel's bedside?

6 A. Examined her, spoken to the parents importantly, see
7 what their concerns were, spoken to the nurses, looked
8 at the charts, got some estimate of fluid balance,
9 although that would have been difficult with the charts
10 as they were. Also addressed urine output, by the way,
11 which is something we haven't discussed yet -- but you
12 may want to come back to that -- and then considered
13 doing some investigations. There may have been many
14 investigations. Obviously in this case it was the
15 blood, urea and electrolytes, but depending on the
16 findings there may have been other investigations to
17 have been done, for example looking for evidence of
18 infection, sepsis, which is actually a more likely
19 scenario than hyponatraemia. So the various
20 investigations would have been done for that and
21 possibly, if it appeared there was an abdominal problem,
22 doing some sort of imaging of the abdomen, X-ray,
23 ultrasound and so on.

24 Q. And presumably, if urea and electrolyte profiling had
25 been performed at that time, that would have identified

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1 So it should have been a red flag, but probably not for
2 the reasons that Dr Curran would have thought it would
3 have been at that time.

4 THE CHAIRMAN: Right, okay. Thank you.

5 MR WOLFE: In asking you as an expert, doctor, to comment on
6 what should have been done for Raychel by that time of
7 the night, your answer, I suppose, has to set aside at
8 least initially what was or was not said to Dr Curran
9 and we'll perhaps come to that in a moment. So the
10 question is objectively, come 9 to 10 o'clock at night,
11 what should have been done for Raychel Ferguson given
12 all that we know about her condition and progress during
13 the day?

14 A. Yes, well, it's really the same as at 5 o'clock, only
15 more so. Dr Curran, again a very junior doctor, this
16 time, though, he was the JHO on call for all surgical
17 patients in the hospital that night, he wasn't just
18 a passing doctor who had been asked to prescribe an
19 anti-emetic. This patient was his responsibility for
20 the whole of that shift, so that's slightly different.
21 By that stage, the vomiting was going on for what was
22 now about 20 hours post-operatively. I think he should
23 have asked for more senior advice either from a member
24 of the paediatric team or from his surgical seniors.

25 Q. So you're drawing a distinction between his acts or what

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1 a low serum sodium?

2 A. It almost certainly would have been abnormal at that
3 time, yes.

4 THE CHAIRMAN: Sorry, even before the bloods come back,
5 would the level and type of fluids attract attention or
6 do you wait for the blood results to come back?

7 A. Are you talking at 9 o'clock?

8 THE CHAIRMAN: Yes.

9 A. Before she'd had the seizure. No, you wait for the
10 blood results to come back, I think.

11 MR WOLFE: And a point you've made earlier, if the bloods
12 had come back showing low sodium, good practice would
13 have dictated that you would think about changing the
14 rate and think about changing the type of fluid?

15 A. Yes.

16 Q. And as you've said earlier, normal saline or Hartmann's
17 would have been indicated on a low sodium result.

18 A. Yes. I'm speculating now, but if say, for example, the
19 sodium had come back around about 130 or well below the
20 normal range, but not as low as it was when it was done
21 a few hours later, then the correct action would have
22 been to reduce the infusion rate and to change to
23 0.9 per cent saline.

24 Q. Just in case I forget about it, you've mentioned the
25 fact that we haven't really discussed urine output.

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1 A. Yes.
2 Q. And you say that's relevant to be considered at this
3 point.
4 A. I think it's very relevant, yes.
5 Q. What the fluid balance chart showed us -- I don't think
6 we need to put it up on the screen -- is at about 10 am
7 that morning there was a record of her having passed
8 urine. We know from the parents that at least the
9 mother brought her to the toilet and urine was passed at
10 some point during the day, perhaps at about 12 o'clock
11 before the vomit that the mother talks about. That
12 wasn't recorded. So in terms of urine output, come 9 or
13 10 o'clock at night, what were the considerations that
14 were relevant?
15 A. Well, correct me if I'm wrong, but as far as I can tell
16 from the charts and all the witness statements, there's
17 no record of Raychel having passed urine at all or
18 having wet the bed from the middle of the day right
19 until she deteriorated. That's a very long time for
20 a child to go without passing urine, particularly if
21 they're on a drip. So we know she's getting fluids so
22 she's not dehydrated and she is not passing urine and,
23 in terms of what actually happened to Raychel, I think
24 that's highly significant.
25 MR CAMPBELL: Mr Chairman, with regard to that point, we do,

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1 MR COYLE: No.
2 THE CHAIRMAN: Mrs Ferguson says she took her to the toilet
3 once.
4 MR COYLE: Exactly, sir.
5 THE CHAIRMAN: I think the nursing evidence, Mr Campbell, is
6 that there's an assumption on Sister Millar's part --
7 MR CAMPBELL: That might be correct, yes.
8 MR WOLFE: The witness captures Mr Campbell's point.
9 If we check the transcript, he said there's no evidence
10 from about the middle of day that there had been urine
11 and I think that captures the point made by Mrs Ferguson
12 that there was an urine output perhaps at about the
13 middle of the day when the vomit occurred.
14 MR STITT: I don't want to appear to be nitpicking, but it
15 has been emphasised by the witness that this is -- he
16 regards this as an important aetiological point and
17 I would just like, for completeness, to refer to the
18 fact that Mrs Ferguson does say -- to be fair to her,
19 I'm sure it's terribly difficult for her to remember
20 exactly for all sorts of reasons -- but she does say on
21 page 11 of her statement -- and I will just read it,
22 it's only one sentence:
23 "I am not sure. I have a memory of taking Raychel
24 to the toilet again."
25 That's after the 12 o'clock because we deal with

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1 however, have evidence from the parents that she walked
2 to the toilet on a number of occasions and we have that
3 corroborated by Sister Millar.
4 THE CHAIRMAN: Well, we have her walking with --
5 Sister Millar says she saw Raychel walking with her
6 father, right?
7 MR CAMPBELL: Yes.
8 THE CHAIRMAN: I think Sister Millar's assumption is she was
9 walking to the toilet, but I'm not sure if it's a fact
10 that she was necessarily walking to -- was she actually
11 going to the toilet, Mr Coyle?
12 MR COYLE: [Inaudible: no microphone] the incident of her
13 going to the toilet as is recorded, sir, at midday, but
14 I don't think the parents agree that she -- certainly
15 Mr Ferguson never took her to the toilet.
16 THE CHAIRMAN: And the time she went to the toilet was with
17 her mother and that was the time when she was very sick.
18 MR COYLE: Yes, that's the same instance. It appears in the
19 statement that Mr Stitt referred you to earlier, sir,
20 but it is not agreed. And Mr Ferguson will say in his
21 evidence that it would have been inappropriate, given
22 her age, for him to have attended the toilet with her.
23 That didn't happen.
24 THE CHAIRMAN: So Mr Ferguson says he didn't take her to the
25 toilet?

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1 12 o'clock and mum goes with daughter and she thinks,
2 but she's not sure, but I just want to put that in the
3 balance.
4 MR COYLE: She also says, "I may be wrong", so it's put
5 forward by Mrs Ferguson most tentatively.
6 MR STITT: That's accepted.
7 THE CHAIRMAN: There's a possibility that Raychel was taken
8 to the toilet one time beyond midday at some undefined
9 point by Mrs Ferguson, but that is the only evidence
10 there is of Raychel passing urine after the middle of
11 the day. Even if she did go once beyond the middle of
12 the day, do you still have a concern about the lack of
13 urine being passed by a girl who has been on a --
14 A. Yes. I think that's very important, if I may say so,
15 Mr Chairman. One small point is that young children
16 will often think they need to go to the toilet when they
17 don't very much and they'll go and not do very much.
18 The fact that Raychel may have walked to the toilet once
19 or twice does not really mean very much in terms of
20 fluid balance. So that's one point. But can I just
21 expand on why I think this is important?
22 THE CHAIRMAN: Yes.
23 A. Raychel's profound hyponatraemia was due not only to
24 being given quantities of hypotonic fluid; it was
25 because in my view -- and this is my opinion -- she did

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1 have to quite an excessive degree this thing that we've
2 mentioned called inappropriate ADH secretion, that is a
3 secretion from the pituitary gland of this hormone,
4 which in certain circumstances the body produces in too
5 great quantities, which shuts the kidneys down, stops
6 the kidneys producing urine. There are many causes for
7 this, as I think this inquiry's heard a number of times.

8 The key to making that diagnosis, apart from doing
9 blood tests, prior to doing blood tests, is the lack of
10 urine output because that's what it does: it stops the
11 kidneys producing urine. It is easy to see and if you
12 have fluid going in and none coming out, too much fluid
13 builds up in the bloodstream. If this fluid is
14 hypotonic, as it was in Raychel's case, that leads to
15 dilute blood and hyponatraemia, which led to the
16 problems. And so although the vomiting was obviously
17 important, the lack of urine output, I think, in my
18 view, was equally important.

19 MR WOLFE: We had a bit of a debate there about the evidence
20 on the inquiry documents about output from urine.

21 Of course, what was available to the doctors and nurses
22 that night was a fluid balance chart, which reflected
23 one episode of urine output at 10 o'clock, 12 hours
24 earlier; isn't that right?

25 A. Yes.

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1 (1.18 pm)

(The short adjournment)

3 (2.15 pm)

(Delay in proceedings)

5 (2.22 pm)

6 MR WOLFE: Good afternoon, doctor. I want to bring you
7 straightaway to Dr Curran's input into Raychel's care.
8 If I could start by contextualising by reference to what
9 he says he thinks he was aware of at the material time.
10 He said in his evidence that he was simply asked to
11 prescribe an anti-emetic. He draws a distinction
12 between being asked to provide an anti-emetic and making
13 an assessment of a child. He didn't make an assessment,
14 albeit he carried out an examination of her abdomen
15 because, of course, she had surgery in that region.

16 He claims that he wasn't told about the
17 coffee-ground vomits and, if he had been told, as
18 I think the chairman mentioned to you earlier, that
19 would have been a red flag for him. Can I ask you
20 this: on reading your report, you say at 222-004-012
21 that in summary, in your view, by 2100 hours on 8 June,
22 with Raychel continuing to receive all IV fluid and very
23 little by mouth, and in the presence of her persistent
24 vomiting, an assessment of her blood electrolyte status
25 was appropriate.

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1 Q. And what you seem to be saying is that was, if you like,
2 another red flag --

3 A. Yes.

4 Q. -- for investigation.

5 A. Yes. Going back to one of your previous questions,
6 "What should a junior doctor or a more senior doctor,
7 for that matter, have done if they were to assess
8 Raychel at those times?" One of things that they should
9 have done was look at the urine output, look at the
10 chart. If they felt the chart was unreliable, ask the
11 parents, the nurses, or even the girl herself how many
12 times she had been to the toilet and how much wee she
13 had passed. And that is something that a more
14 experienced doctor would have done that perhaps the
15 junior doctors wouldn't have thought of.

16 MR WOLFE: I want to come back after lunch and finish this
17 sequence by just looking a bit more at the particulars
18 of Dr Curran's input before moving on to the activity
19 post seizure. I think we could usefully break for lunch
20 now.

21 THE CHAIRMAN: We'll break. We're on track, doctor, to have
22 your evidence finished, I think, by mid-afternoon.

23 Professor Hanratty will be here to add to the evidence
24 that Ms Ramsay gave yesterday. We'll get through both
25 of those this afternoon. We'll resume at 2.15.

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1 A. Yes.

2 Q. You go on to say that that was appropriate, even if the
3 symptoms of coffee-ground vomits and headache were not
4 appreciated.

5 A. Yes.

6 Q. Can I just translate that and correct me if I'm wrong?
7 Are you saying that even if the doctor attending, and it
8 just happened to be Dr Curran, wasn't aware of the
9 coffee-ground vomits, wasn't aware of the headache, the
10 fact of vomiting coming up to 20 hours post-operatively,
11 the fact of the continuing fluids now coming up to close
12 to 24 hours from the commencement at 10 o'clock the
13 previous night, they were the main factors that ought to
14 have been taken into account when deciding on the action
15 to take?

16 A. Yes. As I said previously, 20 hours is a very long time
17 to be able to categorise this vomiting as post-operative
18 vomiting. That's too long after the surgery. So
19 irrespective of whether there was coffee grounds --
20 which as I said previously I don't think is all that
21 critical -- or whether or not Raychel was complaining of
22 a headache, the fact that she was vomiting significantly
23 and copiously, as it appears she was, so long after the
24 operation should have prompted an assessment for other
25 possible causes, and that should have been apparent to

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1 somebody at Dr Curran's level of seniority, I think.
2 Q. I see. So in that sense -- and others can take their
3 own view on this -- I think that Mr Foster, the surgeon,
4 says that while it would of course have been appropriate
5 for nurses to communicate effectively with Dr Curran by
6 showing an indication of concern, nevertheless Mr Foster
7 says Dr Curran should have used his own initiative.
8 A. Yes. I think when an inexperienced doctor is out of
9 their own environment, particularly in what may be
10 considered, to them, the alien environment of
11 a children's ward, they are very much guided by the
12 nurses. It would be wrong to me to say the obligation
13 was on the nurses to tell the junior doctor exactly what
14 to do. However, in reality, experienced paediatric
15 nurses are much better at assessing children in many
16 situations than a very junior doctor who's had very
17 little to do with children. That happens all the time.
18 So I can understand from Dr Curran's point of view that
19 if he thought that these very-experienced nurses weren't
20 all that concerned, if that was his perception, he may
21 have been biased against calling a senior because he
22 sensed that the nurses didn't feel it was necessary. He
23 may have got that impression at the time and that might
24 have discouraged him from contacting a senior.
25 Q. Yes.

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1 previously, in anti-emetic prescribing, he actually
2 prescribed what's generally regarded as being a less
3 potent anti-emetic than what had already been given.
4 Q. So is it implicit in what you're saying that the doctor
5 attending at the request of a nurse should do a bit of
6 digging around to see what the recent history was and,
7 if he had done that, he would have inevitably checked or
8 should inevitably have checked the drug kardex to see
9 what the full picture was?
10 A. The drug kardex is one thing, yes, but also the fluid
11 charts, the previous notes, the operation notes and
12 spoken to the parents as well, which didn't seem to
13 happen. However, I qualify that again by saying that
14 Dr Curran was at a very junior level. He would have
15 reasonably expected to be guided by the nurses'
16 generally feelings, even though the nurses may not have
17 felt able to tell him exactly what to do, but what level
18 of concern there was. So I think he has some
19 justification in arguing that he didn't get that
20 impression at the time.
21 THE CHAIRMAN: And interestingly, Dr Devlin said:
22 "If it had happened to be me who was called out for
23 the second time, I think I would have been more likely
24 to pick up that there was something more amiss."
25 And this is your point, which is made elsewhere in

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1 THE CHAIRMAN: But isn't there one other point that
2 Dr Curran made, which is the very fact that they called
3 him, as a junior house officer, led him to think that
4 the concerns were not significant?
5 A. That's a very interesting question. Is the onus on the
6 nurse to deliberately bypass the most junior tier and go
7 to a more senior tier if she thinks that there is
8 a problem or should she stick to the rigid hierarchy and
9 that varies very much from one unit to another, from one
10 ward to another on what the prevailing culture was.
11 MR WOLFE: Could I bring to you another point which is
12 germane to the action that Dr Curran should or shouldn't
13 have taken? You've said, reflecting upon the fact that
14 Dr Curran in his witness statement was unable to recall
15 whether he was aware of the first anti-emetic, you have
16 said at 222-005-004 that it should have been clear from
17 the drug prescription that the Zofran had already been
18 given, and you say this is significant because the lack
19 of any improvement after the first anti-emetic should
20 have prompted a reassessment.
21 A. Yes. Well, in any situation if you have a problem, you
22 have given a treatment and the treatment doesn't work,
23 rather than repeating the treatment, you think about
24 what else the problem might be. That's talking in very
25 general terms. In the specific, as we were discussing

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1 your report, about people coming in and seeing Raychel
2 once and only once.
3 A. Yes.
4 THE CHAIRMAN: That invites trouble, doesn't it?
5 A. It does. That's a really important point, Mr Chairman,
6 about continuity of care. It's a huge issue throughout
7 the NHS generally and I have to say that's one thing
8 that's got worse since 2001 because doctors now work
9 shorter shifts, so continuity is a problem. It's only
10 human nature: if you come back to see someone yourself,
11 as opposed to someone else as seen them, and you
12 perceive they're worse than they were when you saw them
13 the first time, you are more likely to take action than
14 if somebody else had because you wouldn't have had the
15 original impression that your colleague had.
16 MR WOLFE: Dr Curran signs off on the drug kardex at 10.15.
17 There is a controversy, I suppose on the evidence, in
18 terms of whether he spoke to any of the nurses. He
19 seems to think that he did in his written witness
20 statement. The nurses appear to have had no contact
21 with him.
22 The next development of note is a further vomit
23 written into the fluid balance chart at or around that
24 11 o'clock slot. You know the way the chart works, it's
25 between two times.

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1 You have said in your report:
2 "In my view [this is at 222-004-011] the lack of
3 response to the first anti-emetic [that's, if you like,
4 the Devlin anti-emetic] after four hours and certainly
5 the lack of response to the second one should have
6 prompted more concern and discussion by the junior
7 medical staff with more senior colleagues."
8 A. Yes.
9 Q. So we've looked at the first one, obviously, and that
10 was followed up by Dr Curran's involvement. What do you
11 mean by "the lack of response to the second
12 anti-emetic"?
13 A. She continued to vomit, I think. There was a short
14 period where she didn't, but if I've got the timings
15 right, she vomited --
16 Q. Certainly Staff Nurse Patterson, passing through the
17 ward, is handed by the parents another vomit tray, which
18 she puts into the fluid balance chart at or about 11 pm.
19 There was then an unrecorded vomit or trace of vomit --
20 it depends how the evidence is viewed -- at or about
21 12.30. The nurses in their evidence say this was a mere
22 spot on the pyjama top and they were, I suppose, unsure
23 whether this was new vomit or a trace from an earlier
24 vomit. So just to be clear, whenever you talk about the
25 lack of response to the second anti-emetic, is that

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1 vomiting's longer, there's a second anti-emetic and so
2 on.
3 A. Yes. There was enough time for the second anti-emetic
4 to work if it was going to and it clearly hadn't. Yes,
5 I agree, they -- I think the nurses should have made
6 some contact. Whether they should have bypassed the
7 junior house officer and gone to somebody more senior,
8 as I said just now, it is a debatable point.
9 THE CHAIRMAN: That's the local practice point, is it?
10 A. It's the local practice point, exactly. My personal
11 view is they should have gone straight to
12 a paediatrician, but that wasn't the practice at the
13 time.
14 THE CHAIRMAN: Thank you.
15 MR WOLFE: You have made a point at various junctures about
16 the role of the paediatrician, not unnaturally because
17 you're a paediatrician yourself. Is there a particular
18 issue there about the fact that, on a mixed ward such as
19 this, you have probably very many more paediatric
20 medical patients and the evidence tells us maybe only
21 three or four surgical patients at a time? Surgical
22 patients tended, at least in those days, to be cared for
23 by the surgeons. Do you see a role or do I interpret
24 some of your answers as suggesting that you see
25 a greater role for paediatricians in the care of

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1 a reference to the fact that a further vomit is reported
2 by 11 o'clock?
3 A. Yes. The purpose of giving an anti-emetic is to stop
4 vomiting and it clearly didn't.
5 THE CHAIRMAN: Sorry, can we bring this up, Mr Wolfe?
6 I wanted to bring up one point. 222-004-011, please.
7 MR WOLFE: That's the answer to 5(b), I think.
8 THE CHAIRMAN: Yes. If you can highlight 5(b) for us, the
9 middle third of the page. It's on the fourth line down,
10 doctor:
11 "in my view, the lack of response to the first
12 anti-emetic after four hours and certainly the lack of
13 response to the second one should have prompted more
14 concern and discussion by the more junior medical staff
15 with more senior colleagues."
16 In terms of the lack of response to the second
17 anti-emetic, the junior medical staff were not brought
18 back in after that until the seizure.
19 A. Yes, I accept that. And maybe the way I phrased it
20 there, I didn't take recognition of that.
21 THE CHAIRMAN: I just want to see: does that mean that when
22 the nurses knew or should have known that Raychel was
23 still vomiting after the second anti-emetic, that should
24 have caused them to make further contact with doctors
25 and perhaps at a level above JHO? Because by then the

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1 surgical patients?
2 A. Yes. I can give you my views on that if you want,
3 although it is very much a personal view and I'm not
4 speaking on behalf of all my colleagues in the
5 profession. I feel that surgical children in a district
6 general hospital that does not have specialist
7 paediatric surgeons -- it would not be the same in
8 a teaching hospital -- but in district general hospitals
9 where surgical children are looked after by general
10 surgeons whose primary responsibility is to adults and
11 some of whom don't have much paediatric training, the
12 primary care of all those children, whether or not they
13 have an operation, should rest with the paediatricians,
14 certainly for the younger ones. Arguably, for the
15 teenagers, they could be under the adult surgeons.
16 That's from admission because, as we've already
17 discussed, many children who come in with acute
18 abdominal pain turn out not to have a surgical
19 condition, but also to their post-operative management
20 as well because paediatricians are, in my view, better
21 at assessing children's hydration, their general state
22 of functioning and whether they may have infections and
23 all these factors we've already been discussing. And
24 also, better at doing the practical procedures,
25 importantly, doing the things that children don't like

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1 very much, like having cannulas put in and blood taken,
2 which I think we do with greater skill, I have to say --
3 our surgeons have other skills, but I think
4 paediatricians are better at doing those sorts of
5 things. This is happening increasingly, but I still
6 think there is a potential problem there.

7 THE CHAIRMAN: By way of illustration, does that happen in
8 Salisbury or not?

9 A. It has changed a lot. I'm glad you asked me that,
10 Mr Chairman. I don't want to take up the inquiry's time
11 too much with stuff that isn't directly relevant.

12 THE CHAIRMAN: I'm trying to illustrate the point.

13 A. The issue of who they come in under -- the policy in my
14 hospital changed about five years ago in that all
15 children of whatever age with abdominal pain, even if
16 the GP admitting -- the doctor who sends them up
17 suspects that it's appendicitis come in under the
18 paediatricians. That is now a universal rule and so
19 they're assessed by us. More often than not, we don't
20 need to involve the surgeons. We can either make
21 a medical diagnosis and treat it -- for example, a
22 urinary tract infection -- or we decide it's
23 non-specific abdominal pain, not appendicitis, observe
24 them overnight and send them home. We only involve the
25 surgeons if we have a strong suspicion. So in that

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1 If I could have up on the screen, please,
2 222-005-006. Broadly speaking, you make two points:
3 "The nurses are consistent in their observation that
4 Raychel was not sufficiently ill in herself ..."

5 Do you see that, doctor?

6 A. Yes.

7 Q. "... throughout 8 June to cause them concern. When the
8 JHOs were called at 17.30 and 22.00, it was just to give
9 symptomatic relief in the form of anti-emetic drugs, not
10 because they were concerned about more serious
11 complications."

12 And then you set out some specifics about what
13 certain of the nurses were saying. You are obviously
14 not approaching this from a nursing expertise, but in
15 terms of the nursing observations, in your experience
16 would you have expected the nurses just as much as the
17 doctors, particularly experienced paediatric nurses, to
18 have picked up on signs that this child was not
19 recovering from surgery as well as she might have?

20 A. Yes. As I said earlier, the signs can be quite subtle
21 and I was talking in the context of a paediatrician
22 being better able to pick these things up than perhaps
23 an adult-trained surgeon. The same could be said of the
24 nursing staff in that an experienced children's nurse
25 should almost instinctively be able to detect when

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1 respect it's changed.

2 The post-operative management is usually joint
3 in that we both teams are involved. Just going back to
4 what we were discussing about ward rounds earlier, we
5 try as much as possible to have a joint ward round so
6 that when the surgeons see a child on the ward in the
7 morning, one of the paediatric team is there with them
8 and that doesn't always happen, but we usually try and
9 make sure that happens. So things have moved on since
10 then.

11 However since 2001, I have to say in my own ward it
12 wasn't much different to what was happening in
13 Altnagelvin at the time.

14 THE CHAIRMAN: What you have just described is not standard
15 but it's increasingly common in units that you're aware
16 of?

17 A. It is in many places, yes.

18 THE CHAIRMAN: Thank you.

19 MR WOLFE: So we've looked at the role of the JHOs and the
20 interaction with Raychel. We've looked at, if you like,
21 perhaps an aspirational issue about whether the
22 paediatricians might have made something of a difference
23 here. Could I ask you about the part played by the
24 nursing staff because you've commented on that in your
25 report?

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1 a child isn't quite right and then get a doctor,
2 preferably a paediatrician, to assess her.

3 Q. Yes. We went over the ground this morning about vomits
4 that occurred that weren't recorded and the impact that
5 that might have had on the medical care because what is
6 fed into the doctors affects, to some extent at least,
7 the investigations and the treatment that they provide.

8 A. Yes.

9 Q. There's another point on this page, it's further up the
10 page:

11 "They admitted ..."

12 This is a reference to the nurses accepting that
13 there was incomplete recording on the charts, lack of
14 quantification of vomit and fluid output:

15 "But, in my view, this is no different to what would
16 have happened on any children's ward in the NHS at the
17 time."

18 So what you appear to be reflecting is a looseness
19 or a poor practice across the service with regard to the
20 recording of these things.

21 A. Yes. I think, as we've already discussed, fluid charts
22 particularly do tend to be rather poorly kept on
23 children's wards.

24 Q. And I think many of the nurses, when they gave evidence,
25 reflected upon the fact that urine output wasn't

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1 recorded.
2 A. Yes.
3 Q. Input in terms of sips of oral fluids wasn't recorded.
4 I should add the caveat to urine, of course, that one
5 episode was noted. And they've accepted that there were
6 other vomits that weren't recorded, albeit there is some
7 controversy about whether they saw some of the vomits.
8 The parents making the point, of course, that they were
9 handing vomit trays to the nurses, so they couldn't have
10 failed to have known about them.
11 But just to finalise on this, it is, of course,
12 important from a medical perspective that the nurses are
13 recording accurately --
14 A. Yes, very important.
15 Q. -- because when a doctor comes to see a patient, it
16 would be an appropriate practice for the doctor to
17 consider what's in the charts before deciding what
18 investigations are necessary.
19 A. Absolutely, yes.
20 THE CHAIRMAN: Has that improved in recent years?
21 A. Do you mean keeping of fluid charts?
22 THE CHAIRMAN: And record keeping generally.
23 A. Record keeping generally has certainly improved. I'd
24 hate to generalise about fluid charts because it varies
25 hugely from one place to another. It will never be as

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1 screen, please, 222-004-026. You say there under the
2 conclusion:
3 "Had Raychel's electrolytes been checked in the
4 early evening on 8 June, it is likely that a very low
5 sodium level would have been discovered and intervention
6 by reducing her fluid and changing it to 0.9 saline may
7 well have prevented the later deterioration and her
8 death."
9 Just on a point of precision, "by the early
10 evening", what do you mean by that?
11 A. Well, again, I was intentionally vague in that
12 conclusion because I think it's very difficult to be
13 specific. But I think as we've already discussed --
14 sorry, there's really two answers to that. One question
15 is, "How long should post-operative vomiting go on for
16 before you think there's something else going on?",
17 which I think we've already discussed. The other
18 question is, "How early in Raychel's deterioration did
19 hyponatraemia start to contribute to her
20 deterioration?", which is much more difficult to define.
21 But as I've already said, if at the time she had her
22 a first dose of anti-emetic, which is about 5 pm, so
23 about 18 hours post-operatively, I think, and/or ...
24 Then I would have expected there to have been a change,
25 a low sodium level. So -- and if there had have been

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1 easy to maintain a good fluid chart in a child as it is
2 in adults because, firstly, younger children are in
3 nappies and therefore don't go to the toilet and
4 therefore it's more difficult to measure it, although
5 you can weigh nappies, but that's another issue.
6 Secondly, people are reluctant to do invasive
7 procedures, such as inserting urinary catheters or
8 naso-gastric tubes in children, not surprisingly,
9 because it is unpleasant, they hate it, whereas adults
10 are more tolerant of those things. Also, slightly older
11 children have a tendency to go off and go to the toilet
12 on their own and not tell anybody and it's quite
13 difficult to keep track of that sort of thing. And they
14 may well wet the bed and that's difficult to quantify.
15 There's a whole host of practical reasons why it's more
16 difficult.
17 So while I am being critical of the fluid chart
18 there, I do appreciate the practical difficulties that
19 paediatric nurses have in monitoring fluid balance
20 accurately. It is very difficult.
21 MR WOLFE: Before reaching the point of the seizure and the
22 reaction to that, could I just ask you to look at some
23 of your overall conclusions in terms of what the conduct
24 of electrolytes and the change of fluid might have
25 achieved in this situation. If we could have up on the

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1 and if she had been managed appropriately following that
2 result, then an intervention -- I would have expected to
3 have prevented this.
4 Q. And if the intervention had come later in the evening,
5 by 9 or 10 o'clock when Dr Curran was in attendance --
6 A. I think it would have made a difference, yes. Other
7 experts may have a different view on that. Her seizure
8 was at about 3 o'clock in the morning, so it was about
9 five hours before that. Would that have been enough
10 time to reverse the cerebral oedema? Possibly, yes, but
11 she would have needed fairly intensive management over
12 that period of time.
13 Q. And of course, that would have required presumably
14 a paediatrician to --
15 A. Yes.
16 Q. -- enter the fray and consider the appropriate fluids to
17 use.
18 A. Yes.
19 Q. Might it have required a CT scan at that point to
20 determine the --
21 A. A CT scan wouldn't have been done just on the basis of
22 the electrolyte results or even on the history of
23 vomiting. That would have been done on the basis of a
24 decreasing conscious level and there is some
25 disagreement, clearly, from the different witnesses as

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1 to what extent her conscious level had deteriorated by
2 that time of the evening, by 5 o'clock. If she had
3 become unconscious, even before the fit, then a CT scan
4 should have been considered, yes.

5 Q. You go on in the paragraph or two below:

6 "I do not consider that any blame should be
7 attributed to any of the members of staff for
8 prescribing or administering 0.18 saline in the first
9 place as this was quite clearly routine ward policy
10 at the time."

11 Presumably the emphasis in that sentence is on the
12 words "in the first place"?

13 A. Yes.

14 Q. Because, as I understand your evidence, clearly there
15 were opportunities at various points from late afternoon
16 into the evening to carry out an electrolyte profile and
17 change the fluids from Solution No. 18.

18 A. Yes. There would have been no indication, given the way
19 people used intravenous fluids at that time, for anyone
20 to change the fluids without doing an electrolyte
21 profile first. There wouldn't have been any reason to
22 sort of suddenly change to normal saline if it hadn't
23 been routine ward policy in the first place. It all
24 depends on the electrolytes.

25 I'd just like to make the point again, which I'm

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1 A. Sorry. Do you want me to slow down?

2 Q. Yes.

3 A. There would have been many situations where the staff
4 would have come across children with a very similar set
5 of problems, with vomiting post-operatively, where they
6 may have chosen to do an electrolyte profile and
7 it would have been normal and they would have been
8 reassured and they would not have changed the IV fluids.
9 So most children getting this amount of 0.18 per cent
10 saline for this length of time in this quantity would
11 not get dangerously hyponatraemic.

12 THE CHAIRMAN: Isn't there another aspect, doctor, which is,
13 unfortunately, in our comparatively small jurisdiction
14 there might have been lessons learnt from earlier
15 deaths --

16 A. Yes.

17 THE CHAIRMAN: -- which could have carried over, and in
18 particular, apart from the two deaths that we're aware
19 of in the Royal, which were perhaps in different
20 circumstances -- because everyone's circumstances are
21 different -- there was the death only the previous year,
22 in 2000 --

23 A. Yes. This is --

24 THE CHAIRMAN: -- which is effectively a gastroenteritis
25 death?

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1 sure has been made many times in the inquiry, but many,
2 many, many children would have been given exactly the
3 same fluid regime for exactly the same indications in
4 the same situation and not developed hyponatraemia and
5 cerebral oedema and I'm sure you've heard this from all
6 the witnesses, but I'd like to say that. I personally
7 have never seen this degree of hyponatraemia causing
8 cerebral oedema in this situation in my entire career.

9 Q. And, of course, every case is different and the
10 clinicians and nursing staff involved have got to meet
11 the case that they have in front of them.

12 A. Yes.

13 Q. Can I suggest to you that what you've just said is not
14 intended to suggest that the electrolyte profile
15 investigation that you've indicated should have been
16 done? You are not suggesting that that wasn't in any
17 way appropriate?

18 A. Oh, it certainly should have been done, absolutely.

19 What I'm saying is that the staff would have -- there
20 may have been many other children in a very similar
21 situation where the electrolyte profile would have been
22 done, child vomiting this long after surgery, and so on,
23 getting exactly the same fluids, and it would have been
24 normal.

25 Q. That was a bit fast.

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1 A. Yes. Exactly, yes. This is a different aspect of the
2 inquiry, Mr Chairman, as you'll be well aware. I really
3 can't comment on if or why members of staff didn't learn
4 from those previous cases. I don't really have anything
5 to say about that.

6 THE CHAIRMAN: Thank you.

7 A. Apart from to say that all these cases were -- the
8 question may arise for this entire inquiry, not just
9 relating to Raychel, is why these all happened within
10 a relatively short space of time in Northern Ireland.
11 I can honestly say it was an unfortunate, unhappy
12 coincidence. I can't think it was because of any way
13 that paediatrics was practised in Northern Ireland which
14 was different to the rest of the UK that caused this to
15 happen, but that's not really for me to judge.

16 THE CHAIRMAN: But we know for instance that two of the
17 deaths were actually missed at the time. Claire's death
18 was missed, so that her inquest wasn't held for about
19 another 10 years --

20 A. Yes.

21 THE CHAIRMAN: -- and it was only Raychel's death and
22 inquest, which prompted a re-opening of Lucy's death.

23 A. Yes.

24 THE CHAIRMAN: So in the same way that of the four deaths
25 that we're looking at in any detail, two of them were

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1 not identified, two of them were missed at the time in
2 terms of hyponatraemia. That might be exactly the same
3 pattern as exists in Great Britain.
4 A. It may be, and there may be many other deaths that
5 occurred previous to these in the rest of the UK which
6 went unidentified.
7 THE CHAIRMAN: Yes.
8 A. We don't know.
9 THE CHAIRMAN: That must be a real possibility.
10 A. It must be.
11 THE CHAIRMAN: Just to expand on that a little, we wouldn't
12 know about Lucy's death but for the fact of Raychel's
13 death.
14 A. Yes.
15 THE CHAIRMAN: And we wouldn't know about Claire's death,
16 but for the television documentary which was made about
17 Adam, Lucy and Raychel. There's a few coincidences
18 there, which suggest that perhaps an alternative
19 explanation to your one, which is many other children
20 have been treated the same and haven't suffered the same
21 consequences, is that some other children may have been
22 treated the same, may have had terrible outcomes whether
23 in terms of brain damage and death and that was not
24 recognised as being attributable to hyponatraemia in the
25 same way as Lucy's condition wasn't noticed, nor was

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1 hyponatraemic is for some reason, I don't know why, she
2 produced a very excessive amount of ADH.
3 In other words, the syndrome of inappropriate ADH
4 secretion, for reasons we don't understand, was much
5 more pronounced in Raychel than it normally is and
6 consequently her kidneys shut down completely,
7 consequently the amount of fluid going in vastly
8 exceeded the amount coming out from the kidneys, being
9 excreted in the urine, and the only fluid she was losing
10 was salt-rich fluid, ie vomit -- she wasn't losing
11 urine, she wasn't losing stool -- and so that led to the
12 hyponatraemia. I think it was a very unusual set of
13 physiological circumstances that doesn't happen very
14 often.
15 MR WOLFE: Nevertheless there was enough medical knowledge
16 at that time to recognise that, because of the potential
17 for SIADH physiologically, action should be taken to
18 reduce input from intravenous fluids post-operatively?
19 A. Do you mean general medical knowledge or do you mean the
20 individual doctors concerned?
21 Q. It was in the literature; isn't that right?
22 A. Yes, it was, but as we discussed before in this inquiry,
23 obviously the very junior doctors involved at the time
24 wouldn't have been aware of that.
25 Q. Yes.

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1 Claire's. Well, Claire and Lucy.
2 A. Yes, it's possible that there may have been others.
3 However, I still think it's a very rare occurrence.
4 THE CHAIRMAN: Yes, and what you're reminding me is it is
5 still quite rare, so that because this is
6 a hyponatraemia inquiry we shouldn't be fooled into
7 thinking that it happens all the time.
8 A. No, it doesn't.
9 MR STITT: Mr Chairman, after that very broad and very
10 perceptive point, if may say so, could I ask Mr Wolfe to
11 consider putting this to the witness: if Dr Scott-Jupp
12 with his expertise is saying that he hasn't seen a child
13 on a similar fluid regime develop hyponatraemia to the
14 degree where there is cerebral oedema, could he be asked
15 what relevance, if any, he sees that ADH may have played
16 or may not have played in this particular case?
17 THE CHAIRMAN: I think, from what you have said this
18 morning, you regard it as having played a significant
19 part?
20 A. I think it is. I'm speculating here, I have to admit,
21 without much evidence and perhaps straying a little bit
22 outside my brief. The most likely physiological
23 explanation for me to explain Raychel's very rapid
24 deterioration in a situation where other children might
25 not have deteriorated and may not have become

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1 A. So there was a knowledge of the -- there was a syndrome
2 of ADH secretion. That has been around for a long time,
3 that's not that new.
4 Q. Moreover, and the point that we've been dealing with for
5 some time now, in the presence of what was known to be
6 a low-sodium fluid and in the presence of vomiting over
7 that period of time, it points up the importance of
8 electrolyte profiles at an appropriate stage in the
9 narrative.
10 A. Yes.
11 Q. Could I just deal with one other point before moving to
12 post seizure. In reflecting in your discussion there
13 about the situation outside of Northern Ireland as well
14 as within Northern Ireland, one of the common themes
15 perhaps is that administration of low-sodium solutions
16 to children in the perioperative period is not uncommon
17 or was not uncommon. Could I have up on the screen
18 something that Dr Warde has said about this in his
19 report to Altnagelvin, 317-009-010?
20 In that paragraph, the penultimate paragraph:
21 "Administration of low-sodium solutions to children
22 in the perioperative period is not uncommon. Their use,
23 I believe, stems largely from the fact that it has been
24 known for many years that sodium excretion in the
25 presence of sodium loading is far less efficient in

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1 infants and young children than in adults. Ward
2 policies regarding IV fluid administration in children's
3 wards were developed, in part at least, to ensure that
4 children were not given too much sodium [hence,
5 presumably, the use of Solution No. 18]."

6 It goes on to say that:

7 "Unfortunately, such policies rarely took maturation
8 of body organs with age into account."

9 Is there anything you can usefully add in that
10 respect?

11 A. A very important point that he makes about the risk of
12 hypernatraemia, too high a sodium level, which --
13 obviously, this whole inquiry is focused on
14 hyponatraemia, but I also have experience of seeing
15 children, a long time ago now, die and become
16 permanently brain damaged because of too much sodium in
17 their bloodstream. So there is obviously a tendency
18 here for everybody to focus on hyponatraemia, but let's
19 not forget that it is quite possible, under a slightly
20 different set of circumstances, that Raychel and the
21 other children that the inquiry is investigating could
22 have come to harm from hypernatraemia, and the whole
23 reason why, going right back to the early days of
24 IV fluid policies and the whole reason why low-sodium
25 containing fluids was because of a lot of concern and

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1 time?

2 A. Yes, I assume that's what he means and that it is now
3 safer to give normal saline to older children than we
4 thought it was earlier.

5 Q. At 3 am, very unfortunately, Raychel suffered her
6 seizure. And the nurses were apparently quite quickly
7 on the scene, as was Dr Johnston. Dr Johnston was
8 a senior house officer on the paediatric medical side.
9 He took steps to stabilise her, as the inquiry has
10 heard, and was reasonably immediately suspicious of an
11 electrolyte imbalance and he arranged for bloods to be
12 taken for profile.

13 You have said in your report at 222-004-014 that you
14 do not think that any criticism should be attached to
15 Dr Johnston for not assuming that hyponatraemia was the
16 problem in advance of the blood results.

17 A. Yes.

18 THE CHAIRMAN: I don't know if you know, but Dr McCord gave
19 evidence last week. His view on that was similar to
20 your own and he said that the initial reading of the
21 blood tests after 3 am was so extreme that it would --
22 I think, in his view, virtually inevitably -- prompt
23 a second test.

24 A. Yes.

25 THE CHAIRMAN: Because it's so extreme that you might well

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1 almost paranoia amongst paediatricians about causing
2 damage from hypernatraemia. So one has to keep that
3 in the balance. I think that's the point he's trying to
4 make there. We now know that we were unduly concerned
5 about hypernatraemia when we shouldn't have been.

6 Perhaps I should also add, Mr Chairman, that even up
7 until the early 2000s, when policies changed about using
8 hypotonic fluids, I would have raised an eyebrow when
9 being told we could never use 0.18 per cent saline,
10 which is effectively what we're told now, because
11 I would have said: that might mean a few children are
12 going to have problems with hypernatraemia. We now know
13 that that probably isn't true, but for people of my
14 generation and older, there was a lot of concern about
15 hypernatraemia.

16 THE CHAIRMAN: [Inaudible: no microphone] some resistance to
17 the change of policy in Altnagelvin a few days after
18 Raychel's death.

19 A. Yes, and that would have been the same everywhere,
20 I think.

21 MR WOLFE: With regard to the point in relation to
22 maturation of body organs, is he making the point that
23 the older child might have been more tolerant of higher
24 sodium content in the IV fluid and that was a factor
25 that was perhaps being missed by the profession at the

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1 think, "That can't be right".

2 A. Absolutely. I read the transcript of Dr McCord's
3 evidence and I would agree with him absolutely that it's
4 so extraordinarily low that if somebody phoned me in the
5 middle of the night saying they had a sodium of 118, my
6 first reaction would be, "It's wrong, it's a mistake, it
7 can't be that low". And I would ask, as happened in
8 this case, was it taken from the arm in which the drip
9 was flowing, which it clearly wasn't, and I would insist
10 on it being repeated because it's so outside one's
11 normal experience. Sodiums of mid 120s, 125 to 130, are
12 not uncommon, and we do see that. But less than 120 is
13 exceedingly uncommon.

14 MR WOLFE: Let me then just take these various developments
15 in bite-size chunks if I can. One question that arises
16 is whether Dr Johnston should have been concerned to
17 bring a more experienced, more senior colleague into
18 play earlier than he did. It appears that he took care
19 of the necessary, which was to stabilise the child, and
20 only by approximately 4.15 -- that's about an hour and
21 15 minutes after the seizure started -- did Dr Trainor
22 come to the bedside.

23 A. Yes.

24 Q. Clearly, the situation might have benefited from earlier
25 input.

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1 A. Yes. In terms of treating the seizure, it would have
2 been within the competence of Dr Johnston as
3 a paediatric SHO to do an immediate first aid treatment
4 of the seizure, which it sounds like he did very
5 effectively. And he then rightly suspected an
6 electrolyte abnormality and needed to get the blood test
7 confirmed in order to do that. To answer your question,
8 it would depend on how experienced and confident he was
9 as an SHO and also how tied up he knew his registrar to
10 be because I think Dr Trainor was busy on the neonatal
11 unit and may have been critically involved with a baby
12 that she was unable to leave and he probably would have
13 known that. So those factors come into play as well.

14 Q. The next step, if I can call it that, is for Dr Trainor
15 to arrive at 4.15. At that point, she's receiving,
16 almost as soon as she arrives, the electrolyte result,
17 which, as you've described, is abnormally low. It's
18 either 118 or 119. It doesn't make much of
19 a difference. That fact of an abnormally low result,
20 should that have prompted Dr Trainor to aggressively
21 tackle the electrolyte imbalance by changing the fluid
22 at that point, in your opinion?

23 A. If she was certain that it was genuine, and I think by
24 that stage she was, yes. She, I think, reduced the
25 infusion --

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1 kind of result doesn't fit with what you see or it seems
2 to be completely out of the normal range of experience,
3 repeat it. And I think that was the right thing to do.

4 Q. Can I just test that in this way? Raychel's notes and
5 records, had they been analysed, would have shown that
6 this was a surgical patient and with surgery you have
7 the risk of the antidiuretic hormone's inappropriate
8 reaction. You also have at the bedside the record of
9 the vomiting all day and you have the record of the
10 hypotonic fluid being given all day, arguably at a rate
11 which was too high. Would it not have been possible for
12 a registrar on the paediatric side to have worked out
13 that the fluid or the electrolyte reading that she was
14 getting was in fact very consistent with that history
15 that I've just outlined?

16 A. I think it's very difficult to expect a trainee doctor
17 in the middle of the night to go through those thought
18 processes and come out with that conclusion quite so
19 rapidly, especially as we've said several times, this
20 degree of hyponatraemia is outwith anyone's experience,
21 either her or the other doctors present or anybody else
22 involved. So I repeat, I think the right thing to
23 do was to repeat it, even if she had been fully aware of
24 all those other things going on because she would have
25 come across other children on the same fluids in the

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1 Q. Sorry, at this point, just to be clear this, is 4.15,
2 this is the first result --

3 A. Sorry, following the first result. As I've said,
4 because it's so extraordinarily low, I think it was the
5 right thing to do, to repeat it, before changing the
6 management. In the amount of time it takes to repeat
7 a sample, which I think was about half an hour or so,
8 which is fairly typical, it wouldn't make a huge
9 difference, not in the great scheme of things, in not
10 changing the fluids immediately. As I said, if you got
11 it wrong and the sodium was high rather than low, you
12 could end up going the wrong way and treating it or
13 there may be other completely different reason for the
14 deterioration.

15 Q. Her perspective, to put that into the mix, is that she
16 had never seen such a low sodium. She had been taught
17 or instructed in her training to repeat when the finding
18 is abnormal because of, if you like, the fear, the
19 preoccupation with the possibility that the lab had
20 produced a rogue sample.

21 A. Yes.

22 Q. And that is why she asked for it to be repeated. That's
23 a view you concur with?

24 A. Absolutely, yes. And I would always say to any junior
25 I was teaching: if any laboratory result or any other

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1 same situation who had normal sodiums and where it may
2 have occurred for completely different reasons that had
3 nothing to do with the chemistry.

4 Q. Dr Haynes is an anaesthetic intensivist and he has
5 placed a perspective on the record which I would ask you
6 to consider. It's set out at 220-003-018. He says on
7 that page in his report:

8 "Although the attending doctors may have seemed
9 hesitant to correct the hyponatraemia, it must be
10 remembered that it was of a severity that none of them
11 would previously have seen. Information regarding the
12 correct dose of hypertonic saline would not have readily
13 been available, but I would have expected Dr Trainor to
14 have made some attempt to obtain hypertonic saline to
15 correct the abnormality, even if it meant giving an
16 estimated dose and making serial serum electrolyte
17 measurements."

18 Again, it's the same point that I've been putting to
19 you.

20 A. Well, it's not quite because the issue of giving
21 hypertonic saline -- if I could just address that,
22 because I didn't mention that at all in my original
23 reports because it's so rarely ever used, it's not
24 within the normal competence or the normal range of
25 options open to paediatricians in this situation.

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1 I don't think I've ever in my entire career given
2 hypertonic saline outside of a neonatal unit. It is
3 rather different with newborns compared to an older
4 child. So I didn't consider it as something that should
5 have been done when I wrote my original report.

6 Having now read the experts' reports subsequently,
7 I thought maybe that, if they had got to that stage and
8 thought of it, then could it have made a difference.
9 Well, I suppose conceivably it could, but this is such
10 an unusual situation. If I asked myself what would
11 I have done in that situation and I had known about the
12 low sodium, I don't think I would have given
13 hypertonic -- or I wouldn't have told the registrar on
14 the phone to give hypertonic immediately. I would have
15 spoken to a paediatric intensivist first and got some
16 advice because it's so unusual and certainly, if you are
17 using hypertonic saline, you're almost certainly in an
18 intensive care situation by then and you will be
19 involving intensivists. So my response to that would be
20 that treatment would only be given on the advice of
21 a paediatric intensivist.

22 Q. Just going back to the repeat point, just so that we can
23 put all the bits out on the table: Mr Foster, the
24 surgeon, is of the view that the appropriate response
25 would have been to repeat the battery of electrolyte

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1 on the phone is very brief, so the consultant can get
2 on, get ready and come in as quickly as possible.

3 So having said that, let's just say that the initial
4 statement wasn't "I want you to come in" but "I want
5 your advice about this patient" --

6 THE CHAIRMAN: Sorry, that wasn't, because Dr McCord was
7 quite clear. It was, "Come in as quickly as you can".

8 A. In those circumstances it is difficult because one
9 doesn't want to waste time when you're coming in anyway
10 and you can pick up the story when you get there. And
11 how many treatments -- what treatment is the registrar
12 going to be able to give in that short period of time
13 while the consultant gets in that it really matters
14 where those few minutes are critical, and the answer is
15 probably fairly few. The immediate life saving
16 treatments they should all be doing anyway, the ABCs,
17 airways, breathing and resuscitation, stopping fits,
18 that kinds of thing should all be done automatically
19 anyway.

20 So to answer your original question, under these
21 circumstances it would have been quite a brief
22 conversation. It would have been, "9 year-old girl
23 who's fitting post operatively following appendicectomy.
24 The sodium is very low". And that would be about it.
25 And I guess if it was me, I would say, "Are you sure

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1 tests before you consider what fluid to use. Moreover,
2 the inquiry has heard from the consultant paediatrician
3 Dr McCord, who was contacted by the registrar
4 Dr Trainor. He is of the view that the advice that he
5 would have given would have been to repeat the test
6 before deciding on what fluids to use going forward.

7 Can I just ask you about the interaction between
8 Dr Trainor, the registrar, and the consultant? What
9 would you have expected the registrar to impart to the
10 consultant when she got him on the phone?

11 A. Right, well, actually the skill of a junior doctor
12 phoning a consultant at home in the middle of the night
13 is now something we actively teach because it's not that
14 easy to do it well and not do it badly.

15 But anyway to answer your question, it's not always
16 easy. But she should have stated the patient's age,
17 gender, location, what the background was, a very brief
18 summary of the reasons for admission -- in this case the
19 timing and the nature of the surgery -- and then
20 explained the -- sorry, if I can go back a bit. The
21 very first statement made by the doctor, by the
22 registrar phoning the consultant before getting into
23 that stuff is either, "I want your advice", or "I would
24 like you to come in". If the registrar states, "I want
25 you to come in", then the amount that needs to be said

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1 that's right? Repeat it if you haven't done already and
2 I'll be in. By the time I get in, you might have the
3 repeat back".

4 MR WOLFE: So you would have expected the sodium result,
5 albeit it might have been suspicious of a rogue
6 result -- you'd expect that to be said?

7 A. Yes.

8 Q. Dr McCord's response to that was can't remember whether
9 he was told, but, "Had I been told that, I would have
10 been instructing a repeat --

11 A. Yes.

12 Q. -- I wouldn't have been suggesting using hypertonic
13 solution."

14 But what he went on to say was that if he could be
15 confident about the result, he would have been
16 suggesting normal saline as opposed to hypertonic saline
17 because, like you, he had no experience of 3 per cent
18 hypertonic saline or anything like that.

19 A. That probably would have been my response as well, yes,
20 and I would have said very much the same as Dr McCord
21 did in that situation.

22 Q. He said in his evidence that digesting all of these
23 things quickly and learning about the fact that there
24 were petechiae. Learning about that, he was thinking
25 meningococcal infection, and he did suggest starting

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1 antibiotics, and he added the advice that be sure to
2 ensure that the anaesthetists are available if she
3 deteriorates.
4 A. Yes.
5 Q. In terms of the advice that he gave, how would you
6 comment?
7 A. Absolutely. I would agree with that. Certainly, when
8 a child is rapidly deteriorating, generally most
9 registrars or resident paediatricians would have already
10 thought of contacting an anaesthetist, but just in case
11 they didn't, you'd remind them and tell them not to
12 leave it too long, get your anaesthetist there sooner
13 rather than later, to prepare for a possible need for
14 intubation, which might mean moving them to a different
15 room and getting all the equipment out.
16 The issue of the petechiae is interesting because
17 actually the -- meningococcal septicaemia or meningitis
18 is actually a more likely diagnosis than hyponatraemia,
19 it's more common, and not entirely implausible because,
20 amongst many other ways, that can actually present with
21 abdominal pain. So it's not implausible that the early
22 symptoms of meningococcal meningitis could have been
23 abdominal pain, which led mistakenly to the appendix
24 being taken out and then the rash comes out a bit later.
25 So that wasn't as implausible as one might think. As it

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1 circumstances where you have an emergency facing
2 a patient being cared for under the surgical team, what
3 is your expectation in terms of whether the consultant
4 surgeon on call should be contacted?
5 A. Well, this is difficult because one could argue there
6 was nothing specific for the surgeons to do and, it's
7 true, it was fairly clear that this wasn't a surgical
8 problem in the sense of being an abdominal surgical
9 problem and there was no surgical intervention required
10 at the time. However, simply because she was a surgical
11 patient and still under that team, and because the
12 situation was so critical, this was a child
13 deteriorating and going to intensive care, I think
14 it would have been good practice for a senior surgeon to
15 be involved. Whether that's at registrar or consultant
16 level is arguable, but somebody more senior than an SHO,
17 I would say.
18 MR WOLFE: Doctor, thank you very much. I don't have any
19 further particular questions for you.
20 THE CHAIRMAN: Mr Quinn? Mr Campbell? Mr Stitt?
21 MR STITT: There was one point, if I may, and if you think,
22 sir, that it has been covered, then I apologise. Could
23 we pull up 222-005-007? This is Mr Scott-Jupp's most
24 recent, third report. If we could highlight the middle
25 paragraph, which is numbered 2, beginning "awareness".

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1 happens, the petechiae were probably nothing to do with
2 any infection, but as a consequence of the vomiting.
3 Q. One other possible response that has been implied or
4 hinted at in some of the reports was perhaps the use of
5 mannitol, and you have dealt with that in your report.
6 You said it's virtually never prescribed unless there's
7 objective evidence, usually following a CT scan of
8 a cerebral oedema.
9 A. Yes. Mannitol is an emergency treatment for cerebral
10 oedema. Unless you're confident that's the problem, you
11 wouldn't give it. Again as with hypertonic saline, my
12 own practice would be to give it only on the advice of
13 a paediatric intensivist, only when you knew you had
14 done the most immediate things, which is securing the
15 airway and ventilating the child and treating the fits,
16 and then you give mannitol. By that time, you would be
17 considering admission to an intensive care unit anyway.
18 Q. And it would appear that in terms of a surgical response
19 to this emergency, the sole presence for a long period
20 of time, relatively speaking, was the junior house
21 officer.
22 A. Yes.
23 Q. Other doctors such as the SHO, Mr Zafar, were otherwise
24 detained and he eventually came at or about 5 o'clock,
25 I think the timing is, with the registrar Mr Bhalla. In

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1 If that could be highlighted.
2 May I ask the question directly?
3 THE CHAIRMAN: Let me hear the question.
4 MR STITT: That was following Mr Quinn's style. I'll ask it
5 through you, sir.
6 The first paragraph says:
7 "None of the witnesses including their senior
8 consultants had experienced anything similar previously.
9 None were aware of the previous cases in
10 Northern Ireland. None were aware of the literature
11 from 1992 or 2001. None were aware that there was any
12 risk of hyponatraemia associated with using
13 0.18 per cent saline. None had received any specific
14 training in this area at any stage in their careers."
15 The next sentence:
16 "I do not find this surprising. If the same
17 questions had been addressed to any group of doctors or
18 nurses working on a children's ward at the time,
19 I believe the same responses would have been received."
20 When there's a reference to any group of doctors or
21 nurses, is that within the UK as a whole?
22 A. Yes. The point I'm trying to make, as we discussed
23 earlier, Mr Chairman, was that these ... It could have
24 happened that the series of hyponatraemia deaths could
25 have occurred in another region of England or Scotland

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1 or Wales and then that region would be having its own
2 inquiry now and why it happened in Northern Ireland
3 I have no explanation for. My feeling is that there was
4 no specific deficiency in the way medical practice was
5 carried out that led to this series of deaths in this
6 thing apart from the obvious issue of learning from the
7 previous deaths, which I think you're going to address
8 anyway.

9 THE CHAIRMAN: Yes. My big concern here is I would be,
10 I think, very, very complacent if I thought that the
11 only deaths which had occurred in the UK from
12 hyponatraemia were the deaths with which this inquiry is
13 concerned, for the reasons that I was expressing
14 earlier, that within Northern Ireland two of these
15 deaths were completely missed, and in fact highlighting
16 of the issue of hyponatraemia is largely as a result of
17 the response from Altnagelvin after Raychel's death
18 because there was nothing learnt outside the Children's
19 Hospital after Adam's death.

20 Thank you very much. Doctor, unless there's
21 anything further --

22 A. May I be permitted to ask you a question, Mr Chairman?

23 THE CHAIRMAN: Of course.

24 A. When you publish your report on the entire inquiry, will
25 it be disseminated widely throughout the entire UK or

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1 will it stay in Northern Ireland?

2 THE CHAIRMAN: I send it to the local Minister for Health
3 and he will then publish it. I suspect from what I have
4 heard indirectly from the inquiry's own advisers,
5 there's interest in it beyond Northern Ireland.

6 A. I think it would be a tragedy if the lessons that will
7 be learnt from this valuable inquiry were just kept
8 within the Province because, I think, those of us in the
9 rest of the UK -- and the rest of the world for that
10 matter -- have much to learn from this.

11 And if I could just -- if you'll -- this may be well
12 beyond my brief, Mr Chairman, but the issue of
13 paediatric care of children on surgical wards, not just
14 in the context of IV fluids and hyponatraemia, but in
15 many other areas which is still, I think, an issue,
16 perhaps more so than some of the other things we've
17 discussed, which have been fixed. That is something
18 that, in my personal view, requires a lot of attention
19 and there is still a potential for things to go wrong
20 with lines of responsibility and so on.

21 THE CHAIRMAN: Just while you're on that, do you have
22 a cut-off point for the age of a child coming on to your
23 paediatric ward?

24 A. Well, that's something else I could talk about for
25 hours. That is a controversial area about adolescence.

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1 You're talking about the older children?

2 THE CHAIRMAN: Yes.

3 A. Traditionally, it has been 16. But that has been
4 blurred a lot in recent years. 16 to 18 year-old
5 adolescents can sometimes go to a children's ward and
6 sometimes go to an adult ward. A few hospitals are
7 fortunate enough to have an adolescent ward specifically
8 for that age group, but most don't. If there is no
9 adolescent ward, they can either go to a children's ward
10 or an adult ward.

11 My view is they should go to a children's ward up
12 until their 18th birthday and there's a tendency now to
13 move towards that on the basis that, although neither is
14 ideal for an adolescent, they should go there. In terms
15 of who cares for them, in a district general hospital
16 they would be -- if they came in with a surgical
17 problem, they would be cared for by a general surgeon,
18 whatever age they were. But for a medical problem,
19 paediatricians would look after them on the children's
20 ward and adult physicians on an adult ward.

21 THE CHAIRMAN: Thank you very much indeed for coming back
22 again and for all your help. Thank you, doctor. We'll
23 take a break for ten minutes and then we'll have
24 Professor Hanratty. Thank you.

25 (3.28 pm)

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1 (A short break)

2 (3.38 pm)

3 (Delay in proceedings)

4 (3.48 pm)

5 MR WOLFE: Professor Mary Hanratty, please.

6 PROFESSOR MARY HANRATTY (called)

7 Questions from MR WOLFE

8 THE CHAIRMAN: Professor, thank you for waiting. It has
9 taken us a bit longer than expected to reach you today.

10 A. That's okay.

11 MR WOLFE: Professor, the inquiry is grateful for the fact
12 that you've provided a detailed report, described as,
13 "A chronology of nurse education in Northern Ireland and
14 comparisons with UK mainland and Republic of Ireland",
15 which has obviously been distributed in advance of today
16 and will enable us to go through your evidence with the
17 benefit of that having been read.

18 Before we embark on an investigation of what you're
19 saying in that report, could we just have your CV up,
20 please? It's at 303-048-574. Do you recognise that,
21 professor?

22 A. Yes, I do.

23 Q. You tell us there that you qualified as a registered
24 general nurse in 1965 and as an RMN in 1967. Did you
25 practice as a nurse at all?

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1 A. Yes, I practised between 1967 and August of 1972.
2 I worked as a staff nurse in outpatients, casualty,
3 children's ward, and care for the elderly with skin ward
4 attached.
5 Q. And looking at that paragraph, you have set out your
6 academic qualifications.
7 A. Yes.
8 Q. You're a registered clinical instructor, registered
9 nurse tutor, and you have a Bachelor of Arts --
10 A. That's right.
11 Q. -- as well as Masters degree in 1994.
12 A. That's right.
13 Q. In terms then of your employment, you have told us that
14 you practised as a nurse for some five years or so.
15 Is that when you became a clinical instructor?
16 A. Yes, I did the clinical instructor's course September
17 to December 1972. And in the beginning of January 1973,
18 from that until August of 1974, I worked as a clinical
19 instructor at Craigavon Area Hospital. Then in 1974 to
20 1975, I did the tutor's course at Magee College, as it
21 was known then. Following successful completion of that
22 programme, I came back and worked as a tutor at the
23 Southern Area College until -- I think it was 1983, and
24 I taught students on the adult part of the register --
25 or general nursing, as it was known then -- and I also

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1 nurse, first of all, and then the appointed nurse for
2 Northern Ireland to serve on the regulatory body in
3 London. So from 1998 until 2006 I was the
4 Vice President of the Nursing and Midwifery Council,
5 previously known as the UKCC.
6 Q. If we were to summarise that career, from 1973 or
7 thereabouts to 2007 ...
8 THE CHAIRMAN: I'm just engaged by your optimism about
9 summarising that career, but go on.
10 MR WOLFE: Let's see if I can do it.
11 In the period from 1973 to 2007, you were engaged in
12 nursing education.
13 A. I was.
14 Q. Leaving aside the four or five years in practice,
15 you have, for 35 years or so, exclusively focused on
16 nursing education --
17 A. Yes.
18 Q. -- both pre-registration nurses and in-service training
19 and education?
20 A. That's right. And if I could just say that my time
21 at the regulatory body in London was responsible for
22 setting up the curriculum of both pre and
23 post-registration, but more importantly for the
24 continuing professional development and what was known
25 as prep, that was introduction of the statutory updating

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1 taught nurses who worked in mental health. But I also
2 taught nurses who were being prepared to work in all
3 wards, including children's wards.
4 In 1983, I was asked to take on a role in the
5 continuing education of nurses, so I went then to work
6 with trained staff and did that until 1990 -- whenever
7 the Project 2000 programme came in. It was 1989
8 actually. When the Project 2000 programme came in,
9 I was asked by the director to take on the
10 responsibility for implementing and introducing the
11 Project 2000 programme at the Southern Area College.
12 I stayed there as the assistant director and
13 Director of Education until 2005, and then I was
14 appointed as the Director of Nurse Education at the
15 Royal Victoria Hospital, which was known as
16 Northside College, until 1997, when the students went
17 into Queen's University.
18 At that point, I then moved to the Beeches
19 Management Centre and headed up the in-service training
20 programme for the Southern and Eastern Health Boards,
21 which encompassed about 10,000 trained nurses and
22 midwives and we were responsible for providing ongoing
23 continuing education for that group of nurses and
24 I retired from that post in 2007.
25 Alongside that, if I continue, I was the elected

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1 that nurses undertook from 1997. I was involved in the
2 development of that.
3 Q. Yes. And I know you're probably too modest to mention
4 it, but your contribution to nursing education has been
5 recognised both in terms of the award of a visiting
6 professorship at the University of Ulster and by
7 a special award from the Royal College of Nursing.
8 A. Yes. And I got the CBE for it also, just to continue to
9 be modest.
10 Q. Very well. The report that you have provided to the
11 inquiry involved you bringing together all available
12 documentary evidence in relation to curriculum content,
13 training and continued professional development of
14 nurses in Northern Ireland on the themes of fluid
15 management and record keeping.
16 A. That's right.
17 Q. I want to ask you some questions about that today, but
18 I also want to ask you, within your area of competence,
19 whether you can assist us with training provided to
20 nurses in relation to some of the post-operative things
21 that the inquiry's interested in, including, for
22 example, observations, communications with doctors and
23 suchlike.
24 A. Yes.
25 Q. Are those things within your area of competence?

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1 A. Yes, absolutely. I should be able to address all of
2 those areas.
3 Q. And I should say, perhaps of less relevance to us today,
4 the second part of your report contains a comparative
5 approach, which is there on the record for those who
6 wish to consider that.
7 A. Yes.
8 Q. Before we get to the specifics of what the various
9 curriculums over the years had delivered in terms of
10 teaching for nurses, can we just take a brief journey
11 through the recent history of nurse education? You have
12 said in your report that the Nurses and Midwives Act
13 (1970) triggered a new training programme for nursing.
14 A. That's right.
15 Q. And it was known as "the experimental scheme"; is that
16 right?
17 A. Yes, that's right. Do you want me to elaborate on that?
18 Q. Please, briefly if you would. It was introduced in
19 1973; is that correct?
20 A. It was experimental in a number of ways. Experimental
21 in that we had six by six-month modules, and within
22 those six-month modules there were preparatory
23 theoretical preparation followed by a period of clinical
24 experience and ending up with a consolidation period
25 of -- really to tie up the ends of the learning. And

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1 modules.
2 Q. Yes. The 1973 experimental programme, as it has been
3 described in your report, it stayed in place until 1983
4 when a new syllabus was prepared?
5 A. That's right.
6 Q. So charting this as best we can, the nurses who have
7 given evidence to the inquiry who, if you like, would
8 have fallen within the 1973 academic programme appear to
9 have been: Staff Nurse Roulston, who studied at the
10 Royal Belfast hospital between 1981 and 1984; Staff
11 Nurse McGrath who studied at Altnagelvin between 1973
12 and 1976; Staff Nurse Bryce who was at the Royal between
13 1977 and 1980.
14 Could I just ask you about Sister Millar? According
15 to her evidence, she was a qualified children's nurse
16 who studied via the Royal Belfast Hospital between 1969
17 and 1971.
18 A. Yes. She was more my era in respect of what was an
19 ad hoc preparation. There was a curriculum, of course,
20 and that had to be approved by -- there was a body that
21 did it, but what actually happened prior to the 1970 act
22 coming into being in Northern Ireland is that we were
23 working with the English regulatory body and using their
24 syllabi for all the preparation of nurses in
25 Northern Ireland. And believe it or not, that goes back

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1 that was very novel because, up until that, a lot of the
2 training was ad hoc and night duty was as and when, but
3 in the new experimental scheme, it was much more
4 regularised and nurses knew exactly where they were
5 going to be right across the three-year period.
6 The other thing that happened there was they had
7 a common foundation programme and a branch programme.
8 And it was important that nurses from a variety of
9 specialties came together, but then towards the end of
10 the programme they stayed in the area that they'd
11 applied for, like adult nursing, children's nursing or
12 mental health nursing. Where I was working in the
13 Southern Board, we didn't have children's training in
14 those days, we just had adult and mental health and
15 latterly then we had learning disabilities -- or that's
16 what it was latterly known as.
17 However, all of the colleges or group schools, as
18 they were known in those days, all had a very similar
19 approach. The Northern Ireland Council was responsible
20 for overseeing exactly the content of the programmes.
21 So whether you trained at Craigavon or the
22 Ulster Hospital in Dundonald or Altnagelvin, it was
23 exactly the same content because the officers of the
24 council approved the content and it had to be similarly
25 laid out in the way that I've explained with the

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1 as far as 1919, when all of Ireland -- I'm not going to
2 give a history lesson, but when all of Ireland was under
3 the umbrella of the UK. That one act, the 1919 act,
4 governed the South of Ireland, Northern Ireland and all
5 of the UK countries. So it was the same syllabus in
6 those days.
7 Q. In 1983 then, a new syllabus was introduced.
8 A. Yes.
9 Q. We'll come to the specifics of what each of these
10 syllabuses might have held for the students, but briefly
11 was there any connection in terms of content between
12 1973 and 1983 in general terms?
13 A. In general terms, the content from when I trained in
14 1962 to 1965, the content in terms of the nursing input
15 didn't ever change. And that went even right through to
16 the Project 2000 programmes because the nursing
17 course -- any of the programmes that were developed were
18 developed primarily with a focus on the nursing care of
19 patients. Therefore, what did change as we went through
20 the different syllabi was a greater depth of knowledge
21 more on the sciences side, like physiology, sociology,
22 psychology. But actually, the nursing content never
23 really changed.
24 Q. In terms of the 1983 syllabus, could I have up on the
25 screen, please, 303-048-584? In this section of your

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1 report, you refer to the guidance for the syllabus
2 in the middle of the page --
3 A. Yes.
4 Q. -- and the guidance emphasised two new broad concepts.
5 Can you help with us that, read that for us?
6 A. "The guidance emphasised two new broad concepts, which
7 should underlie curricula. This first is the importance
8 of appreciating that in the study of nursing it is
9 essential to integrate theoretical teaching and
10 supervised practice. The second concept is the delivery
11 of individualised care within a framework of assessment,
12 planning and evaluation. It is acknowledged that the
13 nursing process method is an effective basis for
14 a framework of individualised patient care."
15 Q. I understand from reading your report that this concept
16 of the nursing process method is of some significance?
17 A. It was brought in by the chief nurse, called Doreen
18 Heywood, back as far as 1972 and it was a requirement of
19 the Department of Health in those days that all nurses,
20 midwives, health visitors, wherever they were
21 practising, had to use that approach, which was about
22 assessing the patient, planning their care, implementing
23 their care and evaluating the care. And alongside that
24 it was very, very important that there was a care plan,
25 which was meant to be a contemporaneous document that

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1 the student from being an employee to having what was
2 described as "supernumerary status". What that meant
3 that the student was no longer an employee of the
4 hospital or the unit of management or the trust that
5 they were working in and there had to be legislation put
6 in place to give them access to caring for patients
7 under the supervision of the particular hospital
8 employees. That was the first thing.
9 The second thing that was significant was that the
10 previous training programmes that were in place were
11 20 per cent theory and 80 per cent practice. That
12 changed under Project 2000 to become a 50 per cent
13 theory and 50 per cent practice, which was a significant
14 reduction in the amount of time that students spent
15 in the presence of patients. But that was augmented by
16 the amount of deepening in the knowledge of the nurse
17 because at the end of it they were awarded diploma
18 status rather than certificated status.
19 Q. So Project 2000 signalled a significant change in the
20 sense that nurses were now being delivered of
21 a deeper --
22 A. That's right.
23 Q. -- biological, scientific understanding of their role?
24 A. Yes, the strapline for Project 2000 was "the
25 knowledgeable doer". I don't know what it meant for

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1 would be upgraded depending upon the progress or
2 deterioration of the individual patient.
3 Q. With regards to the 1983 approach, by my reckoning,
4 Staff Nurse Gilchrist, who studied via the Altnagelvin
5 Hospital between 1984 and 1987, Staff Nurse Patterson,
6 who studied via the Royal Belfast Hospital between 1985
7 and 1988, and Staff Nurse Noble who started in 1982,
8 would she have been caught by that syllabus?
9 A. No, she would have been taught by the 1973 syllabus.
10 Q. So although her --
11 A. Yes, but the legal position with regard to students in
12 training was whatever programme they commenced under
13 they had to stay with that. We often had to run two
14 different type programmes parallel until the students
15 who started on the 1973 syllabus completed their
16 programme while we commenced the 1983 or, when it came
17 to the Project 2000, we had a similar situation to cope
18 with.
19 Q. I understand. Project 2000, then, that was
20 a significant new departure, which --
21 A. Yes --
22 Q. -- was introduced in 1990; is that correct?
23 A. Yes, there were a number of significant features of the
24 Project 2000 programme. First of all, there was
25 legislation that had to be enacted in order to remove

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1 those who went before, but it was that nurses had to
2 have a greater understanding of physiology, psychology,
3 before they -- alongside learning about the importance
4 of patient care.
5 Q. There were obviously changes in the decade just gone
6 into the noughties, which we don't necessarily need to
7 concern ourselves with this afternoon. They're dealt
8 within your report.
9 A. Yes. It was because I was the lead person in the UK for
10 taking forward the 2002 changes that students, before
11 they were registered, would have to demonstrate
12 competencies in six areas of competence by the nurses
13 who were mentoring them on the wards and that the
14 universities couldn't sign them off as a registered
15 nurse, except they had met those competences. But that
16 was of necessity because there was a bit of less than
17 satisfactory reporting by employers that nurses coming
18 out from the university system were not necessarily fit
19 for practice and fit for purpose.
20 Q. So to take an example, Staff Nurse McAuley commenced on
21 Project 2000 in or about, I think, 1996 but spent the
22 last two years in a university setting. And what you
23 seem to be saying is that as a result of concerns --
24 A. Yes, there were concerns by employers.
25 Q. -- that the NMC developed six core domains which were

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1 then examined --
2 A. That's right --
3 Q. -- and tested in practice.
4 A. That's absolutely right. And that work commenced in,
5 I think, about 2004.
6 Q. I want now to spend some time on the content of the
7 syllabi that you have highlighted in your report and try
8 to tie that into the themes with which this inquiry is
9 concerned with regard to Raychel.
10 Could I start by going to page 303-048-599 of your
11 report, please? You have said there -- and it's a point
12 that I was putting to some of the nurses -- that all of
13 the curriculum guidance documents listed above, and
14 maybe I should just stop there. Curriculum guidance
15 documents are what?
16 A. Curriculums for the 1973 and 1983 syllabus. The 1973
17 syllabus was based on the 1970 act and the
18 Northern Ireland Council set out the components of
19 content that should be in a curriculum. So they set out
20 the guidelines and then it was up to the particular
21 School of Nursing to take those guidelines and put meat
22 on the bones and develop it into a three-year programme,
23 which then the Northern Ireland Council officers would
24 have come and approved before it was ready for delivery
25 by Schools of Nursing staff to the students. And that

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1 records. We see that ...
2 THE CHAIRMAN: It's the short six-line paragraph, over
3 halfway down.
4 MR WOLFE: You say:
5 "They would also have understanding of what types of
6 observations of the patient's condition would be
7 required and the need to make appropriate records."
8 And we'll come on to explore that in a moment.
9 Just over the page, please, to page 600. Again, you
10 say that:
11 "Comparison of pre and post 1990 curriculum
12 documents indicates that all students would have had
13 many opportunities to learn about the importance of
14 fluid balance maintenance to the health and well-being
15 of an individual."
16 There is a distinction, as I think you've
17 highlighted earlier, between pre-1990 and post-1990 --
18 A. Yes.
19 Q. -- and what that might mean in terms of, if you like,
20 the nuts and bolts of teaching.
21 A. Yes. In terms of the pre-1990, I think irrespective of
22 the 1973 or 1983 syllabus, the 20 per cent time spent
23 in the classroom, a lot of the lectures on disease
24 process would have been delivered by a doctor and then
25 the nurse education picked up the associated nursing

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1 was done in what I would describe as a chronological way
2 because, in the first year, most of the students will
3 have spent their time in what was described as basic
4 care activities, which was about the importance of
5 feeding, bathing, helping, giving assistance with
6 movement. But it did deal in very great detail with
7 observations of patients and the importance of the
8 different observations of what temperature, pulse, blood
9 pressure, what the significance of vomiting, diarrhoea,
10 colour of skin, all of that -- so it took that all into
11 account.
12 Q. We will go to look at some of the curriculum guidance
13 documents in a moment. At this stage in your report,
14 what you're doing is emphasising that within those
15 curriculum guidance documents it is quite clear that all
16 students from 1973 forward were presented with education
17 in relation to the importance of a body's ability to
18 maintain fluid balance and health --
19 A. Yes.
20 Q. -- and the disease processes that might undermine that.
21 A. Yes.
22 Q. And I want to look at that with you presently in terms
23 of just what that might mean. You go on to say on that
24 page that nurses are taught about what type of
25 observations are required and to make appropriate

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1 care. So we had surgical blocks, medical blocks,
2 children's blocks -- and when I say a block, I mean
3 a period of time which had preparation, clinical
4 experience and a consolidation block. So the nurse
5 teachers would have done a lot of the actual teaching
6 and emphasising the importance of the care in respect of
7 the particular conditions. So it was disease-orientated
8 modules that we were looking at all the time.
9 Q. Yes. Let's move forward and look at some of the
10 curriculum content in the various stages of recent
11 history. If we go forward to page 602 where you begin
12 to set out the syllabus for the 1973 programme. You say
13 that as part of the 1973 programme, which we know
14 remained in place for some 10 years --
15 A. That's right.
16 Q. -- that measuring and recording fluid intake and output
17 was a feature.
18 A. Yes.
19 Q. Going down that list, general pre and post-operative
20 nursing care was a feature of the syllabus.
21 Intravenous, subcutaneous and other parenteral infusions
22 was also a feature.
23 A. Yes.
24 Q. And then over the page, the curriculums were expected to
25 deal with the skills of communication.

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1 A. Yes, that's right.
2 Q. And is that between nurse and patient as well as nurse
3 and --
4 A. Nurse and patient, nurse and family. And that was
5 irrespective of the age of the patient. We had always
6 had an emphasis on the importance of communication with
7 the family, but more particularly, when you were dealing
8 with children. But it wasn't exclusively children that
9 we had that emphasis on in the programme.
10 THE CHAIRMAN: It is just a different type of communication
11 with an adult's family rather than a child's family, is
12 it?
13 A. Well, to some degree, sir, but the anxieties were
14 similar and the wanting of information and the
15 explanation of doctors -- well, I wouldn't want to call
16 it jargon, but they always talked in medical terms, so
17 that needed to be followed up with a nurse, explaining
18 what that meant, that the patient understood it, and the
19 relatives.
20 MR WOLFE: I shouldn't have skipped so fast past the
21 previous page. Where you list as part of the syllabus,
22 under the heading of "Principles and practice", that
23 measuring and recording of fluid intake and output was
24 a feature of the syllabus, what, as precisely as
25 possible, was being taught?

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1 wards, that was totalled up every night and the person
2 in charge of the ward had to check that it balanced or
3 why there were gaps and so on, because measuring and
4 recording intake and output was a very significant part
5 of the continuing care of the patient. I'm emphasising
6 this because that's how I practised it and that's what
7 we had to teach when we were teaching the students in
8 the classroom.
9 Q. Yes. Presumably, students were taught a baseline of
10 what was normal.
11 A. Oh, absolutely, yes.
12 Q. Were they taught to recognise what was abnormal?
13 A. Yes, we were taught and I taught myself about the
14 importance of osmosis and diffusion, all of -- and the
15 function of the role of the kidney in performing that
16 and the importance of extracellular, intracellular, that
17 was all taught. Even in the days back in the 60s that
18 was taught.
19 Q. Leading on to what might be regarded as abnormal, what
20 were nurses taught in terms of their role --
21 A. Well, their role --
22 Q. -- if abnormalities arose?
23 A. Their role, first of all, was to make sure that they had
24 proper information about what the particular fluid loss
25 was, whether it was -- well, first of all can I say that

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1 A. First of all, that's a direct lift from the syllabus.
2 So I think that the people who devised the syllabus
3 recognised the importance of that as a nursing
4 responsibility and therefore they highlighted it as
5 something we had to build information around. First of
6 all, in terms of anatomy and physiology -- and that's
7 going back even to pre-1973, we were taught the
8 importance of the fluid make-up of the body and how
9 important the maintenance of hydration was. So that was
10 a theme that ran through from when I started in 1962.
11 And the significance then of fluid loss, whether that be
12 vomiting, whether it be diarrhoea, whether it be fluid
13 lost through the skin or indeed from wounds.
14 So in the teaching, you'd have started off with
15 looking at what normal body hydration was and how that
16 was maintained and moving on then to the ways in which
17 that could be disrupted. And that followed then with
18 the importance in terms of the patient's well-being, how
19 the nurse with her responsibility for caring for the
20 patient would take and make note of any ... We all know
21 what normal urination and the amount during the day or
22 faecal matter -- vomiting's not normal, so therefore
23 when you got into the abnormal, it was important to make
24 a record of any abnormal fluid loss. That was
25 emphasised and, in my own clinical experience on the

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1 in the classroom, in respect of vomiting, diarrhoea,
2 whatever, there was great detail in the classroom on the
3 variations. For example, if you take vomiting, whether
4 it was food undigested, whether it was bile, whether it
5 was coffee grounds, if it was diarrhoea what the colour
6 was, all of that, all very difficult to talk about, but
7 by the same token significant in terms of nurses
8 observing patients. So that when the nurses went out on
9 to the ward, when they observed whether the vomit was
10 bile or whether the diarrhoea was green, not only did
11 they record the amount, but they had to record the
12 consistency, the colour and so on.
13 Q. Yes.
14 A. And those were absolutely fundamental points of
15 teaching.
16 THE CHAIRMAN: Was that a fundamental point of teaching all
17 through your experience of teaching?
18 A. Absolutely.
19 THE CHAIRMAN: Over 30-plus years?
20 A. What I said, sir, was that irrespective of the different
21 programmes that we delivered, the emphasis that I'm
22 putting on observations and the care for the patient
23 never waned. The difference was that there was some
24 deeper knowledge, but the actual nursing care never
25 waned and the emphasis was on the importance of the

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1 nurse being at the bedside and knowing what was
2 happening to the patient.
3 THE CHAIRMAN: What about in terms of something which has
4 been a bit inconsistent and may necessarily be about
5 volume, whether it's vomit plus, plus plus, plus plus
6 plus? Because I've had at least three different
7 interpretations from different nurses of what plus plus
8 means. It means anything from small to medium to large.
9 A. Well, I listened to that too.
10 THE CHAIRMAN: Is that inevitable?
11 A. It probably is. If a person spontaneously vomits, you
12 cannot measure that because it's all over the
13 bedclothes, but you'd know if it was something that they
14 had spit up or if there was a fairly hefty vomit and
15 in that case you would, but it has always been
16 encouraged if at all possible, whether it's a urine
17 output or whether it's vomit, that you would make sure
18 that you give the receiver and then -- because if the
19 patient is being sick and nauseated, there would have to
20 be something by the bed in case the patient
21 spontaneously vomited. It's not difficult to measure
22 that, sir.
23 THE CHAIRMAN: That's what Mr and Mrs Ferguson say they did:
24 they did catch Raychel's vomit in these kidney bowls and
25 handed them over.

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1 vomiting, but it was the impact that that vomiting
2 was -- continuous vomiting would have had on the
3 patient's fluid balance. And I've already referred to
4 us having taught that. And about the importance of
5 whether or not the patient was being dehydrated. It
6 wasn't until the Project 2000 programmes where we had
7 a deeper emphasis and more time to spend on
8 physiological aspects that there would have been greater
9 emphasis put on the electrolytes and what the nurses
10 might have known.
11 So what I would say for the 73 and 83 syllabus, the
12 nurses would have known what was normal, they would have
13 known about the importance of observations and they
14 would have known about the importance of observing and
15 measuring because of the impact it was going to have on
16 fluid balance and beyond that it then became a problem
17 or an issue for the doctor to -- because the important
18 thing from the nurse's perspective is they had to tell
19 the doctor, otherwise the doctor wouldn't have known.
20 Because the doctors have 50-and-one different things to
21 do. The nurse is the person on the 24/7 around the bed
22 by the patient and therefore they had a responsibility
23 and a duty of care to keep the doctor informed of
24 what was happening to the patient, and in particular,
25 in relation to children, they had to be the child's

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1 A. I heard that. I have no difficulty whatsoever with
2 the -- I mean, the -- and I'm not talking about any
3 particular patient here, I'm speaking generally. If
4 a patient complained of nausea, the first thing you did
5 was you went and got a receiver, set it on the locker by
6 the patient's bed in case they were sick. Patients
7 never wanted to vomit on their bedclothes or on their
8 nightdress or pyjamas. It gave them a comfort that
9 there was something there they could be sick in to. In
10 my experience and in the way we taught, you would always
11 have made every effort to measure the amount that a
12 patient vomited and particularly when that vomiting was
13 persistent because that was very significant in being
14 able to continuously assess the patient.
15 THE CHAIRMAN: Thank you.
16 MR WOLFE: We've highlighted here measuring and recording
17 fluid intake and output. To what extent was the
18 teaching designed to impart, if you like, a more
19 sophisticated knowledge of when electrolytes were in
20 danger of being imbalanced?
21 A. There would have been reference in the 73 and 83
22 syllabus to the importance of -- as a reason for
23 recording, say, the amount of vomit. There would have
24 been reference in the lectures to explaining to the
25 nurses that it wasn't just the fact that the patient was

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1 advocate if the parents weren't readily available.
2 Can I just say, sir, that I'm not talking about an
3 ideal world here? I'm talking about what is expected of
4 any reasonable nurse. And I want to make that point.
5 These are the things that nurses were taught in respect
6 of caring for patients.
7 Q. And I ask that question about whether the education was
8 such as to give nurses an insight into the potential for
9 electrolyte imbalance because presumably it was
10 necessary to have at least a basic understanding of that
11 so that you knew when to red flag the doctor?
12 A. I mean, they had to know what the adverse effects of
13 either continuous and significant vomiting or diarrhoea
14 was having on the patient, so that they would be able to
15 alert the doctor to that.
16 Q. Yes. If we could then go over the page to 603 and
17 highlight there another part of the syllabus, "The study
18 of man and his environment". So what you're telling us
19 or what this curriculum is telling us is that there was
20 education afforded to nurses and during that period
21 in relation to the general structure of the body --
22 A. Yes.
23 Q. -- in relation to function, how the body works.
24 A. Yes.
25 Q. And is --

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1 A. We went from the normal to the abnormal, sir, if I can
2 put it that way. So the nurses had an understanding of
3 what normal body functioning was, what the different
4 structures within the body, what their role and function
5 was and we moved from that then to how disease and
6 illness could affect them.

7 Q. On down the page under (iii), you set out part of the
8 programme, which was "The nature and causes of ill
9 health, principles of prevention, nursing care and
10 treatment of sick people". And under the bullet point
11 within that section, there's a requirement to have an
12 ability to interpret the observations made.

13 A. Yes.

14 Q. "To understand the significance of disturbed function
15 and to know the pattern of defined diseases and the
16 patient's response to treatment [et cetera]."

17 When it talks about observations there, is it
18 talking about vital signs, the pulse, the temperature,
19 blood pressure, or observations broader than that?

20 A. That's part of -- I mean, what I would call the
21 technical observations, that's the taking of
22 a temperature, the checking of a pulse, the counting of
23 respirations of the taking of blood pressure. When you
24 went to a patient, you didn't only depend on what
25 recordings you made, you also listened to what the

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1 cyanosed or restless.

2 Q. Part of this must be experience --

3 A. Yes.

4 Q. -- but to what extent were nurses educated or trained as
5 part of their educational programme in relation to these
6 observations?

7 A. Without a doubt, observation was not just temperature,
8 pulse and respirations. Observations was all the things
9 that I have just described.

10 Q. But how can that be taught? How was it taught?

11 A. How was it taught? Well, for example, very much you'd
12 have taught observations as a nursing lecture and then
13 when you went to -- I'm taking bronchitis because it
14 takes us away from why we're here -- but when you went
15 to teach about bronchitis, you'd have gone again into
16 the vital symptoms that the patient would have
17 demonstrated, so the nurse would have not only known
18 about blood pressure, pulse, temperature, but then she'd
19 be looking at respiration rate, and it would be raised,
20 whether the patient could breathe easily or whether they
21 had pain. And you'd be looking at the colour of the
22 skin because quite often it would be quite cyanosed.

23 So it's wrong to say that temperature, pulse and
24 respiration and blood pressure was the beginning and end
25 because they're four and they're only four of a variety

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1 patient had to say, you asked them how they were in
2 comparison to earlier in the day or if they had some
3 treatment had they responded positively or negatively to
4 that. And you looked at things like the colour of their
5 skin, you looked at whether they were alert, whether
6 there were drowsy. So you weren't just doing the -- you
7 weren't doing tasks, you were dealing with a whole
8 individual and that was the whole process.

9 When we talked earlier on about assessment,
10 planning, implementing and evaluating, and when also
11 that made reference to what was described as
12 "individualised care", because you could have two
13 patients coming in with bronchitis, for example, but
14 they wouldn't necessarily have exactly the same set of
15 symptoms. One might have a more harsh cough with blood
16 in the sputum, another might have a hacky cough. So you
17 had to listen to the individualised symptoms that the
18 patient complained of, and that process that I have
19 described earlier on ran through in terms of an
20 individualised approach.

21 So when you went to the patient, you just didn't
22 take their temperature and walk away, you had a sixth
23 sense sometimes about patients also. From experience,
24 you would know that that person wasn't as good as they
25 were earlier in the day. Maybe they were a bit more

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1 of symptoms that a patient would present with. And the
2 nurse would know from the medical diagnosis of the
3 patient coming in what to expect. So therefore, you
4 would be looking for more than just the things that are
5 very often described as observations, which are
6 temperature, pulse and blood pressure, respirations.

7 Q. Could we go over the page to 604, please? For the nurse
8 to be carrying out observations, both technical and
9 these more general type observations that you've
10 described, they will need to know something about the
11 expected course of a disease; isn't that right?

12 A. Yes.

13 Q. I see listed at (e), "Normal course of illness, possible
14 complications". Was that part of the syllabus?

15 A. Yes, oh absolutely.

16 Q. Can I ask you this: we're dealing here in this inquiry
17 with Raychel's care and treatment, we're dealing with
18 intra-abdominal surgery.

19 A. Yes.

20 Q. The inquiry has heard a lot of evidence about what might
21 have been expected following a, if you like,
22 straightforward piece of surgery and what are the
23 possible complications. Was something as specific as
24 that kind of surgery in the child patient something that
25 was taught as part of the 1973 and subsequent education

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1 programmes?
2 A. In respect of -- if you take the removal of the gall
3 bladder, which is a fairly simple straightforward
4 operation, or you can take appendicectomy if you wish,
5 the normal healing process and the normal expected
6 outcome would be taught. And there was always a section
7 in each of the lectures that we did for what was
8 described as possible complications. And the possible
9 complications that you could expect in, say,
10 appendicectomy, would be where the gut has been handled
11 and have the appendix removed, that you would maybe get
12 a period -- and the doctor referred to it this
13 morning -- where the bowel activity stopped. And in
14 respect of that, it'd be very important, the nurses
15 would be taught that when you start to give the patient
16 fluids after surgery, that you start with very small
17 amounts because if the gut isn't working in the
18 peristaltic movement way, which is like contracting and
19 relaxing, if you give them too much fluid, the patient
20 starts to be sick, so you have to pull back from that.
21 Nurses would know that, they would have been taught
22 that, they would have reported when the doctor come to
23 do the round that they had attempted to give fluid, but
24 it didn't work, or whatever the situation was.
25 If you had an appendicitis that was burst -- and I'm

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1 administration. She said Solution No. 18 was the fluid
2 that she understood to be a safe fluid because it had a
3 little sugar in it. But just dealing with the point
4 about training in relation to IV fluid administration,
5 and just that point, would she have had training
6 in relation to IV fluid administration if she had
7 followed the education arrangements before 1973?
8 A. Yes, because I was in that period and we were very
9 clearly taught in the classroom. In fact, there was
10 a bed in the practical room, there was a giving set,
11 there was a fluid -- bag of fluid attached to it, and
12 we were all taught about -- now, in those days it was
13 very much the prerogative of doctors to put up the
14 giving set, to put the needle into the patient's vein,
15 so the doctor did all of that. And we were taught --
16 and I taught also -- that the responsibility then of the
17 nurse was, once the fluid was erected, to make sure that
18 the prescribed rate and flow and that the site where the
19 cannula or the needle was in the arm -- or wherever it
20 was -- that that was not infected and that it was still
21 in place and that the amount was to be given over
22 a period of time or whatever particular ... That was
23 part of the teaching prior to 1971. Most definitely.
24 Q. Moving into the point that she makes about not knowing
25 anything about a replacement regime --

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1 sure we've all heard of a burst appendix -- that is
2 a much more serious situation because in that situation
3 there would likely have been some faecal matter would
4 have released out into the abdominal cavity. That again
5 is a serious complication and the nursing practice is of
6 greater intensity around that patient because that
7 patient has the potential of being ill, they would be
8 put on maybe intravenous antibiotics. So all of that
9 was covered, it wasn't just a light lecture on somebody
10 has their appendix out, you do this. You go into the
11 straightforward -- what the normal pathway would be and
12 then you look at what complications might arise, and the
13 complications that might arise, one of them would be
14 vomiting. I've partly given a reason for why that would
15 be.
16 Q. Yes. Before leaving the 1973 syllabus and moving on,
17 could I put to you some perspectives offered by some of
18 the nurses who came through that programme? Just having
19 said that, can I start with Nurse Millar, who didn't
20 come through that programme --
21 A. She came through the same era as I did, so I'm well able
22 to speak to that.
23 Q. She said in her evidence on 28 February 2013 at page 21
24 that she didn't know anything about a replacement
25 regime, she had never had any training on IV fluid

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1 A. I can't really comment on that because not until
2 latterly would I have also learnt about the difference
3 between what we would have called maintenance fluid and
4 I mean I was familiar in my clinical experience of
5 a No. 18 Solution being put up, but I'm not speaking
6 about children, sir, I'm speaking about adults. But
7 No. 18 was the fluid of choice that was put up if
8 somebody was losing fluid until more monitoring was done
9 as to what electrolytes -- replacement, whether it was
10 potassium, sodium or whatever that needed to be
11 replaced.
12 THE CHAIRMAN: Sorry, just to get that clear, professor,
13 it's only latterly that you know of the difference
14 between a replacement fluid regime and a maintenance
15 fluid regime?
16 A. Yes.
17 THE CHAIRMAN: And until then, the general point that the
18 nurses have made is that they understood the big risk
19 for Raychel was dehydration and they understood that, as
20 long as she was getting IV fluid, that would prevent her
21 getting dehydrated and therefore they thought she was
22 safe in terms of fluid. And that is the context in
23 which they were being asked about the difference between
24 replacement and maintenance fluid. Do I understand from
25 your last answer that, in broad terms, you accept their

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1 evidence?

2 A. In broad terms I would say that there wasn't a great
3 differentiation made between maintenance and
4 replacement. I think that's the point I want to make,
5 that the importance was that whatever fluid was
6 prescribed by the doctor was -- that the nurse's
7 responsibility was to make sure that that fluid was
8 given at the right rate at the right time and all of
9 that. So it was really about ensuring that the patient
10 was getting fluid replacement or maintenance, as the
11 case may be. It wasn't terminology that was widely used
12 back when I was in practice. It was something that has
13 come in much latterly because people are making that
14 differentiation now.

15 THE CHAIRMAN: When you say "latterly", are we talking about
16 the last 10 years or ...

17 A. Well, when I hear that I'm 35 years teaching, I find it
18 difficult. But it would probably have been more around
19 the introduction of Project 2000 where there was
20 a greater emphasis on the nurses knowing in more detail
21 about the whole electrolyte balance thing. Because
22 prior to that -- and even to this day -- that
23 responsibility still rests with the doctor. They have
24 the responsibility for making sure that the right fluid
25 is in place for the patient.

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1 replaced. Can I ask you this: should nurses have
2 appreciated the different types of fluids and their
3 composition that were available?

4 A. Yes, they would have been -- that would have been part
5 of the teaching in respect of when you were talking
6 about intravenous fluids. For example, if you're
7 talking about a patient coming in with diabetes, for
8 example, in the main it would be like a glucose
9 infusion. Where somebody was vomiting, you would be
10 talking about maybe a normal saline being put up. But
11 the point I'm trying to make to you is that while we
12 talked about that and they would have recognised that
13 when they were checking the infusion that they needed to
14 make sure it was a No. 18, or it was a normal saline or
15 it was a dextrose infusion so, that they didn't put up
16 the wrong one, and that they were doing was following
17 the doctor's prescription.

18 With experience and indeed with discussion, nurses
19 would have picked up that there needed to be different
20 fluids put up and sometimes, for example, something like
21 potassium had to be added. Nurses would have known
22 that. And that would have been the result of blood
23 sample being taken for electrolytes and urea, that will
24 go off to the laboratory and come back and just by the
25 very presence that you're there and you're knowing about

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1 THE CHAIRMAN: Thank you.

2 MR WOLFE: Just to build on that point with some of those
3 who went through the 1973 curriculum, to take for
4 example Staff Nurse Noble, she says she was familiar
5 with maintenance, what maintenance fluids meant, but she
6 had used the term "replacement fluids" almost
7 interchangeably with maintenance when she came to write
8 her statement to the inquiry. That level of confusion
9 on the part of nurses, thinking that because an infusion
10 was in place while a child was vomiting, those fluids
11 were being replaced, is that a confusion that you can
12 understand of those who came through the 1973 programme?

13 A. Yes, because, like I've said already, the
14 differentiation between maintenance and replacement
15 wasn't all that often articulated. It was the fact that
16 the patient would have an intravenous infusion put up or
17 erected to make sure that their fluid balance was
18 maintained. What was put up was the responsibility of
19 the doctor.

20 Q. Again, Ms Ramsay, who has given evidence to the inquiry,
21 said in her report that, as a minimum, she would expect
22 experienced paediatric nurses to be aware that where
23 there are gastric losses, they needed to be replaced.
24 Perhaps the difficulty is that the nurses were assuming
25 that because an infusion was in place, they were being

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1 the patient and you would see because the laboratory
2 technicians would highlight abnormalities, you would
3 know that this patient needed some of those things. But
4 you know, this was a partnership working between the
5 nurse and the doctor with the doctor taking the lead in
6 respect of what fluids go. So I don't want to say here
7 categorically that the nurses would have, should have
8 known back in those early days about the difference
9 between maintenance and replacement. What they would
10 know was that the patient needed to have intravenous
11 fluids and that the doctor would direct as to what that
12 should be.

13 THE CHAIRMAN: Let's suppose you had a nurse who, through
14 experience or training, is more alert to the fact that
15 the fluid can be supplemented with potassium or sodium
16 and that isn't happening, what was the training of
17 a nurse to do in that scenario?

18 A. Well, any time that -- I mean, taking the example that
19 I've been listening to where you had a patient who was
20 on an ongoing intravenous infusion and the vomiting was
21 continuing, then the responsibility -- I'm back to
22 saying that the responsibility for the nurse was to make
23 sure that the doctor heard loud and clear that this
24 person is continuing to vomit.

25 THE CHAIRMAN: In practical terms, that means that the

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1 doctor's bleeped, the doctor rings the ward to find out
2 why and then comes to the ward. Is that the importance,
3 when the doctor arrives at the ward, of having
4 a discussion, even if it's a short discussion, with
5 a nurse?

6 A. Well, first of all, the nurse exercised her duty of care
7 to the patient by ringing the doctor. But she has to
8 continue that, and if she's not going to be there when
9 the doctor comes, she needs to make sure that whoever is
10 there will give the doctor the right message.

11 THE CHAIRMAN: It cuts both ways, professor, doesn't it?
12 Doesn't the doctor have to make sure he gets the right
13 message?

14 A. Yes, but the doctor is -- I've said it before. The
15 nurse is there 24/7. So the nurse is the person
16 observing the patient and making sure that any
17 difference in the health status of the patient is picked
18 up. It is for the nurse as the accountable
19 practitioner -- and I'm saying that deliberately -- who
20 has experience of dealing with patients to be picking up
21 on what are the changes that have happened in the
22 patient's life from when they were seen previously,
23 making sure that that is -- and it would be verbal and
24 written records, which is important. And that the
25 doctor is made absolutely clear as to what it is that

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1 different, using language that was familiar at that
2 time. The information presented is based on general
3 nursing guidance as it has not been possible to locate
4 a 1983 guidance document."

5 A. Yes. The responsibility for the approval of all syllabi
6 for the schools of nursing in Northern Ireland were held
7 by the Northern Ireland National Board and that was from
8 1983 through to 2002. So when I went to look for all of
9 those documents nothing was available at the Public
10 Records Office from 1986 to 2002. So the best efforts
11 was to see what colleagues who had retired and had gone
12 elsewhere and to see what I could get -- but there
13 didn't appear to be a significant difference in what was
14 in the 73 syllabus and what was in the 83 syllabus. So
15 the emphasis would still have been there on records,
16 record keeping, input and output charts, observations
17 and so.

18 Q. And so the points that you have made and illustrated by
19 reference to the curriculum guidance document for 1973,
20 we can imagine that they were in place in 1983 as well?

21 A. Absolutely, they didn't waver because it was about
22 nursing care.

23 Q. On this page then, you indicate the introduction of the
24 Project 2000 programme.

25 A. Yes.

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1 the nurse -- you see, I think it's important that the
2 doctor understands why the nurse is concerned.

3 THE CHAIRMAN: Yes.

4 A. And that's the message, that's the communication that
5 has to exist first of all. Because if I bring a doctor
6 just because somebody has had one vomit, the doctor will
7 say, "That was a bit of a fuss about nothing because
8 anybody can be sick". But if the patient is vomiting
9 and continues to vomit and the amount of vomit and all
10 of that -- and that has got to be emphasised to the
11 doctor that this is somebody who is not as well as they
12 were in the morning --

13 THE CHAIRMAN: Right.

14 A. -- and here are the reasons why, because it's important
15 to back that up.

16 THE CHAIRMAN: Thank you.

17 MR WOLFE: The 1983 syllabus. You deal briefly with that in
18 your report, moving along to 605. I think the problem
19 for you was that you weren't able to obtain a copy of
20 the relevant guidance; isn't that right?

21 A. Yes. The --

22 Q. You can see it in front of you. You say:

23 "In relation to the IV management, record keeping
24 and communication, the outlying content is very similar
25 to that set out in the 1973 syllabus. The layout is

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1 Q. And you set out over the page the curriculum reference
2 to IV fluid management, record keeping, communication
3 skill and accountability, and if we could look at that
4 at page 606. What are you setting out here, just to be
5 clear? You've highlighted at the top that you're
6 looking at a particular unit, unit C8 of "The well
7 child".

8 A. Yes.

9 Q. Is this part of the general nursing Project 2000 course
10 or is it specific to children?

11 A. It's specific to children. This is part of the
12 Altnagelvin-approved programme that was delivered in
13 respect of the care of children because they had
14 a children's programme.

15 Q. Yes.

16 A. And the Project 2000 programme was very much based on
17 a wellness model or a health model and looking at what
18 the healthy child was like and then moving into the
19 difficulties that children can encounter. So the unit 9
20 then, that was looking very much at the importance of
21 the communication that should be used with the child and
22 family.

23 Q. Can I just stop you there? One of the nurses, that is
24 Staff Nurse McAuley, came through Project 2000 towards
25 the end of that decade and into Queen's for the final

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1 two years of her studies. Broadly speaking, albeit that
2 she attended for her training in Belfast, this is an
3 Altnagelvin programme?
4 A. Yes.
5 Q. But broadly speaking, is this the kind of material that
6 she should have followed when studying for her
7 certificate in children's nursing?
8 A. Well, first of all, she started in -- what year did you
9 say she started? Started in 1996, did she?
10 Q. Yes. That's right.
11 A. Well, like I said earlier, because that was the
12 programme that she started with, she would have
13 continued on that particular syllabus, even though the
14 students were moved into Queen's, because that was
15 a legal requirement, that they would complete the
16 programme they signed up to in the beginning. So all
17 that's on that page would all have been part of her
18 theory and then the associated practice would have been
19 got in the clinical areas.
20 Q. And then just looking through it at various aspects,
21 section 12, number 7, communication with children and
22 family will have been taught?
23 A. Yes, absolutely.
24 Q. And again, we've heard of a concept of family-centred
25 care. Is this the principle that's being articulated in

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1 that's on that -- and can I just emphasise that that
2 would have been checked out by about the National Board
3 officers who would have come and inspected what the
4 teachers were doing in the colleges to make sure that
5 the components of the syllabus that they set out were
6 being taught.
7 Q. It was something you said earlier, professor, where
8 I think you said that by contrast with the programmes of
9 73 and 83, by Project 2000 trainees, pre-registration
10 nurses are getting in a bit deeper in terms of the
11 detail that they're getting about electrolytes and what
12 have you.
13 A. Well, even the very fact that it's mentioned there about
14 fluid and electrolyte imbalance is a deviation to what
15 I would have been able to put in the 73 and 83 syllabus.
16 Q. Over the page to 607. We jump around a little bit, but
17 at the bottom of the page, under unit C10, again
18 number 3, "Adequate fluid and electric [sic] balance" --
19 A. I think that should be "electrolyte".
20 Q. -- is being taught in that part of the programme as
21 well. Just help us with this: does that suggest that
22 under the various units that are being taught, this
23 issue is coming up on a repeated basis?
24 A. Yes, you can see that the knowledge base is deeper, so
25 therefore under the Project 2000 programmes there was an

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1 a course such as this?
2 A. Yes. The first thing I would want to say about that is
3 that in the main that Project 2000 programme -- the
4 students who were undertaking that course of study had
5 to have their nursing care delivered by nurses who were
6 already registered sick children's nurses and who then
7 went on and embarked on an teaching programme. And that
8 again had to be underpinned by them having a degree
9 because they were teaching students up to diploma level
10 at that stage. So the whole notion of the child as part
11 of a family coming into hospital to be cared for was the
12 setting in which the nurses would have been taught. So
13 they weren't looking at just the child, they'd have had
14 to have looked at the child in the context of the
15 family, whatever that family looked like. It could have
16 been grandparents or it could have been, you know,
17 mother and father. So it had to be looked at -- and
18 indeed the impact of the child's illness on siblings.
19 Q. It goes on in this page under section 8 towards the
20 bottom:
21 "Nursing theory and practice. Fluid and electrolyte
22 imbalance."
23 That's something that was taught?
24 A. Absolutely. Yes, that's a direct lift, sir, out of
25 their programme in Altnagelvin, and therefore everything

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1 expectation that the nurses would have a deeper -- they
2 were described as "the knowledgeable doer", so therefore
3 there was an expectation that they would have a greater
4 knowledge base. Now, that -- can I just say that while
5 they were being taught that, that was not to undermine
6 in any way the role the doctor had for making sure that
7 the patient got the right fluids. But it gave the nurse
8 a knowledge base on which to make an accurate report to
9 the doctor. Is that fair?
10 Q. Yes.
11 THE CHAIRMAN: Is this part of what has been broadly
12 described to me as the developing importance of nurses
13 and them asserting more of their own professional
14 obligations and standards?
15 A. Yes. And to be fair, sir, that only comes about when
16 you're knowledgeable.
17 THE CHAIRMAN: Yes.
18 A. It can come about with experience also, but the whole
19 purpose of having the Project 2000 programme and having
20 it at diploma level was to make sure that nurses were
21 more knowledgeable and therefore could make informed
22 decisions on the basis of the care they were delivering
23 and what the patient's response to that was so that they
24 could -- I'm not saying that the pre-1990 nurses
25 couldn't actually reflect what the patient's state was,

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1 but this was to equip the nurses with a bit more
2 knowledge and make them -- what they described as
3 "knowledgeable doers".
4 THE CHAIRMAN: But it enables them to make a more
5 significant contribution?
6 A. Yes.
7 THE CHAIRMAN: And if they can do that, then is it their
8 obligation to do that by raising issues with the doctors
9 that they didn't necessarily raise before?
10 A. I'm not sure that I agree with that.
11 THE CHAIRMAN: "To be more assertive" is how I think it was
12 described to me at an earlier stage in the inquiry.
13 A. I would say this: that in all of my own experience and
14 in teaching, that what was important was that you did
15 what was required by way of giving good care to
16 a patient, that you were clear about the observations
17 you were making and that you made sure that if there was
18 any deviation that you were concerned about, that that
19 was communicated to the doctor.
20 THE CHAIRMAN: Okay.
21 A. The point that I think I'm making here at C10 is that
22 the nurse, having come through the Project 2000
23 programme, would have a greater knowledge base upon
24 which to maybe make a better decision about why
25 a deviation has occurred, but again it doesn't absent

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1 the patient responding in terms of how they're getting
2 on or how they're improving or deteriorating. So the
3 nurse has to use all the powers of observation to make
4 sure that they're capturing any changes in the patient's
5 condition. It's much easier to do it when a patient is
6 conscious, but I'm throwing that in because it
7 highlights the need for nurses to use their powers of
8 observation all the time and to -- if they see something
9 that they think is going wrong, at least report it to
10 the sister or talk to the doctor about it. Continuous
11 evaluation is making sure that whatever care is being
12 delivered is having the desired effect.
13 Q. To use an example closer to home, we've heard about the
14 fact that Raychel was nauseous and had vomited on the
15 morning of 8 June and there was some period of time into
16 the late afternoon before an anti-emetic was prescribed.
17 In that context, what should the teaching or the
18 education of nurses have taught them which would have
19 assisted them in that context?
20 A. I think, first of all, it would be important to remember
21 that when somebody's had an anaesthetic and they have
22 been fasting for a period of time before they had the
23 anaesthetic -- when patients in general are recovering
24 from an anaesthetic it is very, very common for patients
25 to be nauseated and to vomit. So that is almost like

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1 her from referring it to the doctor because, at the end
2 of the day, all we do is carrying out the doctor's
3 instructions --
4 THE CHAIRMAN: Thank you.
5 A. -- in most cases, except you were very sure that
6 something that they were advising wasn't, and then you
7 can take that up at a more senior level.
8 MR WOLFE: Towards the top of the page, there's a reference
9 to continuous evaluation of care. In practical terms,
10 what is that getting at?
11 A. That's ... If you are delivering an aspect of care such
12 as pain relief, it's not enough to just go and give the
13 patient the medication that's been prescribed, it's very
14 important to go back after half an hour or so to find
15 out if that medication had the desired effect, or
16 indeed, if the patient calls you and said, "I don't feel
17 well, I've got this or that", it may be that the
18 patient's reacting to the medication that's been
19 prescribed. That's what I mean by continuous
20 evaluation. When you're working with patients, you're
21 continuously observing purely by the content of
22 conversation and by your own powers of observation
23 whether or not you think the patient is -- I mean, if
24 you're ... On many occasions, nurses are looking after
25 unconscious patients and therefore they have no way of

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1 a normal reaction to the anaesthetic and indeed because
2 the patients were hungry and that means that their
3 stomach is filled with gas and that makes a patient
4 sick. So you have to differentiate between that as
5 a kind of normal reaction to the anaesthetic and then
6 something that develops as the day goes on because
7 I can't -- and you may help me, but my understanding was
8 that the patient's progress after surgery, which was
9 about 1 o'clock in the morning, through, was uneventful,
10 I would describe it as uneventful. Therefore they had
11 started to give the patient sips of water.
12 Q. Yes.
13 A. Am I right on that?
14 Q. That's right.
15 A. That was a period of natural progression, which you
16 would have expected. Then when you started to find that
17 there was nausea and vomiting, then you began to think
18 something else isn't right. My first thought would
19 be: has this peristaltic movement that I talked about
20 earlier, is that not functioning? So you would begin to
21 be concerned about why the person who was well and
22 taking sips of water suddenly began to be sick. So even
23 at lunchtime your concerns would begin to be heightened.
24 MR QUINN: Mr Chairman, I think the learned professor may
25 have got it slightly wrong in that the parents will say

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1 all she had was maybe one sip of 7 Up.
2 THE CHAIRMAN: Two capfuls.
3 MR QUINN: Maybe two caps of 7 Up.
4 THE CHAIRMAN: Yes.
5 A. I knew she had some fluid.
6 MR WOLFE: Two small amounts, described as "capfuls".
7 THE CHAIRMAN: We are talking about negligible amounts of
8 fluid. I mean, very small caps; is that it?
9 A. Yes.
10 THE CHAIRMAN: Two small caps.
11 A. In fairness, when you're starting a patient off post
12 anaesthetic, or post surgery, you'd be talking about
13 a spoonful, a sip of water, just to see how that is
14 tolerated by the patient. So that's not that abnormal
15 an amount. But as the day went on and the patient got
16 more nauseous and vomiting, then you would be -- if
17 I could just say that as it moved towards what I would
18 call close of play for doctors, it would be very, very
19 important that the people on the ward would have made
20 sure that the patient was seen before doctors go home.
21 MR WOLFE: Is that 5 o'clock or 6 o'clock?
22 A. About 5 o'clock or 6 o'clock. Once the consultants and
23 senior staff leave the hospital, it's actually quite
24 difficult to get them back. So it is important that if
25 you see somebody whose condition is deteriorating then

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1 Again, it would appear that there's overlaps or
2 similarities between that and the one that we've just
3 been looking at. If we could --
4 THE CHAIRMAN: There should be, shouldn't there, because
5 they're all coming from the same base document?
6 A. Yes, it's all coming from the National Board's guidance,
7 which had been circulated to all the colleges of
8 nursing.
9 MR WOLFE: What Staff Nurse McAuley said in her evidence was
10 that she can't recall whether she was taught about the
11 circumstances in which a risk of electrolyte imbalance
12 might occur. Looking at the syllabus, certainly
13 electrolyte imbalance was something that was apparently
14 taught.
15 A. Yes, yes it was. And if I could just say, sir, I'm not
16 a trained children's nurse, but we did a module for
17 children's nursing within the adult syllabus and very
18 specific attention in preparation for nurses going to
19 work on the children's ward because the ratio of fluid
20 content in the body is greater in a child than it is in
21 an adult, and therefore any deviation in relation to
22 fluid imbalance in a child is more significant. So even
23 as an adult-trained nurse working in a children's ward,
24 we were taught that and the students were taught that.
25 So I'm not accepting at all that that wouldn't have been

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1 you highlight that so something can be done.
2 Q. You have gone on in your report --
3 THE CHAIRMAN: Sorry. To be fair, that did happen. Because
4 there had been a delay in a doctor responding to the
5 bleep in the mid to late afternoon, it was Sister Millar
6 who went out on to the ward and effectively grabbed
7 a passing doctor, Dr Devlin, to ensure that Raychel
8 would be seen. So she was making -- so that fits in
9 with what you think --
10 A. Yes.
11 THE CHAIRMAN: -- should have been done, to make sure that
12 a doctor does see --
13 A. Yes.
14 THE CHAIRMAN: Okay.
15 MR WOLFE: You've gone on in your report at page 609 to set
16 out the syllabus from Northside College; is that the
17 Belfast based --
18 A. Yes.
19 Q. -- campus? When I asked you about Staff Nurse McAuley
20 earlier, I should perhaps have been pointing you in the
21 direction of this syllabus because she was following the
22 syllabus in Belfast and she was working towards
23 a certificate in children's nursing.
24 A. Diploma.
25 Q. A diploma in children's nursing, which she achieved.

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1 taught.
2 Q. In fairness, it's a recollection issue that she has
3 raised, not a denial that it was taught.
4 A. Well, if I could just say, being taught -- but working
5 in the Sick Children's Hospital in Belfast, because
6 I had responsibility for that when I was the Director of
7 Nurse Education there, it would have been quite unusual
8 to have had a child in the Children's Hospital that
9 wouldn't have at some point needed intravenous fluids.
10 It's a very common procedure, given the serious --
11 because that was the central hospital for the sick
12 children.
13 THE CHAIRMAN: Yes, you got the sickest children.
14 A. Yes. The sickest children, and therefore they were the
15 ones who needed the greatest care.
16 MR WOLFE: She says that she was certainly taught that an
17 electrolyte profile was carried out to assess
18 electrolyte balance as directed by medical staff, so she
19 can certainly recall aspects of that.
20 So just to sum it up, Professor Hanratty, what
21 you're saying is that throughout the recent history of
22 nursing education in this jurisdiction in the periods
23 described, you are confident on the basis of your
24 research and practical experience that nurses had
25 a thorough grounding in the importance of fluid balance

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1 in a patient?
2 A. Yes, I'm absolutely certain of that, and indeed also not
3 only of fluid balance, but in the importance of the
4 maintenance and the delivery of fluid, the whole
5 management of fluid processes, whether it be intravenous
6 or parenteral or whatever. That was all taught because
7 that bit of it is very much the purview of the nurse, to
8 be there at all times for the patient.
9 Q. And you've reflected the fact that the degree of
10 intensity of that education programme in that area was,
11 if you like, ramped up after 1990.
12 A. Yes.
13 Q. And that's reflected in the syllabus that we've just
14 looked at.
15 A. There was 30 per cent more time for the students to be
16 in the classroom and to get that increased depth of
17 knowledge. It wasn't made available to students who did
18 the earlier programme, so they only had 20 per cent of
19 classroom time.
20 Q. And the second point then, in summary, is in relation to
21 that important area of observations throughout the whole
22 recent history of education delivery to nurses. That
23 was a point that was again emphasised, not just the
24 technical observations, but these more generalised
25 observations and the importance to evaluate a patient's

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1 all, in turn, delivered to the nurses and they would
2 have had notes and handouts to support that.
3 MR WOLFE: Very well. Sir, I have no further questions?
4 THE CHAIRMAN: Can I take you off track for a moment? One
5 of the things that worried me much more so in Adam's
6 case than Raychel's is that, when Adam died and there
7 was some form of inquiry or scrutiny of what happened in
8 the Royal, no nurses were involved in that. In fact, it
9 was so poor that the Director of Nursing, Ms Duffin, who
10 I guess you know --
11 A. Yes.
12 THE CHAIRMAN: -- wasn't even aware that Adam had died,
13 despite the fact that it was described to me as "the
14 talk of the hospital". That suggests that at least in
15 1995 when the events around Adam took place that nurses
16 were almost regarded as being irrelevant to any
17 investigation or any follow-up or any scrutiny of what
18 happened. Are you surprised that when Adam's death was
19 being looked at by surgeons, anaesthetists and
20 nephrologists, that the nurses were effectively
21 excluded, or you're not surprised but ...
22 A. I really do feel I want to say something, but it's going
23 to be on the record, I take it.
24 THE CHAIRMAN: Either you respond on the record or you don't
25 respond, professor.

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1 care when you've carried out these evaluations.
2 A. Yes, and I used the unconscious patient as an example to
3 highlight that. The nurses were taught about the care
4 of an unconscious patient. Therefore, irrespective of
5 what communication there was between nurse and patient
6 or nurse and relative, the nurse had to have developed
7 a very acute sense of observation of the patient and
8 their condition because there was no response coming
9 from the patient and you had to be able to report that
10 when the doctors came to do the round if you didn't have
11 to send for them in the meantime. I think that's a very
12 important part of all of this, that emphasises that it's
13 not just about the taking of pulse, blood pressure or
14 temperature, it's about the skills that a nurse has.
15 Q. And the third point, in summary, was that nurses had
16 a grounding in terms of the education provided of what
17 to expect --
18 A. Yes.
19 Q. -- in terms of a normal recovery and deviations from
20 that?
21 A. We called them complications, but, yes, or potential
22 complications was probably a better way of describing
23 it. But that was all part of the lecture that was given
24 and we looked at specific entities such as
25 cholecystectomy, appendicectomy, thyroidectomy. It was

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1 A. Well, I will respond because I have made great play in
2 what I've said here this afternoon about the significant
3 and important role that nurses play in relation to the
4 24/7 care of patients. So if you're going to have an
5 investigation into a sequencing of events, how can you
6 do that sequence of events if you haven't got the people
7 who are there 24/7 to add to it?
8 THE CHAIRMAN: Yes.
9 A. That's what I would say, if that makes sense.
10 THE CHAIRMAN: It does, thank you very much.
11 Mr Quinn, any points?
12 MR QUINN: I have a question, Mr Chairman. I would like to
13 ask in relation to the vomiting, the large number of
14 vomits that went on in the day that the nurses observed,
15 in the professor's experience would that be cause for
16 concern among the nurses, having observed the child
17 vomit two, three, four, seven, eight, nine times?
18 THE CHAIRMAN: I picked up an answer that you gave a few
19 moments ago, professor, saying that you would have been
20 concerned by lunchtime or certainly from lunchtime on.
21 MR QUINN: Yes, I picked that answer up. I just want to
22 emphasise that. I wanted to ask, following on from
23 that, when should that concern have become, as it were,
24 urgent?
25 A. I'm not sure. I mean, I've heard the information that

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1 has been imparted here between yesterday and today about
2 what the family had reported in respect of their --
3 I mean, the whole emphasis of the care of a child,
4 whether they're in hospital or wherever is meant to be
5 a partnership arrangement between the nurses, the
6 parents and the child. So if the parents were coming to
7 me and telling me that their child was vomiting and if
8 they were bringing receivers or kidney dishes, whatever
9 they called it, with vomit in it, I would be absolutely
10 making sure that that was recorded and I'd be making
11 sure -- and that would be taught to nurses to make sure
12 that that was imparted to a doctor.

13 I made the point about 5 o'clock or 6 in the evening
14 because if the vomitus was gaining momentum and the
15 nausea was there, it was really quite important that
16 this was not left as a problem for the night staff
17 coming on. I haven't heard that mentioned, but that is
18 quite an important part of the relationship between day
19 staff and night staff. You don't set problems on the
20 night staff's hands that you could maybe have done
21 something about before the night staff come on.

22 So listening to what I've heard -- and I can only
23 listen and hear what I heard -- that really should have
24 been -- there should have been some action taken to make
25 sure that the night staff were not being left with

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1 they had no concern that Raychel's life was in danger as
2 opposed to not having a concern that she was vomiting
3 all day. Now, I'll take submissions about whether they
4 were concerned enough, but I think it's clear, and this
5 goes back to Claire again, I'm not sure that anyone
6 really picked up what was happening.

7 MR QUINN: Claire's case is slightly different.

8 THE CHAIRMAN: It's different in a whole lot of ways.

9 MR QUINN: Because no one realised how ill Claire really
10 was. The point I'm making in Raychel's case is -- the
11 parents make the point and they must make it through me,
12 that the nurses told them there was no cause for concern
13 at the September meeting. That's the point I'm making
14 here.

15 THE CHAIRMAN: Okay.

16 A. I think the time of day that that was articulated is
17 what's relevant here, if you don't mind me interjecting,
18 sir.

19 THE CHAIRMAN: If the nurses said in September -- sorry,
20 Raychel died in June, there was a meeting in September
21 with the family, at which some nurses were present. And
22 if it is the case that they said at that meeting that
23 they had no cause for concern about Raychel, then if
24 it's meant as starkly as that, that might be surprising.

25 A. Any time from particularly the 8 o'clock version that

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1 children who was gradually becoming more ill. I'm not
2 sure at what point the coffee-ground vomit -- but that
3 for me was absolutely something that I as the nurse in
4 charge would not have been looking to a junior doctor to
5 help me out with.

6 MR QUINN: Thank you very much for that answer.

7 THE CHAIRMAN: That takes us back into Claire's case a bit
8 because there was an issue about the day doctors
9 leaving, Dr Steen was one, and two others, Dr Webb and
10 Dr Sands, who all go away, and there's little enough
11 left being picked up about Claire on the evening; isn't
12 that right?

13 MR QUINN: That's correct. And following on from that,
14 could I ask through you again, this is for the
15 governance issues, trying to tidy up with a view to
16 looking forward to those issues. Could you ever
17 envisage a meeting occurring where the nurses, or one or
18 two or three nurses, sit back at that meeting and say
19 that they had no cause for concern about Raychel's
20 demeanour and her whole observations on that day?

21 A. Well, I suppose --

22 MR LAVERY: That's pure speculation, Mr Chairman.

23 THE CHAIRMAN: I think we had this point before, Mr Quinn.

24 I understand the point because it reads very starkly on
25 the witness statements, but I interpreted it as that

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1 I've heard onwards was cause for great concern.

2 THE CHAIRMAN: 8 pm?

3 A. Yes. I mean, I'm not sure that I've got exactly the
4 sequence of events, but there was --

5 MR WOLFE: Could I make the point clear that in terms of
6 this witness, Professor Hanratty, she has been briefed
7 to deal with the education process and so any example
8 that's put to her has to be filled out with the details
9 so she can adequately comment.

10 MR CAMPBELL: Sir, the questions of the nurses' concern and
11 the way that was expressed has to be put in the context
12 of them saying that they were analysing this in the
13 context of their expectation of this being normal
14 post-operative nausea and vomiting.

15 THE CHAIRMAN: Yes. I think there's probably a limit to how
16 far we can go on that.

17 Mr Campbell, do you have any issues? Mr Lavery?

18 Professor, thank you very much. Thank you for your
19 paper and thank you for topping it up today with your
20 evidence over the last hour and a half. You're free to
21 leave. Thank you very much.

22 (The witness withdrew)

23 Ladies and gentlemen, that brings an end to today's
24 hearing. Tomorrow we're having Mr Orr and Mr Foster,
25 who are going to give evidence together as the expert

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1 surgeons and taking into account also the additional
2 statement made by Mr Gilliland, as we discussed
3 yesterday. I understand that tomorrow morning there's
4 to be a consultation involving Ms Anyadike-Danes,
5 I think Mr Stitt and Mr Lavery maybe, and Mr Orr, and
6 I'm told to tell you we are starting at 10 o'clock sharp
7 tomorrow morning. We'll see.
8 (5.22 pm)
9 (The hearing adjourned until 10.00 am the following day)
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